

EXAMINING THE EXTENSION OF SPECIAL NEEDS PLANS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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EXAMINING THE EXTENSION OF SPECIAL NEEDS PLANS

WEDNESDAY, JULY 26, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322, Rayburn House Office Building, Hon. Michael C. Burgess (chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Barton, Shimkus, Murphy, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Green, Schakowsky, Butterfield, Matsui, Castor, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representative Costello.

Staff present: Paul Edattel, Chief Counsel, Health; Jay Gulshen, Legislative Clerk, Health; Katie McKeough, Press Assistant; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Counsel, Health; Jeff Carroll, Minority Staff Director; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Member Services, and Outreach; and C.J. Young, Minority Press Secretary.

Mr. BURGESS. Very well. I will ask all of our guests and Members to take their seats. The Subcommittee on Health will now come to order. The Chair recognizes himself 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Today the committee moves forward with its work in regular order to examine extending and improving the Medicare Advantage Special Needs Plans. Special Needs Plans enjoy bipartisan support because of their successful record in providing comprehensive coordinated care to two million Medicare beneficiaries.

This committee is especially interested in understanding how we can help improve Special Needs Plans for dual eligibles, since the majority of Special Needs Plans

enrollees are dually eligible beneficiaries who are enrolled in both Medicare and Medicaid. Dual-eligible beneficiaries often have multiple chronic conditions, physical disabilities, and cognitive impairments. Yet, too often, these very beneficiaries are forced to

navigate two Government programs with benefit structures, rules, and incentives that are often less than simple or intuitive.

Today, we embark on our process to try to not only extend the Special Needs Plans, but improve the tools that States and plans have to help these beneficiaries. So in addition to hearing from our three experts before us, we also invite stakeholders' feedback on a bipartisan discussion draft recently released. The goal is simple. We want detailed feedback from stakeholders on the policies and specific language in this draft. We all share the goal of helping improve health outcomes, enhance quality, and improve the patient experience for Special Needs Plans enrollees who are some of the most vulnerable, high-need beneficiaries in Medicare.

As a starting place, the discussion draft includes a number of provisions including reauthorizing the Institutional Special Needs Plans permanently, and extends the dual-eligible Special Needs Plans for 5 years. It streamlines Medicare and Medicaid benefits through one process so it is easier for duals to navigate their benefits. It improves access to supplemental benefits for patients with chronic illnesses through the inclusion of a bipartisan proposal supported by various members, including the gentleman from New Jersey, Mr. Lance. It enhances quality by directing HHS actions and holds us accountable for results, by requiring a number of studies so Congress receives appropriate feedback on policy changes.

I hope members will thoughtfully engage in today's discussion, examine the policies carefully, and provide feedback to committee staff as we move forward.

Thank you to each of our witnesses. We certainly look forward to hearing from each of you this morning.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

The subcommittee will come to order.

The chairman will recognize himself for an opening statement.

Today the committee moves forward with its work in regular order to examine extending and improving Medicare Advantage Special Needs Plans (SNPs). SNPs enjoy bipartisan support because of their successful record in providing comprehensive, coordinated care to about 2 million Medicare beneficiaries.

This committee is especially interested in understanding how we can help improve SNPs for the dual eligibles—since the majority of SNP enrollees are dually eligible beneficiaries who are enrolled in both Medicare and Medicaid. Duals often have multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness. Yet, too often, these very beneficiaries are forced to navigate two Government programs with benefit structures, rules, and incentives that are often less than simple and intuitive.

Today, we embark on our process to try to not only extend SNPs, but improve the tools that States and plans have to help these beneficiaries. So in addition to hearing from our three expert witnesses before us, but we want to invite stakeholder's feedback on a bipartisan discussion draft we released. Our goal is simple: we want detailed feedback from stakeholders on the policies and specific language in this bill. We all share the goal of helping improve health outcomes, enhance quality, and improve the patient experience for SNP enrollees who are some of the most vulnerable, high-need beneficiaries in Medicare. As a starting place, this discussion draft includes a number of provisions, including:

- Reauthorizes Institutional SNPs permanently and extends D-SNPs and C-SNPs for 5 years;
- Streamlines Medicare and Medicaid benefits through one process so it is easier for duals to navigate their benefits;

- Improves access to supplemental benefits for patients with chronic illnesses through the inclusion of a bipartisan proposal supported by various members, including Mr. Lance;
- Enhances quality by directing HHS actions;
- Holds us accountable for results, by requiring a number of studies so Congress receives appropriate feedback on policy changes.

I hope Members will thoughtfully engage in today's discussion, examine the policies carefully, and provide feedback to committee staff as we move forward.

Thank you to each of our witnesses. We look forward to hearing from each of you.

Mr. BURGESS. I would yield to the gentleman from Kentucky, but he is not here. Let me yield back my time, and I will yield to the gentleman from Texas, the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement, please.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman, and thanks to our witnesses for being here this morning. We are here to discuss the extension of the Special Needs Plans that serve some of our most vulnerable and highest need Medicare beneficiaries. The Medicare, Prescription Drug, Improvement and Modernization Act of 2003 established a new Medicare Advantage coordinated care plan, options specifically for individuals with special needs. This type of MA plans known as Special Needs Plans, or SNPs, are authorized to target enrollment to one or more types of individuals with distinct healthcare needs. Specifically, institutional SNPs, or I-SNPs, are largely enrolled beneficiaries who live in nursing homes; dual-eligible SNPs or D-SNPs, enrolled beneficiaries who are eligible for both Medicare and Medicaid; and Chronic Condition SNPs, or C-SNPs, enroll beneficiaries with certain severe and disabling chronic conditions like end-stage renal disease.

Since the enactment of the Affordable Care Act, all new and expanded D-SNP plans are required to have contracts with the State Medicaid agencies to coordinate and deliver benefits and the ACA created a subset of D-SNPs known as fully integrated, dual-eligible, FIDE SNPs.

Mr. Chairman, we have to keep up with all these short-term things.

More than 2 million Americans are enrolled in 600 SNPs nationwide. There is a great amount of variety across SNPs and how they work in each State. Since the ACA, SNPs have been extended four times, more recently in the Medicare Access and CHIP Reauthorization Act or MACRA in 2015. Authorization of the program is currently set to expire at the end of the calendar year. Discussions about SNP reauthorization has largely focused on duration of the authorization, with a growing number of stakeholders advocating for permanent authorization.

Today, I look forward to learning more about the advantage of long-term or permanent authorization of SNPs and I am also interested in how we can address challenges to integrating benefits and providing high-quality care for complex patients with health and socio-economic needs. The SNP extension is an opportunity to complement other efforts in Medicaid to integrate the delivery of benefits and improve care coordination and quality.

Finally, I would like to acknowledge the debate going on now in the Senate and actions the House took earlier this year will cast a shadow on the total discussion. The American Health Care Act and the Better Care Reconciliation Act both devastate Medicaid, ultimately cutting funding by 35 percent. Medicaid cuts will harm the ability of States to integrate in SNPs and other long-term services and support offering. Cuts in Medicaid will undermine these successes and harm our most frail citizens.

While Medicare provides critical benefits, Medicaid wraps around that coverage and fills in the gaps. I hope my colleagues will abandon the pursuit to return to meaningful bipartisan work to improve our health system, like improving and extending SNPs.

Thank you, Mr. Chairman. I look forward to today's discussion, and if anybody on my side wants my last minute and 50 seconds? No. I yield back, Mr. Chairman.

Mr. BURGESS. Will the gentleman yield?

Mr. GREEN. Sure.

Mr. BURGESS. So I have been contemplating introducing a bill that would modify or perhaps prohibit TLAs of the future. Three-letter acronyms. Does anyone else on the majority—

Mr. GREEN. I would be glad to co-sponsor it.

Mr. BURGESS. Does anyone else on the majority side seek time for an opening statement? Anyone else on the minority side seek time?

The Chair apparently concludes with opening statements. The Chair would like to remind Members, pursuant to committee rules, all Members' opening statements will be made part of the record.

We do thank our witnesses for being here today, taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by a round of questions from Members.

This morning, we will hear from Mr. Chris Wing, the CEO of SCAN Health Plan; Dr. Larry Atkins, President, National MLTSS Health Plan Association; and Ms. Melanie Bella, who has been to this committee before, I believe, consultant and former Director of the Federal Coordinated Health Care Office, Centers for Medicare and Medicaid Services.

We appreciate all of you being here this morning. Mr. Wing, you are now recognized for 5 minutes to give an opening statement, please.

STATEMENT OF CHRIS WING, CHIEF EXECUTIVE OFFICER, SCAN HEALTH PLAN; G. LAWRENCE ATKINS, PH.D., EXECUTIVE DIRECTOR, NATIONAL MLTSS HEALTH PLAN ASSOCIATION; AND MELANIE BELLA, INDEPENDENT CONSULTANT AND FORMER DIRECTOR, MEDICARE-MEDICAID COORDINATION OFFICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

STATEMENT OF CHRIS WING

Mr. WING. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you very much for the opportunity to testify today.

When it comes to SNPs, SCAN covers the waterfront. We are the only fully integrated dual-eligible SNP in California. We have an Institutional SNP in California. We also have three chronic illness Special Needs Plans in California.

Like patient advocates, SCAN supports permanence for all SNPs. SCAN does come at the subject from a special vantage point. SCAN was a Social HMO for 22 years before the demonstration project evolved into SNPs. We have seen over 3 decades how tailoring care to meet the special needs of seniors with complex conditions is the right approach. The care is better for the beneficiaries and the cost is less.

Let me give you one example. Several years ago, SCAN asked the research firm Avalere Health to compare SCAN's dual-eligible population in California to fee-for-service duals. Using the CMS' five percent sample, Avalere found 5,500 fee-for-service duals in California who had similar risk characteristics as our 5,500 duals. We tracked them for over 2 years. We called it a Doppelganger study.

What did it find? Hospital admissions were 14 percent less for the SCAN population. And re-admissions were 25 percent less. Not only did the extra care provided by SCAN provide better care for the beneficiary by eliminating hospitalizations and re-hospitalizations, but it saved the Government a significant amount of money.

It is clear that duals, who are the system's most in need and most expensive group of patients, are significantly helped by fully integrated D-SNPs. That is why SCAN supports permanency for D-SNPs.

We also strongly support moving all D-SNPs on an expedited schedule toward full integration.

C-SNPs have also succeeded in giving patients better care through added benefits and specialized networks. We think C-SNPs have also earned permanency.

We are happy that the committee is proposing to make I-SNPs permanent as well. However, let me point out one flaw with the current I-SNP structure.

SCAN runs an Institutional SNP in California, meaning that we strive to keep our nursing home eligible beneficiaries in their own homes in the community and not in the nursing home. However, our plan has shrunk dramatically because we are not allowed by law to give beneficiaries the home and community-based services they need to stay in the community and lead independent lives. To get those long-term services and supports, they have to spend down their assets and go on Medicaid and being dually eligible.

To rectify that, we strongly urge the committee to consider including bipartisan legislation introduced in the last Congress by Representatives Leonard Lance and Kurt Schrader, here on Energy and Commerce, as well as Representatives Linda Sanchez and Pat Meehan on Ways and means. It would create a demonstration project to target a limited amount of Medicare funding toward frail individuals who are in the cusp of spending down their income and becoming dually eligible. It would allow them to receive home and community-based services, which is now allowed today. This demonstration would allow these individuals to stay in their homes, where they and their families want them to stay, preserving their

dignity and comfort and would be a first step towards cost savings and entitlement reform.

Finally, we want to strongly support the provision in your bill which grants increased flexibility to all plans, not just SNPs, to use supplemental benefits for nonmedical services.

We appreciate you folks very much. Thank you.

[The prepared statement of Mr. Wing follows:]

Chris Wing
CEO, SCAN Health Plan
Energy and Commerce Health Subcommittee Testimony
July 26, 2017

Chairman Burgess, Ranking Member Green and Members of the Subcommittee:

Thank you very much for the opportunity to come before you today regarding extending Medicare Advantage programs for special needs beneficiaries.

SCAN has been designing programs for complex chronically-ill and frail seniors since 1984, more than 20 years before the advent of special needs plans. SCAN began as a community initiative to provide seniors with social services to help them continue to live independently in the community despite their mounting health challenges.

Today SCAN serves about 185,000 seniors throughout California, making us the fifth largest not-for-profit Medicare Advantage plan in the United States.

When it comes to special needs plans, we "cover the waterfront."

We are a fully integrated dual eligible special needs plan - the only one in California outside of the duals demonstration.

We have an institutionally equivalent special needs plan, meaning that all of our beneficiaries in that plan qualify for a nursing home under California standards, yet each person is able to continue living independently in the community with our support.

We also have three chronic illness special needs plans -- for heart, diabetes and end stage renal disease.

Like the rest of the health insurance industry, SCAN supports permanence for all SNPs. SCAN comes at this subject from a special vantage point.

SCAN was a Social HMO for 22 years before that demonstration program evolved into what are now SNPs. We have seen over three decades how tailoring care to meet the special needs of seniors is the right approach.

The care is better. The cost is less. Let me give you one example.

SCAN asked the research firm Avalere Health to compare SCAN's dual eligible patient population to fee-for-service duals. Using CMS' five percent sample, Avalere found 5,500 fee-for-service duals in California who had the exact same conditions as each of SCAN's 5,500 duals over a two year period. We called it The Doppelgänger study.

What did Avalere find?

First-time hospital admissions for the SCAN population were 14 percent lower than for the fee-for-service population, and hospital re-admissions were 25 percent lower. Not only did the extra care provided by the SCAN special needs plan provide better care by eliminating hospitalizations and re-hospitalizations, but it saved the government a significant amount of money.

It is clear that duals, who are the system's most in need and most expensive group of patients, are significantly helped by special needs plans. That is why we support permanency for D-SNPs.

We also strongly support moving D-SNPs on an expedited schedule toward full integration, as your legislation proposes. Now, plans should not be penalized if existing state law and regulations present barriers to full integration. But we urge Congress to work with the NGA, the Medicaid Directors, CMS and CMMI, patient groups and plans to smooth out current barriers and move to full integration as quickly as possible.

C-SNPs have also succeeded in giving patients better care through added benefits and specialized networks not available through straight MA. We think C-SNPs have earned permanency.

And we are happy that the committee is proposing to make I-SNPs permanent. However, let me point out one flaw with the current I-SNP structure.

As I said, SCAN runs an Institutional Equivalent special needs plan, meaning all of our members qualify for a nursing home, yet we strive to keep those beneficiaries in their own home and community. However, our plan has shrunk dramatically over the years because we are not allowed by law to give eligible beneficiaries the home and community-based benefits they need to lead independent lives. To get those long-term services and supports, they have to spend down their assets and go on Medicaid.

To rectify that, we strongly urge the committee to consider including legislation introduced in the last Congress by Representatives Leonard Lance and Kurt Schrader here on the Energy and Commerce Committee as well as Representatives Linda Sanchez and Pat Meehan on Ways and Means.

Their legislation would create a demonstration program to target a limited amount of additional Medicare funding toward frail individuals who are on the verge of spending down their income and becoming dually eligible. It would allow them to receive home and community-based services, which is not allowed today. The aim will be to postpone them going into a

nursing home, spending down their assets and then going on Medicaid where they will become hugely more expensive.

This demonstration will allow these individuals to stay in their homes where they and their families want them to stay, preserving their dignity and comfort. And it would be a major step toward cost savings and entitlement reform.

Finally, I want to strongly support the provision in your bill which grants increased flexibility to all plans, not just SNPs, to use supplemental benefits for non-medical services.

That means, for instance, that plans can purchase air conditioners for those with asthma or COPD to reduce emergency room visits -- and wouldn't that be a relief during this hot D.C. summer. This is a major advancement in plan flexibility, and I wanted to call attention to it because with all the concentration on SNPs, it might get overlooked.

It says to plans: you have taken financial responsibility for these chronically-ill seniors. Give them what they need to stay healthy and enjoying their lives.

The legislation you are considering is hugely important and holds the potential to make life better for millions. Thank you for your work and your time.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. Dr. Atkins, you are recognized for 5 minutes for an opening statement.

STATEMENT OF G. LAWRENCE ATKINS

Dr. ATKINS. Thank you, Mr. Chairman. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify on reauthorizing the Special Needs Plans.

My name is Larry Atkins and I am the Executive Director of the National MLTSS Health Plan Association which I am sure the chairman will be happy to know does not fit into a three-letter acronym. Association members are the managed care plans that contract with States to manage long-term services and supports. Member plans are in 18 of the 22 States that have MLTSS and enroll nearly a million members in MLTSS plans and 175,000 in duals demo MMPS, the Medicare-Medicaid Plans.

Managing LTSS focuses on helping individuals with functional needs and their families, attain their goals by obtaining the assistance they need either in institutions or in their homes and communities. We partner with our States to achieve shared objectives of rebalancing from institutions toward more home and community-based settings and integrating beneficiaries in the community and managing Medicare expenditures.

SNPs, in particular, SNP for dual eligibles, the D-SNPs, improve our success with dual eligibles through opportunities to engage in fully integrated programs where we can bring Medicare's medical benefits together with the MLTSS benefits that we provide to provide a fully integrated and coordinated care for the individual.

We fully support SNP reauthorization and urge the committee to consider a permanent reauthorization at this time. The cycle of repeated reauthorizations since 2003 has created uncertainty about the future of SNPs that deters plan investment and beneficiary enrollment in SNPs.

D-SNPs, in particular, are a critical building block for integrating plans.

Why is integration so important? Managing care for people with the most complex care needs is the key to controlling healthcare spending overall. Only six percent of Medicare beneficiaries use LTSS. They account for 43 percent of the spending, much of it medical in Medicaid.

Providing better support in the home and community can prevent the failures that trigger unnecessary and expensive hospitalizations and institutional admissions that make up a lot of our healthcare spending. To do that, plans need to be able to manage both medical and nonmedical resources to communicate and share information between care managers and LTSS and medical providers and to capture savings on the medical side that can support the necessary services on the LTSS side.

For duals, this means combining Medicare and Medicaid and right now, only a small proportion of duals are actually in integrated plans.

We need an aggressive effort to expand integrated plan availability and enrollment. A barrier to integration is the difficulty of

aligning Medicare and Medicaid coverage, that is, enrolling an individual in the same organization's Medicare and Medicaid plan. Most States auto-enroll Medicaid participants in their Medicaid managed care plan. On the Medicare side, beneficiaries choose. And in the SNP program, it allows for monthly decisions about election of plans' coverage. And they often remain in traditional Medicare or in another organization's Medicare plan which limits the MLTSS plan's ability to manage and coordinate care and share information among providers.

The fully integrated dual SNP, the D-SNP, the FIDE SNP, and the MMPs, put the two plans together and offer them to beneficiaries as a single package. Only a handful of States have opted for either of these models to date. The problem is they use voluntary enrollment or passive enrollment with an opt out, either of those two approaches, which is actually acting to keep integrated models from reaching a large share of the duals' population.

We urge the committee to permanently authorize SNPs. We support the effort to expand FIDE SNPs in more integrated approaches and we recommend that the Congress allow States to require duals that are in an MLTSS plan to be enrolled in an aligned MA plan.

For the future, we propose adopting a common legislative and regulatory framework for plans that integrate Medicare and Medicaid to try to get around some of the alphabet soup that we have. To this end, we support creating a unified appeals and grievance process for integrated plans. We also support expanding the authority of the Medicare and Medicaid Coordination Office to encompass oversight of all integrated plans.

Finally, we thank the committee for moving quickly on SNP reauthorization. SNPs alone though cannot drive the expansion of coverage under integrated plans. We look forward to continuing to work with the committee on strategies to bring the benefits of fully integrated plans to a larger portion of the population in need of LTSS. Thank you.

[The prepared statement of Dr. Atkins follows:]

House Committee on Energy and Commerce, Subcommittee on Health
Testimony of G. Lawrence Atkins, PhD, Executive Director
National MLTSS Health Plan Association
July 26, 2017

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee:

Thank you for the opportunity to provide testimony today on the role and importance of special needs plans (SNPs) as you consider whether and how to extend their statutory authority.

Introduction

My name is Larry Atkins and I am the Executive Director of the National MLTSS Health Plan Association. Members of the Association are managed care organizations that contract with state Medicaid programs to provide managed long-term services and supports (MLTSS). Across 18 states, our members enroll nearly a million members in MLTSS plans and 175,000 members in Medicare-Medicaid plans (MMPs) through CMS's Financial Alignment Initiative (FAI). Together, we account for about 70 percent of the MLTSS market and about half of the MMP enrollment.

As health plans specializing in managing long-term services and supports (LTSS) for state Medicaid programs, we have been successful in helping individuals with functional needs and their families attain their goals through obtaining the assistance they need. Our work helps states achieve their objectives of rebalancing and integrating beneficiaries in the community, and managing Medicaid expenditures.

As we work toward those goals, we aim to improve our success through opportunities to engage in fully-integrated programs – particularly for dual eligible beneficiaries - where we can bring Medicare’s medical benefits and Medicaid’s LTSS benefits together to provide fully-integrated and coordinated care for the individual.

Summary

The National MLTSS Health Plan Association supports reauthorization of Medicare Advantage Special Needs Plans (SNPs), with some modifications to H.R. 3168 as reported by the House Ways and Means Committee. SNPs provide the most effective approaches for managing medical care for Medicare beneficiaries with complex care needs, and afford a means for integrating and coordinating Medicaid long-term services and supports with Medicare medical services for beneficiaries who are eligible for both programs (“dually eligible”).

Specifically:

- We urge the Committee to permanently reauthorize SNPs rather than continue them for another 5 years, necessitating Congress to revisit and reauthorize the program yet again 5 years from now.
- We support continuation of the dual-eligible SNPs (D-SNPs), which, when aligned with an individual’s Medicaid coverage, enable a higher level of integration and coordination and a more seamless experience for the eligible individual.
- We believe persons with dual eligibility are best served in fully-integrated plans and support provisions in the bill that are aimed at achieving greater alignment of Medicare and Medicaid coverage.

- Further, we recommend that States be given the flexibility to require that dual beneficiaries enrolled in an MLTSS plan be enrolled in an aligned MA plan, either a Fully-Integrated Dual Eligible SNP (FIDE-SNP) or a D-SNP offered by the organization providing their MLTSS coverage.
- The Congress should strive for a common legislative framework for plans that integrate Medicare and Medicaid services that would provide consistency in many of the plan requirements, while preserving the unique aspects of different models of integration. To this end, we fully support creating a unified appeals and grievance process for integrated plans. We also support expanding the authority of the Medicare-Medicaid Coordination Office to encompass oversight of all integrated plans.
- Finally, we thank the Committee for considering this important legislation to advance integrated care for individuals who have functional limitations and need LTSS. Reauthorizing SNPs will not by itself drive the necessary expansion of coverage under integrated plans. We look forward to working with the Committee in the future on additional strategies to bring the benefits of fully-integrated plans to a larger portion of the population in need of LTSS.

SNP Reauthorization

Medicare Advantage (MA) Special Needs Plans (SNPs) were created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as a way to improve care for populations in the Medicare program with more complex care needs. SNPs were authorized initially through 2008 and then reauthorized periodically. This pattern of short-term

reauthorizations has created uncertainty about the future of the program that has been a deterrent to organizations offering SNPs, to states adopting integrated models, and to beneficiary enrollment in SNPs.

With the authority for SNPs set to expire next year, we encourage the Committee to make reauthorization permanent this year and make a stronger commitment to the future of these types of plans. Only with certainty about the future of SNPs will it be possible to generate the interest and support necessary to expand SNPs and MLTSS to more states and enroll a larger portion of the Medicaid and Medicare populations that could truly benefit from this approach.

Integration is Key to Achieving Better Outcomes and Lower Costs

The diverse populations our member organizations serve in their Medicaid managed LTSS plans have substantial functional assistance needs often combined with multiple chronic health conditions. Coordination of care across medical and non-medical sectors is critical to success in managing the quality of care, creating a seamless care experience for the individual and family, and managing spending effectively for states and the federal government. Coordination and integration of medical and LTSS coverage enables plans to share information, enable individuals to remain independent in their homes and communities for as long as possible, avoid unnecessary ER visits, hospital admissions and re-admissions, and avoid or defer institutionalization.

Plans that combine Medicare and Medicaid resources can reduce medical utilization and apply these savings to providing more effective supports and services in home and community settings. In this way, integrated managed care organizations are able to partner with states to

achieve goals for reducing the amount of expensive institutional care and rebalancing toward more integrated home and community-based settings.

Our plans are able to coordinate medical care and LTSS effectively for enrollees who have only Medicaid eligibility and receive all of their coverage through a single managed care organization. However, most of our plans' members have dual eligibility for Medicare and Medicaid, and have their medical coverage in Medicare fee-for-service or a Medicare Advantage plan and their LTSS coverage in a Medicaid plan.

Integration with D-SNPs

Dual-eligible SNPs (D-SNPs) are the SNPs that were created for the purpose of improving integration and coordination of care for Medicare beneficiaries who are also eligible for Medicaid. Persons with dual eligibility are a diverse population with very complex care and support needs. There are approximately 10 million dual eligible individuals, accounting for 20% of the Medicare population and 34% of all Medicare spending. In terms of Medicaid, they are 15% of the enrolled population and account for 33% of all spending.¹ Successfully managing care for this population has the potential to substantially reduce both Medicare and Medicaid spending.

Nearly half of all dually-eligible beneficiaries rely on LTSS and those who need LTSS have much higher levels of medical spending than those who don't: total spending for dual-eligible beneficiaries increases anywhere from 2 times to 4.5 times if the individual relies on any kind of LTSS, including nursing home care and home- and community-based services (HCBS).²

¹ "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." MedPAC & MACPAC, Jan. 2017. Web. <https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf>.

² *Ibid*

As of June 2017, 80% all persons enrolled in a SNP of any kind are in a D-SNP and approximately 70% of all SNP health plan contracts are for D-SNPs.³ D-SNPs have been effective in providing quality health care for these beneficiaries. A report from the General Accountability Office (GAO) found that “D-SNPs’ performance on seven health outcome measures (including maintaining healthy cholesterol, blood pressure, and blood sugar levels) was 5 percentage points higher than average for all beneficiaries and 7 percentage points higher for those with six or more chronic conditions” compared to those in traditional MA plans.⁴

Achieving full integration is critical to managing overall spending for this population. A study released last year by the HHS Assistant Secretary for Planning and Evaluation compared the medical utilization of enrollees in Medicaid only plans with enrollees in Minnesota’s fully-integrated Senior Health Options (MSHO) program. They found that enrollees in the fully-integrated plan were 48 percent less likely to have a hospital stay and those who were hospitalized had 26 percent fewer stays overall compared to a similar population without these services.⁵

D-SNP Integration: Challenges and Opportunities

In order to provide the maximum benefit of integrated care, it is necessary to align Medicare and Medicaid to provide both through either separate plans offered by the same organization or a single plan that combines both parts. Currently, there is no way to ensure that

³ “Special Needs Plan Comprehensive Report June 2017.” Centers for Medicare and Medicaid Services (CMS), June 2017. Web. < <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2017-06.html>>

⁴ “Disabled Dual-Eligible Beneficiaries”. United States Government Accountability Office (GAO), August 2014. Web. < <http://www.gao.gov/assets/670/665491.pdf>>

⁵ WL Anderson, et al. Minnesota Managed Care Longitudinal Data Analysis. ASPE, DHHS. March 31. 2016.

a dually-eligible individual participating in a Medicaid managed care plan or an MLTSS plan will be enrolled in a D-SNP or even a Medicare Advantage plan, let alone a D-SNP offered by the same organization.

There are several challenges. To start with, only about half of the states so far have established managed care plans for Medicaid eligible older adults or adults with disabilities. Currently, 22 states have either MLTSS plans or participate in CMS's demonstration Financial Alignment Initiative in all or part of the state.

Where states have MLTSS, getting alignment for dually-eligible beneficiaries of their Medicaid and Medicare coverage has been challenging. Most states auto-enroll their Medicaid beneficiaries in a Medicaid managed care plan. However, since Medicare beneficiaries have choice of coverage, many remain in traditional fee-for-service Medicare, and others may be in MA or D-SNP plans that do not align with their Medicaid coverage.

Some states have tried to address this problem by assigning or re-assigning dually-eligible beneficiaries to their Medicaid plan based on the organization they have chosen for their MA or D-SNP coverage. This may improve alignment initially, but Medicare beneficiaries retain their rights to change managed care organizations or return to or remain in traditional Medicare.

FIDE-SNPs

The Affordable Care Act created a category of D-SNP that is aimed at improving alignment - Fully-Integrated Dual Eligible SNPs (FIDE-SNPs). FIDE-SNPs must offer Medicare coverage paired with a Medicaid managed care plan of the same organization and must coordinate Medicare and Medicaid benefits through a single managed care organization. Plans

are required to use aligned care management and specialty care network methods for high-risk beneficiaries, and coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

Like other fully integrated plans (e.g. the Financial Alignment Initiative's Medicare-Medicaid Plans (MMPs) and PACE), FIDE-SNPs have been limited by a slow-uptake by states and low enrollment in the states that offer them. In most states that offer FIDE-SNPs, dual eligible beneficiaries have a choice and must voluntarily enroll in the FIDE-SNP, unlike MMPs that have used passive enrollment. Beneficiaries have been reluctant to move from traditional Medicare or from their current MA plan to enroll in these new integrated plans. As of June 2017, 8 states have operating FIDE-SNPs and plans have enrolled approximately 145,000 beneficiaries in a FIDE-SNP.

Advancing Integration for Dual Beneficiaries

If the Congress is truly committed to improving the care experience, improving outcomes, and slowing the growth in medical spending for those with the most complex care needs, it should commit to advancing models that can fully integrate Medicare and Medicaid benefits. This can be achieved with aligned D-SNP and Medicaid MLTSS plans or through FIDE-SNPs and MMPs. Initially this will only be possible, though, in states that enroll dual beneficiaries in Medicaid managed care plans.

Congress should aim, though, to afford all eligible Medicaid beneficiaries the benefits that come with full integration of LTSS and Medicare. To this end, we support provisions in H.R. 3168 that would encourage movement toward FIDE-SNPs and other more-integrated models. In

states that have managed LTSS, fully-integrated models should be advanced as preferred options for the MLTSS population.

We encourage the Committee to further consider allowing states that enroll dually-eligible individuals in Medicaid managed care to require those dual members to receive all of their benefits from a plan that fully integrates Medicare and Medicaid services, whether it be a FIDE-SNP, an MMP, PACE, an ACO, or some other new modality.

A Common Framework for Integrated Plans

As we look to the future, we believe a common framework should emerge for all arrangements through which organizations take broad capitated risk (e.g., for medical and non-medical services) – a framework that would allow for a variety of modalities⁶ to fit the unique needs of individual beneficiaries in different circumstances. The framework should:

- Apply to all plans that integrate and hold financial risk for medical, behavioral health, LTSS and other non-medical services and supports;
- Provide for payments to these plans that combine all applicable federal and state Medicare and Medicaid funds through a single payment determination and administration process that provides for pooling and sharing of overall savings between the state, federal government and the plan;
- Incorporate financial performance measures that create accountability to government payers for managing costs, for achieving state and federal payer goals of rebalancing,

⁶ Modalities would include current varieties: Program for All-Inclusive Care for the Elderly (PACE), Medicare-Medicaid Plans (MMPs), Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Dual Special Needs Plans (D-SNPs), Medicaid Managed LTSS (MLTSS) plans, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans that take risk for LTSS, and other possible varieties of plan.

reducing institutionalization, readmissions to hospital and institutional settings, and reducing avoidable episodes of care;

- Provide for accountability to government payers and consumers and their families through performance measures that speak to progress toward consumer satisfaction and quality of life, and societal goals of reduction of health disparities, impact on social determinants of health, and rebalancing among settings and effective community integration;
- Allow broad benefit flexibility to provide services that best meet the unique and varied individual needs of consumers through “In Lieu of Services” that may be specified in statute or regulation; and
- Provide a consistent standard for care coordination and the resulting care and service plans across Medicare and Medicaid programs, with the Person-Centered service planning process as the gold standard.

Toward this end, we support language in the H.R. 3168 that would create a unified appeals and grievance process for integrated plans, and that would expand the authority of the Medicare-Medicaid Coordination Office.

Quality Measures: Challenges and Opportunities

An important step toward broader adoption of integrated plans will be the development of robust performance measures that speak to progress toward consumer satisfaction and quality of life, and societal goals of reduction of health disparities, impact on social determinants of health, and rebalancing among settings and effective community integration.

Quality reporting is well-developed with regard to health care and Medicare Advantage plans in general, but has been lacking with regard to Medicaid plans, particularly MLTSS plans.

While MLTSS plans are required to collect, analyze and report on volumes of data about their members and the services they receive, there are, to date, no generally agreed-upon, national, validated measures to hold plans accountable for the quality of those services or to reliably compare performance state-by-state and nationally. In a recent report to Congress, the Government Accountability Office (GAO) found that most of the states analyzed in the report did not link payments to plan performance on meeting national MLTSS program goals because “standardized measures for long-term services and supports are not available.”⁷

To address this gap, the Association has initiated an effort to adopt a set of LTSS quality measures that can meet state requirements for quality reporting from MLTSS plans. The Association has met with a range of stakeholders engaged in quality measure development (e.g. NQF, NCQA, and CMS) to discuss the selection of measures and specifications. The measures we are adopting are derived from data that our member organizations can produce without undertaking major new data collection or data processing activities, and can begin reporting in the near future to states. In so doing, we hope to assist States in adopting quality measures for MLTSS and encourage greater consistency among states in what is measured and reported. We look forward to working with the Committee as we finish our specifications for metrics and look for ways to promote the adoption of quality measures better suited to assessing the quality of MLTSS and fully-integrated care.

⁷ “Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports.” United States Government Accountability Office (GAO), January 2017. Web. < <https://www.gao.gov/assets/690/681946.pdf> >

Conclusion

In conclusion, we urge the Committee to approve legislation to permanently reauthorize SNP, particularly D-SNP. We further offer our support and assistance to the Committee as you continue to work on ways to advance fully-integrated approaches that can serve all consumers who need LTSS. Thank you again for the opportunity to present our views and we look forward to working with you on legislative proposals that could enhance integration opportunities in the future.

Mr. BURGESS. The Chair thanks the gentleman. Ms. Bella, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF MELANIE BELLA

Ms. BELLA. Chairman Burgess, Ranking Member Green, members of the committee, thank you for having me this morning. My name is Melanie Bella. My background is in Medicaid and duals. I have been fortunate to serve as a Medicaid Director and more recently ran the Office of Duals within CMS.

Today, as you know, there are a little over 11 million people who are eligible for Medicare and Medicaid. We spend about \$350 billion annually on their care. The majority of those individuals are not in programs that integrate their Medicare and Medicaid. However, there are promising models that bring those two programs together.

Three such models are the Special Needs Plans that we are talking about today; Medicare-Medicaid Demonstration Plans, and the PACE program. Of note, PACE is the only permanent program. This means that for all of our 11 million dual eligibles, we have 1 option that is permanent to integrated clinically and financially the Medicaid and Medicare programs.

We need to do more. We have an opportunity to do more and one such opportunity is before you today with the permanent authorization of Special Needs Plans. My remarks today will focus on the dual-eligible plan specifically.

There are three things I want to kind of plant in your mind today. Number one, is that this takes investment. This is an active choice to make an investment of time and resources, and there is an opportunity cost to choosing this path that is pretty complicated over others. It is much easier to make investments in things when they are stable. So authorizing this, giving permanency to this program, allows States, plans, and even beneficiaries who are choosing to be in these programs the assurance they need that they are not going to worry every few years, that the program might be going away.

The second is that full integration is really difficult. There is no doubt that the bar should be high and that if we want to have Special Needs Plans and dual-eligible Special Needs Plans, we should have an expectation that there is full integration of Medicaid and Medicare. But what that means is that we have to help State Medicare agencies get their long-term supportive services and behavioral health services into managed and integrated products so we can pair those together. So what we should be doing is continuing to break down any barriers that stand in the way of doing that.

In my written testimony, I have included examples of areas where the Duals Office within CMS could be given authority to break down many of those barriers, largely administrative, that make it really difficult for States and plans to bring those two worlds together.

Lastly, we have to talk about States. States have to be our full partners in this. They are already resource constrained, and so they need incentives and capacity to be able to do these things. They also need tools to ensure that if we have these aligned programs that people are actually in them. So today, there are a few States where you have fully aligned programs, where Medicaid and

Medicare are available, say if I am the dual-eligible beneficiary. But large numbers of people aren't in those plans. And so there are tools that we could be using to help facilitate those choices. One example where CMS could be very helpful just today would be to lift the moratorium on something called seamless conversion which is something that allows States and plans to ensure that people are getting their services from the same entity.

So to reiterate an earlier point, States are in the same bucket of wanting assurance that this program is going to be stable and it is not going away which is another reason in support of permanency for these programs.

In closing, this is I think my favorite subject in the world, so I would like to thank the committee for taking it on. This is a really important step. There are many more we could take, but the opportunities here really are ones that lend themselves very well to, I think, areas where we could have bipartisan agreement, so I appreciate the opportunity very much.

[The prepared statement of Ms. Bella follows:]

Examining the Extension of Special Needs Plans

Melanie Bella
Independent Consultant
Former Director, CMS Medicare-Medicaid Coordination Office

Statement Prepared for the
Committee on Energy and Commerce Committee
Subcommittee on Health

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Chairman Burgess, Ranking Member Green, and Members of the Committee, thank you for the invitation to discuss the extension of Medicare Advantage Special Needs Plans, a critical vehicle for integrating care for individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees).

My name is Melanie Bella. My testimony today reflects my experience as a Medicaid Director where I experienced firsthand the misalignment between Medicaid and Medicare and, more recently, as Director of the Medicare-Medicaid Coordination Office (MMCO), created by Congress in 2010. The office acts as a liaison and translator both inside and outside CMS, with responsibility for making the two programs, as well as the federal and state governments, work better together.

When the Medicare and Medicaid programs were created, it was not with an eye toward how they would work together; they were created as distinct programs with different purposes. As a result, the programs differ in virtually all areas, including eligibility, covered benefits and payment. This is very difficult for the roughly 11 million people (6.5 million seniors, 4.6 million people under 65 with disabilities) who are eligible for both programs, the providers who serve them, and the public payers (e.g., state Medicaid agencies and Medicare Trust Fund) who finance their care.

As the number of people who rely on both programs grows and with annual costs exceeding \$350 billion, there is an increasing need to align these programs. Today, the majority of Medicare-Medicaid enrollees are not in programs that integrate their Medicare and Medicaid benefits. Medicare covers acute care needs, such as

hospitalization and post-acute care, and prescription drugs. Medicaid provides supplemental benefits, particularly long-term care supports and services, and helps with Medicare premiums and cost-sharing as well as in the financing of prescription drugs via the Part D “clawback”. The lack of alignment between the two programs can lead to fragmented care, cost shifting, inefficient spending and poor outcomes.

Three promising pathways for integration are Special Needs Plans (SNPs), Medicare-Medicaid Plans (MMPs) and the Program of All-Inclusive Care for the Elderly (PACE). Today’s hearing is focused on extending SNPs, a type of Medicare Advantage plan authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, that is allowed to tailor benefits to certain types of Medicare beneficiaries. There are three types of SNPs: dual eligible (D-SNPs), chronic care (C-SNPs) and institutional (I-SNPs). Current enrollment in SNPs is over 2 million, with the majority in D-SNPs. The focus of my remarks today will be on D-SNPs and their role in furthering the integration of Medicare and Medicaid benefits. Specifically, I will focus on D-SNP permanency, state considerations, and the role of the Medicare-Medicaid Coordination Office.

D-SNP Permanency

SNPs, currently set to expire in 2018, have undergone a series of temporary extensions. Just as PACE was made a permanent option for Medicare-Medicaid integration after a number of years of learning and refining the model, it is time to make D-SNPs

permanent. A core question is how much integration with Medicaid should be required of D-SNPs.

Since the inception of D-SNPs in 2003, Congress has taken important steps to make D-SNPs and Medicaid programs work more closely together. Where once there may have been little to no relationship between a D-SNP and state Medicaid agency, today D-SNPs must have a contract with the state Medicaid agency documenting key areas where they will work together, and a subset of D-SNPs, called Fully Integrated Dual Eligible (FIDE) SNPs, offer Medicare and Medicaid benefits through a single managed care organization.

The ultimate goal should be to achieve true clinical and financial integration of Medicare and Medicaid. This requires breaking down barriers that stand in the way of: (a) plans providing truly integrated Medicare and Medicaid benefits; (b) Medicare-Medicaid enrollees enrolling in such plans, often referred to as “aligned” plans; and (c) aligning the financing so that both states and Medicare have incentives to participate.

Permanently extending D-SNPs is a critical piece of advancing that goal as one barrier is the ongoing uncertainty of SNPs. Plans, states (existing and new), CMS, Medicare-Medicaid enrollees and other interested parties need the assurance of stability to continue to invest both time and resources on increasing the number of aligned plans and Medicare-Medicaid enrollees in those plans.

The Medicare Payment Advisory Commission (MedPAC) has recommended that Congress permanently reauthorize only D-SNPs that are integrated with Medicaid¹. While full integration and aligned plans should be the goal, the requirement for plans to

be aligned and taking risk for both Medicare and Medicaid benefits needs to take into account a ramp-up period for states to get to full integration on the Medicaid side. In addition, to reap the benefit of requiring full integration, mechanisms to ensure Medicare-Medicaid enrollees are enrolled in aligned plans must be used. Today, even in states where aligned plans are an option, large numbers of Medicare-Medicaid enrollees are not enrolled in these plans, thus not benefiting from having one enrollment card, a coordinated care team, enhanced services, etc. Potential mechanisms include lifting the moratorium on seamless conversion, improved coordination of enrollment processes, enhanced outreach to promote aligned plans, and a willingness to examine policies that may erode continuity of care (e.g., when and how often Medicare-Medicaid enrollees make enrollment choices, curtailing use of brokers, etc).

State Considerations

States that have gone down the path of integration, whether with D-SNPs, MMPs or PACE, will tell you it is not an easy one. Medicaid agencies are resource constrained – in terms of both people and dollars – and often feel the benefits of integration are not equitable between the two payers. For example, if Medicaid expends dollars to improve care for Medicare-Medicaid enrollees and Medicare benefits in the form of reduced admissions/readmissions or better drug management, Medicaid does not get to share in any of those savings. This has been a major barrier to date in the broader context of Medicare-Medicaid integration.

To support the goal outlined above of true clinical and financial integration with D-SNPs, state Medicaid agencies need to move toward capitation of their LTSS and behavioral health benefits. To devote the resources necessary to do so, they need capacity, incentives, flexibility around administrative requirements (more detail below) and tools to make sure Medicare-Medicaid enrollees are enrolled in and receiving care from these aligned plans. And, importantly, they need assurance that if they go down this path, the future of D-SNPs is not uncertain.

Medicare-Medicaid Coordination Office

Created by Congress in 2010, the Federal Coordinated Health Care Office, or MMCO, is uniquely positioned within CMS to drive the integration of Medicare and Medicaid in ways designed to improve outcomes and control or reduce costs. Just as Congress is seeking to raise the bar for D-SNPs in order to further advance integration, Congress could raise the bar for MMCO in terms of its responsibilities and authority. An expanded role for MMCO has been suggested by two other Congressional Committees as well as the Bipartisan Policy Centerⁱⁱ, among others. Specifically, MMCO could be given expanded authority to work with states that have either implemented or are in the process of developing aligned programs to:

- Align procurement and contracting timing and processes;
- Coordinate enrollment processes, including the use of a single enrollment card;
- Enable joint review of marketing and enrollment materials;

- Simplify member materials, such as the summary of benefits, annual notice of change, comprehensive formulary and enrollment form;
- Integrate assessment and model of care requirements to include LTSS, behavioral health and social determinants of health;
- Improve the grievance and appeals process to allow use of an integrated notice and align timeframes for filing appeals;
- Coordinate external quality reviews and quality improvement initiatives;
- Align payment incentives with Medicaid value based purchasing initiatives;
- Utilize network standards based on Medicare-Medicaid lives; and
- Deploy a joint state/CMS contract oversight team.

Because all states are in different places and will require some flexibility and adaptation, it would be difficult to specifically mandate the list above. However, Congress could direct the Secretary, through MMCO, to align and simplify administrative requirements that have become burdensome to states, CMS, enrollees and plans, thus creating roadblocks to true integration. Expanded authority for MMCO should come with the expectation that consumer protections are also aligned and upheld.

Closing

The issue of Medicare-Medicaid integration is one of the few in health care today where there seems to be bipartisan interest in working together to come up with solutions. As Congress looks beyond SNP reauthorization, I would encourage continued thinking

about shared savings models between state Medicaid agencies and Medicare as well as keeping an eye on the state-based financial alignment duals demonstrations.

Currently, close to 400,000 Medicare-Medicaid enrollees are receiving care through a MMP, which is fully integrated both clinically and financially. CMS and each respective state Medicaid agency jointly oversee and finance the demonstration. The state-based demonstrations, begun in 2013, have staggering end dates, some through 2020. They have begun providing valuable learning but need continued time to be able to mature and produce the full effect of expected outcomes. MMPs are in the period of testing and modifying, similar to the process of testing and modification that PACE went through before becoming permanent and being discussed today for SNPs and their path to permanency. All three (SNPs, MMPs, PACE) are critical pathways for integration and should be supported and strengthened.

Thank you for the opportunity to appear before you today and for your continued interest in Medicare-Medicaid integration and in raising the bar for the programs available to the people who depend on them.

ⁱ Medicare Payment Advisory Commission. "Report to the Congress: Medicare and the Health Care Delivery System," March 2013. Available at: http://www.medpac.gov/docs/default-source/reports/mar13_entirereport.pdf.

ⁱⁱ <https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.

Mr. BURGESS. The Chair thanks the gentlelady. The Chair thanks all of the witnesses for your testimony. We will move into the Members' questions portion of the hearing. I want to begin by recognizing the gentleman from Illinois, 5 minutes for questions, please.

Mr. SHIMKUS. Thank you, Mr. Chairman, and welcome. This is an interesting topic.

And Ms. Bella, you mentioned, I have listened to all of the testimony, but my first question was going to be on seamless conversion which you talk about, but I was going to direct to Dr. Atkins and then Ms. Bella, you can follow up.

The question is on the seamless conversion, can you tell us how this helps ensure coordinated care for beneficiaries and whether you think or not, I know Ms. Bella thinks this is something we should address or will be involved in the legislative fix.

Dr. ATKINS. The seamless conversion operates on the Medicaid side that States can move beneficiaries because the beneficiaries are automatically enrolled in Medicaid managed care plans in most States. States can reassign them to a different plan, but it aligns with a D-SNP.

Arizona, for example, has had a pretty aggressive program to realign their Medicaid beneficiaries with their D-SNP coverage. The problem is that they can still move, the beneficiaries can still change their coverage on a monthly basis on the Medicare side. So the fact that as long as there is this complete flexibility and freedom of choice on the Medicare side, it is very difficult to achieve full alignment.

Mr. SHIMKUS. So, and I can ask anyone, so is this something that you think we should try to address legislatively and fix on the Medicare side?

Dr. ATKINS. Yes.

Mr. WING. Yes.

Mr. SHIMKUS. Ms. Bella?

Ms. BELLA. Yes.

Mr. SHIMKUS. OK, good. Let me go to, I think Mr. Wing and Dr. Atkins again, and of course, Ms. Bella, if you want to chime in. So the Medicaid CHP Payment and Access Commission, because I don't like these acronyms, especially, can you imagine somebody listening to these opening statements and not knowing what any of these terms are? They would be thinking we are talking in a foreign language.

The Medicaid CHP Payment and Access Commission noted that dual eligibles may often be enrolled in up to three health plans, a SNP, a Medicaid plan, and a limited benefit plan such as behavioral health or long-term services and supports. While we know how that has evolved, I think that the discussion here is that integrated care should be integrated care. And it is kind of silly financially to have to go through, for the individual consumer very confusing.

Can you speak to the degree to which the committee's draft legislation addresses this issue of the possibility of three different plans and whether there are additional steps the committee should take?

Mr. WING. We believe in full integration. And we still have a lot of work to do. SCAN has been dealing with dual eligibles for 40

years, as I mentioned. One of the areas, and you mentioned one, is behavioral health. Thirty years ago, the industry made a mistake about separating the medical component of care from the medical component of care and we now have pilots, especially if we have permanence, it makes a lot of sense. We are not a not-for-profit, but we have to be diligent with our capital deployment. But we now have a pilot in anticipation of either a 5-year permanence and we have a pilot in Riverside where we are actually coordinating bringing a telephonic Skype-based telemedicine that is focused exclusively on behavioral health. So from SCAN's perspective, we need to integrate this so it is totally seamlessly integrated for the beneficiaries, for the State and for the plan.

Mr. SHIMKUS. Dr. Atkins?

Dr. ATKINS. I think the legislation helps. It creates much more of a push toward FIDE SNPs which is really the only full-integrated approach. And then you know, I think the challenge is that in many States you don't have the managed LTSS or you don't have managed behavioral health to be able to integrate with the D-SNP. So you can't get everybody into a FIDE SNP if you don't have the managed LTSS and behavioral health.

And then I think you spoke to the issue of a managed Medicaid plan, just generally, and then often these separate MLTSS or behavioral health plans, but I think if the States can be moving more directly to integrating on the Medicaid side, then I think the challenge comes down to trying to find a way to get that alignment to happen on the Medicare side.

Mr. SHIMKUS. Ms. Bella, do you want to add anything to this?

Ms. BELLA. I would say it is an important incremental step. It is taking us one step further. It is still not getting us to a point where we have one program fully integrated without all the incentives, but to do that, we have a lot of enrollment and other financing issues to tackle. So it is an important step. It is not the end game.

Mr. SHIMKUS. Thank you very much. I yield back, Mr. Chairman.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions, please.

Mr. GREEN. Thank you, Mr. Chairman. Ms. Bella, you noted that the clinical and financial integration are both critical to actually achieving true coordination between Medicare and Medicaid. As part of your testimony, you also highlighted that even in States where fully aligned plans are offered, sometimes beneficiaries do not enroll in these plans. You mentioned specifically that improved enrollment processes and enhanced outreach to promote aligned plans could address some of these issues.

Ms. Bella, can you provide an example of what you mean by improved enrollment processes?

Ms. BELLA. Sure. I think part of the challenge is these are difficult programs to explain to people who are eligible for them. And we make it more difficult with having a different set of requirements for Medicaid and a different set of requirements for Medicare that complicate.

We also have different processes for reviewing and approving those materials, so the end result is to talk to real people. The in-

formation isn't as clear as it could be. So it is sort of one set of things around materials and processes. It is another set of things around and this is probably more detailed than we have time to go into today, but the Medicaid program looks at people one way and has one set of eligibility rules, and the Medicare rules look at that exact same person a different way. And so we have conflicts in terms of how people are enrolled, how long they are enrolled, when and how often they can make enrollment choices and all of those things just they create problems for people and they really just erode a continuity of care and being able to keep people in a plan.

Mr. GREEN. Do you have any examples of how we can improve that outreach?

Ms. BELLA. Yes, there are examples. There are examples of how you can coordinate member materials, so requirements on the Medicare-Medicaid side around summary benefits, annual notice of coverage. So some of that is being tested in the demonstration States and in Minnesota right now, tested well.

There are examples of how you can have joint review of those materials. What was just discussed about seamless conversion, allowing that to proceed, lifting the moratorium on that would be important. So I would be happy to present some more explicit examples outside of the hearing, but there are definitely concrete things, many of which are being tested today.

Mr. GREEN. If you would give that to us so we could include it in the record, I would appreciate it.

Ms. BELLA. Sure.

Mr. GREEN. Thank you, Ms. Bella. Finally, there are certain States that Congress should look to as models that have been very innovative and promoted integration between Medicare and Medicaid. Do any of the panelists have thoughts on certain States that we might look at, whether it be Minnesota or someone else?

Dr. ATKINS. Well, there is certainly, you know, there are the States that started first with full integration. Massachusetts, Minnesota, Wisconsin were the early States. And Massachusetts is another State to look at for their FIDE SNP. They have a senior care options program for the seniors, and they are in the duals demonstration for the under-65 population.

But I think a lot of the States now who have gone either to adopt MMPs or have pushed more on integration, there are a lot of States out there that I think coming at it from very different perspectives have done a great deal in this space. The ones that are now sponsoring FIDE SNPs are an example.

Mr. GREEN. Ms. Bella, I have another question. It seems like there is a menu of options available to dual-eligible and chronically ill beneficiaries. I think we need a basic review of the system of care as it stands for these beneficiaries so that we better understand how the pieces fall together.

What are the options a dually eligible or chronically ill beneficiary is available to them in any given State? For the record, what is a D-SNP, a FIDE SNP, and what is a duals demo and the PACE program and how do all these different care options fit together.

Ms. BELLA. Are you asking what each of them is for the record?

Mr. GREEN. Yes, for seeing how they all fit together.

Ms. BELLA. I think of it as sort of menu of integration. So you start with sort of—your goal is to get to full integration, which means Medicare-Medicaid benefits are delivered by one entity, and they have financial integration, too. So the financial alignment duals demonstrations integrate the services, the payment. One entity gets a set amount of money every month to provide that care.

One step down from that are the FIDE SNPs, the fully integrated, dual-eligible SNPs. so they have a contract with Medicare as a Special Needs Plans. They have a contract with a Medicaid agency for long-term care and behavioral health. They manage those two separate contracts. They get two separate funding streams, but they are still responsible for everything, just not quite as integrated as the Medicare-Medicaid Demo Plan.

One step down from that is a regular dual-eligible SNP, so they have contract with Medicare as a SNP. They may or may not have a contract with Medicaid and so they are not quite as integrated as the FIDE SNP, because they are not managing the long-term care and the behavioral health benefit.

And then one step down from that would be a regular MA plan because there are many duals that are in regular MA plans. They have no relationship to Medicaid at all.

And I erred by saying PACE should be over here beyond the MMP plan, because PACE is completely clinically and financially integrated with both Medicaid and Medicare.

Mr. GREEN. Thank you.

Dr. ATKINS. Is it all right if I comment on that? I think PACE has a lot of features that would be beneficial for other integrated plans and the other thing is that the MMPs have a three-way contract between the State, the Federal Government, and the plan. And that actually is the plans have reported, and I think the State and Federal Government feel the same way, that that has enhanced the level of communication that goes on between the three entities and it is really moved to a much higher level of coordination. So I think the three-way contract is another interesting piece.

But we advocate for eventually a single kind of overarching design for integrated plans and to try to allow these different modalities, but to bring them in under a kind of a common architecture because I think they are really are there because that is the way they have evolved. They are not there because that is the way that makes the most sense.

Mr. GREEN. Thank you. Thank you, Mr. Chairman. I appreciate the information as we look at this legislation.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Pennsylvania, Mr. Murphy, 5 minutes for questions, please.

Mr. MURPHY. Thank you, Mr. Chairman. This just sounds like one of the biggest Rube Goldberg messes the Government could come up with. So let me try and peel back a little bit here.

Mr. Wing, I was fascinated by what you talked about with some of these patients through telemedicine. I am assuming you have some sort of telepsychiatry consult. We know that people who have a chronic illness or acute illness doubles their risk for mood disorder, depression. When that is untreated, it increases their costs.

Who does that, the work that you talked about in your plan, who actually does those teleconsults?

Mr. WING. Actually, right now we have a pilot. I am under a non-disclosure agreement, but we have a pilot.

Mr. MURPHY. I don't mean what the group does, I mean is it a psychiatrist, psychologist, social worker?

Mr. WING. Well, actually, it is everything above. I can discuss the intervention.

Mr. MURPHY. Briefly.

Mr. WING. I came from a physician group that did a really good job, DaVita Medical Group. But diagnosing opioid abuse, substance abuse, and depression is easier said than done. So in this modality, the primary care physician is given an iPad and when he even suspects that there is opioid abuse, substance abuse, or bipolar disease, put the patient in a private exam room, give them an iPad that is connected to Skype to a specialized geriatric nurse practitioner. She is the one that does the better assessment and then she can then connect the patient through telehealth through a national network in behavioral health.

Mr. MURPHY. Let me ask a couple of things that would make it even worse. Are you aware that even in that, that primary care physician because of a regulation put forth in the Nixon administration, if that person is already in treatment or receiving methadone or Suboxone, that doctor may not have access to the records and therefore may prescribe an opioid for his pain or the treatment, they don't even know that person is in treatment because of this thing called the 42 CFR Part 2. Are you aware of that?

Mr. WING. Yes.

Mr. MURPHY. It is another mess that we have to fix. Plus, we also have a strange thing that even those psychologists may do the work, they have to bill through the psychiatrist and so which adds administrative costs and takes the psychiatrist away from their work. So it is another expense that we add to the system. So let us continue to build on Rube Goldberg.

And in this, too, I want to ask all of you, if you are aware, too, what we find is that a true coordinated care model is the physician can really understand we have a complex case. You have a person, dual eligible, so they already are having multiple problems. And we even know, when you have got the flu it is hard to manage your flu. But when you are dealing with a chronic illness and perhaps mental illness on top of that, behavior and physical medicine have to be integrated together, but that requires a lot of work. But even in that context, I want to make sure I understand, because my understanding is Medicare doesn't pay for these services that are needed. For example, responding to a patient's phone call about a symptom or problem may not be paid for; or communications between the primary care physician and specialists to coordinate a care isn't paid for. Communicating between community physicians and emergency room isn't paid for or providing proactive telephone outreach to high-risk patients to say we want to make sure we see how you are doing, be aware of these symptoms, etcetera, how is your medication going, not paid for. Spending time with a patient in shared decision making to map out a game plan for them isn't paid for. Hiring nurses or another staff member to do education,

patient education on medication, treatments, anything else isn't paid for. Providing palliative care isn't paid for. And even such things as getting the patient to the doctor's office. I have heard of one program in Miami that actually does this. They actually bring the patients to the doctor's office and deliver medication and guess what? Patient compliance goes way up.

So is it your understanding, too, or am I getting this right, in a coordinated care plan with these very, very difficult cases, these things aren't paid for, but we know that those things save money.

Dr. ATKINS. Can I comment on that? I think this is a critical issue because Medicare actually is much more restrictive about what can be covered and not covered than Medicaid is. Medicaid is more flexible, but neither one of them is particularly flexible. And when you put the two together, you still have to deal with limitations on coverage, coverage restrictions and things that are built in the statute.

So what we would advocate for is that as we go toward these more integrated models, that in the context of an integrated system where you are fully capitating across all of these services and supports, behavioral health, long-term services and supports and the medical, that you give the plans the flexibility to be able to provide the services that make the most sense in the case that they are dealing with, understanding that they are financially at risk for the overall cost of care for that patient. But if they see the possibility of providing a service, whether it is a counseling service or whether it is an inhome service that would help to reduce the medical costs on the medical side, they have the opportunity to do that.

Mr. MURPHY. So this goes back to eliminating Rube Goldberg and saying if we empower the physicians to work closely with the patient and make some determines what they need and work more directly with that, and have a system of payment that is designed to cover that patient, let the medical practice decide what is best, we can actually save a lot of money and it is quite frankly, I believe more compassionate and works toward better healthcare.

Dr. ATKINS. And I would urge you to include the fact that it is just not medical because for a lot of these people, the more significant services for them really are the services and supports that help to reduce medical expenditures.

Mr. MURPHY. Yes, I add to that also psychological behavioral services. Thank you very much. Mr. Chairman, I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions, please.

Ms. CASTOR. Well, thank you very much for calling this hearing, Mr. Chairman. And thank you to our witnesses for your expertise here.

You all, based upon your testimony you say that not enough dual eligibles are enrolled in the Special Needs Plans, correct? And you have made recommendations to improve that, remove barriers, work with States to improve the enrollment there.

Do you all agree that as we move in this direction, the Government could see substantial cost savings?

Mr. WING. This is Chris Wing. The answer is yes. In our fully integrated D-SNP, we actually have two products. We have more

of an ambulatory program for the aged, blind, and disabled dual eligible. It is called Connections.

We have another program in California. These members have to meet the California standards for being certified for nursing home eligible. In our program, for the seniors that in that Connections at home, all of them nursing home certifiable, we keep 96 percent of them, 96 percent in the community and outside of nursing homes. And if you do the math, this isn't a DRG where it is \$12,000 or \$14,000. This could be a 7-year length of stay and \$4,000 or \$5,000 a month. The savings to the system are very, very profound, coupled with a better quality of life, better quality of care for beneficiaries.

Ms. CASTOR. And I am going to ask you a little bit more about that, but do you all agree?

Dr. ATKINS. Yes, if I could just reinforce that. HHS released a study this spring of the MSHIL program in Minnesota which is a fully integrated program and it was a comparison of the people who were in the MSHIL program to people who were just in MLTSS alone without the integration with Medicare. They found a very substantial reduction. I don't know the figure on top of my head, but there is a very substantial reduction that is possible.

Ms. CASTOR. And Ms. Bella, do you agree? And then how do we keep track? What measures are in place? How do we keep track of cost savings over time so we are investing where we need to invest?

Ms. BELLA. Well, I do agree there is cost savings, but they are not immediate and they accrue more immediately on the Medicare side for things like hospitalization, readmissions, better prescription drug management. It takes more time to see on the Medicare side and that is part of the problem is that we have a mismatch between when the savings happen and how the payers benefit. And so that is why you haven't seen as much take up of some of these so that is one of the things we need to address. We track that by looking at outcomes, the hard utilization outcomes that are measurable around key utilization areas that are driving costs, around all the inpatient buckets. And then on the Medicaid side it services all the long term care and how much of that can be moved into home and community-based settings and how are we seeing those shifts. So there is ways of tracking.

Ms. CASTOR. And that is the responsibility of CMS?

Ms. BELLA. It needs to be the responsibility of CMS and the States, but also MedPAC and MACPAC also play an important role because they can bridge those data together and help do some of the academic pieces of that that the governments aren't necessarily staffed to do.

Ms. CASTOR. So we are really struggling with the escalating cost of prescription drugs all across the board and all kinds of insurers. Is this a way where we can realize cost savings as well for prescription drugs paid by the Government under Part D and Medicaid and how would that work?

Ms. BELLA. Certainly, prescription drugs is an area that when the two programs aren't talking to each other, the costs can go up because there is no coordination, there is no one managing the meds, and there are all of those things. So the integrated program where you have one entity responsible who is seeing everything

that that person is getting, yes, they have an opportunity to improve the medication management and presumably drive costs down.

Ms. CASTOR. Are there incentives in place to do so?

Ms. BELLA. The health plans have incentives. I mean the health plans are fully capitated have incentives to make sure that the dollars are being used wisely. Those incentives don't always flow back to the States and the Federal Government, and so again, there is sometimes mismatches in where investments are being made and where savings are being recouped, but the health plans have incentives across the board when they have responsibility for both pots.

Ms. CASTOR. Did you want to comment on that, too?

Mr. WING. The answer is that we have the risk. We are going to work with our providers to profile aberrant prescribing patterns and also try and work with the patient to make sure we understand what their desires are, what their goals are, we meet their desires so they will be more compliant.

Dr. ATKINS. There is also, I think, an issue of medication adherence which is that very often we have spent a lot of money in this country on prescriptions that people either don't take or don't take properly and they really don't have the effect that they need to have. So one of the advantages of an integrated program is that there is a lot of emphasis on medications.

Ms. CASTOR. And there has also been increased recognition of the importance of social determinants, things like social supports and an individual's physical environment and that is how we can help create positive outcomes and cost savings and this is something that Medicaid has worked on for a while and I am glad to see Medicare learning from Medicaid here.

Mr. Wing, SCAN, I understand, has been very innovative in its thinking about social determinants of health and how nontraditional services and interventions can help. Tell us a little bit more about that.

Mr. WING. You know, we were founded to focus on complex seniors especially dually eligible. And it is amazing what small things can really make a profound difference.

I came from DaVita Medical Group, and doctors do a great job, but oftentimes they don't know what is going on in the home. So we have a program where we put social workers and care navigators into the home to take stock, do an HRA, but take stock as far as the whole social determinants of health, and report back to the doctor. We don't only provide the transportation back to the doctor which often is a barrier for dually eligible, but oftentimes we have a care navigator go with a patient and make sure the doctor knows the social determinants and everything else that is going on in the home.

One case—if I can—about 2 years ago, we videotaped a member who was socially isolated, living by himself, a Latino gentleman. He already had Parkinson's, but he had glaucoma. Our community health navigator, not a high cost, in the home identified—the member was doing the best he can to put the eye drops in, but couldn't do it. A \$12 wrist guard, a \$12 wrist guard. The doctor thought the member was doing his best, but did not know he couldn't do it. A \$12 wrist guard, all of a sudden this patient now can slow the

delay of the glaucoma and fast forward in 5 years, if he had gone blind, had Parkinson's, if he showed up in ER, he is going to get admitted. But that is not the worst outcome.

The worst outcome is when he was about to be discharged. He is not going to be discharged back to the community. He is going to go to custodial care the rest of his life. So these social determinants probably predict anywhere between 20 to 80 percent of health outcomes. And when you are totally integrated like SCAN is for a fully integrated D-SNP, we have all the incentives to work with the doctors, but also make sure we are in the home and we know everything that is going on with that patient, their care givers, and their family situation.

Ms. CASTOR. Thank you.

Mr. BURGESS. The gentlelady's time has expired. The Chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions, please.

Mr. LANCE. Thank you, Mr. Chairman. As the chairman indicated, I am one of the sponsors in the bill that would enable expanded supplemental benefits to meet the needs of the chronically ill, Medicare Advantage enrollees.

I want to work with the entire panel on this issue. New Jersey has struggled with behavioral health and substance abuse issues. Dual eligibles who are in the program, we have in New Jersey, try to address the whole person, both physical and mental health.

In the panel's opinion, does this kind of dual payment integration foster clinical integration?

Mr. WING. Again, the answer is yes. You know, for our Medicare Advantage plan, not for our SNPs, we are prohibited from offering nonhealth type of services. Let us take the individual who needed a \$12 wrist guard, boy, would that make a difference in somebody who is in a Medicare Advantage population? Yes.

We all know about the hip fractures for seniors often lead to bad outcomes, whether it is nursing home care, institutional care, but if we could provide solid grips in the bathrooms, by the toilets, that would make a profound difference. But right now, Medicare Advantage plans cannot offer, by law, Medicare benefits to a Medicare Advantage only audience.

Mr. LANCE. Well, thank you. And I want to continue to work with the panel on this and other issues because I think this is an incredibly important area and I commend those on the other side of the aisle, including Congressman Schrader, who is working with me on this issue and it is to be continued.

Mr. Chairman, I yield back the balance of my time.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from California, Mr. Cárdenas, 5 minutes for questions, please.

Mr. CÁRDENAS. Thank you, Mr. Chairman, Mr. Ranking Member. I would to thank you for holding today's hearing and allowing the committee to shine a light on a program that is helping to improve the lives of so many medically vulnerable Americans.

Too often in these discussions, we lose track of the real-world effects of our decisions. The conversation today is not about some obscure policy provision. It is about real people with real needs.

One of those real people lives in my district. Let us just call her Cassandra. Cassandra is 73 years old and has several chronic conditions including congestive heart failure, diabetes, and hypertension. For anyone unfamiliar with diabetes testing, a blood glucose test, or an A1C score above 8 is considered uncontrolled. This can lead to range of negative health effects including amputations, kidney failure, and loss of vision.

Before joining the Special Needs Plans, Cassandra had an A1C reading of 12. This is dangerously high. This, along with her other poorly controlled conditions, led to at least seven hospitalizations over the course of just 1 year. Cassandra joined an SNP in 2014 and today her A1C level is just 7.6. Cassandra has also only been to the ER once since her enrollment and has only been hospitalized for one scheduled surgery. Cassandra's care is coordinated by her care team and she has regular meetings with her primary care provider and nutritionist to keep her conditions under control.

For the first time, Cassandra is getting healthier as she gets older, and her quality of life is much, much better.

Cassandra is just one example of the millions of people benefiting from these specialized plans. We owe it to these patients to provide the certainty that these plans will be there for them in the future and that is why I believe it is so important to reauthorize them permanently to make them more effective and more efficient. Bottom line, better quality of care.

One of the many populations that are treated through Special Needs Plans and are end-stage renal disease, otherwise known ESRD patients, so I have a question for Mr. Wing. 21st Century Cures took the first steps in developing ESRD specific quality measures for ESRD C-SNPs. As you know, not all quality measures are applicable to such a specialized patient population due to the uniqueness of the ESRD patient population and the type of specialized care they receive.

So Mr. Wing, do you believe ESRD C-SNPs could better measure the quality of care provided if more specialized measures were developed?

Mr. WING. The answer is yes. And actually we have an ESRD Special Needs Plans in Riverside with DaVita Medical— actually, DaVita, the parent. And it is amazing here. Not just we have the quality metrics. We can always improve quality metrics. We think the stars measures have fundamental changed the conversation between health plans' providers because there is the economic incentives now. We always think there is improvement. Well, boy, when you talk to the nephrologists, when you talk to the patients, when you talk to the nurses about the care that dialysis patients get, ESRD Special Needs Plans, the savings are there, but again, the beneficiary satisfaction, the patient satisfaction is there as well. So the answer is we do applaud the current measures, but we can always improve upon them.

Mr. CARDENAS. Mr. Wing, I have been listening to your answers today and I really appreciate you sharing your expertise with us. But one of the things that seems to be the common thread in all of this that you have been explaining and that is the communication between human beings. I mean we have all been incredibly impressed with the technology and the advances and the efficiencies

of being able to be more accurate when it comes to seeing what is really going on with a patient down to the molecular level, but at the same time it seems like every single one of your answers seems to point toward we need to make sure that our human beings are actually able to communicate with each other and share information and that seems to be the driving factor to having much, much better results. Would you agree?

Mr. WING. I would agree. Hopefully, I am not a one-trick pony, but I think there is two tricks, integration and risk-bearing entities will always strive to innovate for better care, better quality and better financial outcomes. But I am always amazed, when we put people into patients' or beneficiaries' homes to find out what is going on, the doctors, as good as they are, as committed to quality as they are, they don't know what is going on in the home. We have to have eyes and ears in the home to translate to the doctors. So communication and risk-bearing entities I think are a large part of the solution for this type of population.

Mr. CÁRDENAS. And unfortunately, in this modern world, the human element seems to be in so many systems that want to get eliminated. This one we have to be very careful to understand how important that that human touch is. Thank you so much. I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from Missouri, Mr. Billy Long, for 5 minutes for questions, please.

Mr. LONG. Thank you, Mr. Chairman. And Dr. Atkins, in your testimony you discussed fully integrated, dual-eligible Special Needs Plans. The uptake by States has been slow and enrollment has been relatively low, yet you state Congress should commit to advancing models that can fully integrate Medicare and Medicaid benefits.

There is a concern that if we move too quickly, we are trying to force rather than facilitate integration. How do you respond to this concern?

Dr. ATKINS. Well, you know, the difficulty with the uptake has been just that we have a lot of States that don't have managed MLTSS and behavioral health. So trying to integrate, and you can't really do a FIDE SNP if you don't have integration—managed care on both sides. So that is one of the challenges.

And then, you know, I think the enrollment issue has been a substantial challenge in both the MMP program and the FIDE SNP program. It is either voluntary enrollment that people voluntarily choose to enroll as beneficiaries in the combined plan or in the case of MMP, there has been passive enrollment with an opt-out and so people find themselves in the plans, don't really know quite how they got there and often are persuaded either by their physician or by an LTSS provider to opt-out of the plan without really understanding what the choice has been.

So I think the challenge has been to address these questions about enrollment because what we find is that when people do enroll in these plans, the level of satisfaction goes ways up. So in the disability community, for example, in the younger disability community, there has been some resistance to going into managed care. So there has been some resistance to going into these inte-

grated plans, but a lot of that is built on a lack of understanding about what is going on in these plans. And when beneficiaries get in, they report they are much more satisfied with this experience. So I think it is going to be a lot of education.

I think in many cases, the MMPs were launched in the State without adequately communicating in advance what these plans were. And then when you look at the beneficiaries who get assigned to these plans, often these are very hard to reach beneficiaries and when they get into an MMP, it is the first time anybody has ever shown up and had contact with them about what is going on with their healthcare or what are their services and supports. And so it has been very difficult to kind of get to everybody and get the information out there, but I think that we need to have some strategies around how do we get more people to enroll in these plans.

Mr. LONG. All that being said and talking about enrollment, could this lead to fewer comprehensive plans being offered?

Dr. ATKINS. I am sorry, I didn't understand the question.

Mr. LONG. I said could this lead to fewer comprehensive plans being offered, forcing rather than facilitating?

Dr. ATKINS. If we go to a FIDE SNP, for example? I mean I think a FIDE SNP is incredibly—

Mr. LONG. Trying to move too quickly, is that going to—

Dr. ATKINS. Oh, if we go too quickly, are we scaring people away? Well, I think in each State where these products get launched, the State has to do the work initially. It may take a year or more to work with all of the groups that are affected.

Just as an example, in Kansas when they brought managed LTSS to the IDD population, intellectually and developmentally disabled population, which has been carved out of most of these in many States, at first blush, there was a lot of resistance because the State had not communicated what was going on to the population. The plans had to spend the first year just communicating with the advocacy groups, working with the service delivery system that was there, getting them to understand what was going on before they actually started to launch services and enroll people. So those are the things that just have to happen because there is so much lack of understanding.

Mr. LONG. I have got one more question, it is again for you, Dr. Atkins. You also state in your testimony that facilitating full integration will only be possible initially in States that enroll dual beneficiaries in Medicaid managed plans, yet enrolling dual eligibles in managed care requires a waiver, and the process of retaining a waiver can often be long, challenging, and uncertain.

How can we, as a committee, facilitate integration, while not relying on States to get waivers from CMS?

Dr. ATKINS. Do you want to answer that?

Ms. BELLA. Depending, there are ways that States can have their beneficiaries in managed care. They don't require—they are not 115 waiver process. They can do it through a State plan process. And so, depending on the path the State takes, there are more or less complex ways of doing that.

If you are asking are there ways that we could make it easier for States who want to do integrated programs—

Mr. LONG. Right, as a committee, how can we assess?

Ms. BELLA. Yes, there are ways to do that. They are somewhat State-specific, depending on how the States structure their program, but there are always ways that we can simplify and making these two programs work better together.

Mr. LONG. OK.

Dr. ATKINS. But I will say that there is a very strong movement in this country right now toward managed LTSS. We have got three more States coming in this year. We have a number of States lined up starting the process for next year and beyond. And so we have expanded the number of States already that are involved in MLTSS and that movement is pretty strong because it is really to the States' advantage in trying to manage these costs to do these managed care contracts because they can really get their arms around trying to figure out how to keep the population that has been in institutions or is headed toward institutions really stabilized in the community.

Mr. LONG. Thank you. Mr. Chairman, I have no time left, but if I did, I would yield it back.

Mr. BURGESS. The Chair appreciates the gentleman's offer. The Chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DEGETTE. Thank you very much, Mr. Chairman. I want to thank Chairman Walden and Ranking Member Pallone for having this hearing on SNPs, and you, too.

I am really happy that the SNP Reauthorization Act includes this bill that I have been working on with Representatives Lance and Kennedy and also our colleagues on Ways and Means, Congressman Meehan and Congresswoman Sewell.

What this bill does, H.R. 3044, it expands supplemental benefits for chronically ill Medicare Advantage enrollees. What it does, under the bill, both traditional Medicare Advantage plans and SNPs, would be able to offer individualized benefits that meet the specific healthcare needs of chronically ill enrollees. And I know you have all been talking about this today.

Supplemental benefits could include services that are not traditionally covered by health plans like meal delivery, as long as there is a reasonable expectation that such services will maintain or improve health. For example, somebody mentioned today that the new flexibility would allow plans to purchase air conditioning for COPD or asthma patients who couldn't otherwise afford it. Now even though that is not a traditional healthcare service, such a change in a patient's living environment could have huge health benefits. I think that this common-sense legislation will lead to better health outcomes and improve quality of life, including in my own State, 273,000 seniors.

And I just really want to thank the committee on a bipartisan basis for including our bill in this broader bill that we are considering today. And so I hope we can continue to work in a bipartisan basis to reauthorize the SNP program and include this common-sense bill that we have.

Mr. Wing, I was really struck by your testimony about the gentleman who had Parkinson's and glaucoma and how all you needed to get was a wrist band for him so he could put his eye drops in.

This is true with so many seniors and what we end up doing, and part of it is because Congress doesn't really know how to look at budgeting for prevention and management. And it is very frustrating for our constituents. This is something that Chairman Burgess and I have actually been working on for a long time, trying to figure out how to incentivize prevention through the budget process, rather than just paying for more and more emergency services and whatever.

And so, I am just wondering, I know in your testimony, you said you strongly support provisions in the SNP Reauthorization Act that grant increased flexibility to use supplemental benefits of non-medical services. Do you have some other examples that you can share with the committee today?

Mr. WING. Sure. Thank you for the question. I mentioned that the fall often necessitates a hip fracture and a hip fracture necessitates not only a hospital admission, but oftentimes long-term facility admission. Oftentimes, if you have just grips in the toilet, the shower, and solid flooring in the kitchen, solid flooring in the bathroom, you can negate the fall that precipitated the hip, and again, knowing what is going on in the home.

Oftentimes, a doctor is going to look for medical solutions, but oftentimes there is a social solution. Maybe a little bit of inhome support, a low-level person coming in and helping with food, with bathing, with activities of daily living for a member that is in a straight MA plan. We prevent them from having an ER visit, a hospital visit, and since we are at risk for the Medicare benefits want to give us the flexibility to prevent that and provide better care for the beneficiary and reduce costs for the system.

Ms. DEGETTE. Doctor, I see you nodding your head. Did you want to add to that?

Dr. ATKINS. I think it is a very important move forward and given this flexibility in MA. Because we have to keep in mind that the only benefits we provide on long-term services and supports in this country are under Medicaid. And so we are serving a very small portion of the population that has fairly substantial LTSS needs. The more we can do to create more flexibility in the Medicare Advantage program in cases where the services that we are going to authorize the plans to provide actually help reduce the overall costs of the plan anyway.

Ms. DEGETTE. Right.

Dr. ATKINS. So it is really improving outcomes and reducing costs. I think that is really important to try to explore as much of that as possible. And I know you are familiar with the Bipartisan Policy Commission. In fact, Council's report recently about other ways to do that.

Ms. DEGETTE. Thank you. Thank you very much. I yield back.

Ms. BLACKBURN [presiding]. The gentlelady yields back. Mr. Carter, you are recognized 5 minutes.

Mr. CARTER. Well, thank you all for being here, certainly an important subject.

I want to start off with something that is bothering me. I get the SNPs. I get the Institutional in I-SNPs. I was a consultant pharmacist in a long term care setting for over 25 years. And I can understand and see how they work. And I can see the benefit of that.

I can see the chronic, the C-SNPs. I can see the benefit there. I have witnessed that through my practice in retail pharmacy. I have seen how they are beneficiary.

What I struggle with and I have always struggled with is the dual eligible. Explain to me why we have to have dual eligible? Explain to my why we can't introduce legislation that says you have to be one or the other. You are not going to be both. I mean just simplify it for me.

Dr. ATKINS. Well, one of the critical things is that Medicare doesn't really cover anything but medical expenses and for many of the people we are talking about who have very complex care needs, being able to address their nonmedical needs can have more impact on their overall health than the cost of care for them than spending the money on the medical side. So Medicare is limited in its capacity to serve this population completely.

For those people who are in Medicaid and have the long-term services and supports covered in the Medicaid program, they have those services available to them. Where you have dual coverage—

Mr. CARTER. Then why don't you just let them be Medicaid? Say you are going to be Medicaid. You are not going to be Medicare.

Ms. BELLA. In 1965, the then Congress created two programs with two separate titles. These folks qualify under both title. So the only way to get rid of it is to have a new title that encompasses the medical—

Mr. CARTER. OK, I want to introduce a new title, and it is going to be you are one or the other. Just explain to me. I just struggle. I have always struggled with it.

Ms. BELLA. The challenge with this population is they, right now, they are eligible to get their medical needs met through Medicare and their long-term supports and behavioral health and wrap-around services met through Medicaid. So you can't really put them in one or the other because they—right now, the system gives them both. And so if you want to make a choice, then you have to make them ineligible for one or the other because today, they are eligible for both and they need both types of services, medical and nonmedical.

Are they delivered in the right way? No. Is it efficient to have them delivered this way? No. Do we need a new title? Yes. Are these things that we are talking about today, are they important steps? They are, if we can align incentives which is part of what we are talking about today to put things together, give the money to one entity and start to fix some of these problems that have kept having accountability.

Mr. CARTER. Is that what your PACE program is?

Dr. ATKINS. Yes, that is what PACE is.

Mr. CARTER. So that is the answer I am looking for here. Is we need PACE.

Dr. ATKINS. Well, PACE needs to be—

Ms. BELLA. They are two separate titles.

Mr. CARTER. So we are just going to create another title.

Dr. ATKINS. The only thing I would suggest, I think there should be a category of integrated plans and they should have their own statutory and structure and regulatory structure. But to get away

from having two sources of money coming into these programs, one from the Federal Government and one from the combination Federal and State government, the Federal Government would have to be willing to essentially take the Medicare money for these people and give it to the States to serve that population.

Mr. CARTER. And what would be wrong with that?

Dr. ATKINS. Nothing.

Mr. CARTER. Listen, the source remains the same.

Dr. ATKINS. Right.

Mr. CARTER. Whether it is Medicare or Medicaid, guess where it is coming from originally. It is coming from here, whether it is administered through the State.

Dr. ATKINS. Right. In the MMP program we have a three-way contract with the Federal Government and the State and the plan all work together. If the Congress so chose, they could take that Medicare money and just essentially hand it to the States and let them run the contract, if that was what people wanted to do. But that would be a major shift from where we are today.

Mr. CARTER. I can't imagine. I just have struggled with this for many years to understand this, why we can't simplify to it where you are on one or the other. And I get it. I know that people who are eligible for Medicare who are lower incomes need that safety net program to help them because there are services that are not covered, but still, I don't understand why and maybe I need to understand the PACE program. I have got 20 seconds left. Can you tell me how it is going to benefit and how it would help with this?

Ms. BELLA. Both PACE and what he is referring to as the MMP, which is Medicare-Medicaid Plan, give an entity the payment for both Medicaid and Medicare services. There is one contract. So you are not kind of fighting two different regulators. You attempt to align the administrative requirement. So they are the closest things we have to sort of having it be seamless that there is really two programs behind it. So they are the models that you would use if you were trying to get away from having two separate programs that are constantly at odds with each other.

Mr. CARTER. OK. My time is up. I yield back. Thank you.

Mr. BURGESS [presiding]. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions, please.

Mr. SCHRADER. Thank you very much, Mr. Chairman. I appreciate that. Dual eligibles is really the absolute gold standard by which I think healthcare delivery in this country will be judged if we are going to make improvements. They are the most expensive population, require the most attention, to my good colleague's comments earlier, the fact that we have got two different programs dealing with a complex population with many needs is confounding.

I would take a slightly different approach. I like what I was hearing from Mr. Atkins about, you know, starting over, an integrated model with overarching rubric that the States could play into that combined the better aspects with one set of criteria, not two, with Medicaid having one set of eligibility requirements and Medicare having another. It seems like the time has come with the SNP programs, the MMP programs, come up with some sort of way that we could have a common standard by which the monies get

delivered to one spot, however much money that is, and then the States again, under some overarching rubric, come up with a better way, more efficient, more coordinated way that would be maybe up front a little costly, but over the long haul yield measurable, better outcome results that would decrease the cost for these very difficult patients going forward.

That would be fun to work on. I think based on the testimony I have heard so far, I think you would find a lot of willing participants, both sides of the aisle, across the political spectrum to do that.

Currently, the money that comes into these MMPs or the SNP, the dual SNP programs, is it the—I am a little ignorant here also in terms of how the money flows. Is it always a case that the full Medicaid payment and the full Medicare payment come into these programs and are utilized by whatever program delivery system is there, Mr. Atkins?

Dr. ATKINS. Well, yes, I would defer to my colleague who actually ran the program to be a little bit better informed on how the mechanics work. But go ahead.

Ms. BELLA. Sure. The Medicare-Medicaid rate, the Medicare-Medicaid Plans, the Federal Government and the States set the rate, and they give Medicare and Medicaid money to the plan, and it encompasses the full set of Medicare and Medicaid benefits.

In the arrangements where you have Medicare managed care and a SNP or a FIDE SNP, it varies by State. In the most integrated products, the same plan is getting capitated amount for all the Medicaid benefits and Medicare benefits?

Mr. SCHRADER. So how does the overall amount of dollars compare to the two separate payments that are out there?

Ms. BELLA. In the MMP products, the two payers, we took those factors into account and assumed benefits of coordination and reduced duplication and took cost savings off the top of that.

Mr. SCHRADER. I think that has a lot of appeal to members on both sides of the aisle. Instead of having two big payments that add up to X plus, we have one that adds upto X or X minus because of that coordinated care. I think you a lot of willing participation.

Dr. ATKINS. Yes, and one of the other issues is just when you are dealing with a very frail or a population with a lot of very complex care needs is the risk adjustment that goes into the payment to make sure that it adequately reflects the social factors that are binding on these populations as well.

Mr. SCHRADER. And risks gaming the system a little bit, not that anyone would do that, but everyone then would be compensated for the degree of risk that they are incurring given the complex needs of their particular people going forward.

I guess the other point I would make that Mr. Wing touched on a little bit is that there is a very fantastic bill out there that Mr. Lance and myself have to keep people from falling into, hopefully, the dual-eligible situation, i.e., making sure low income Medicare patients can access some of the advantages of this integrated approach and I would hope that there is an opportunity as we go forward to include this type thing. Again, we are thinking of cost savings rather than having someone have to spend themselves down

into Medicaid to be able to take advantage of the dual-eligible MMPs or PACE or whatever the program is. We could start giving some of these inhome, community-based services earlier on and save a ton of money from having to pay for these very same people on a more institutionalized or more expensive setting going forward.

So I would hope the Chair and ranking member would look forward to working with us on this, maybe going forward and see if we can't continue to improve a very good system that seems to be developing here. With that, I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from North Carolina, Mr. Hudson, 5 minutes for questions, please.

Mr. HUDSON. I thank the chairman and thank you, panel, for being here today. It is very helpful helping us grapple with this very complex issue. You have touched on this in your testimony a little bit, but I have a question, sort of about the deadlines and time frames under our discussion draft. Do you think these time frames and deadlines for integrating benefits and providing services is realistic to States that need more time? I just ask if anybody has a comment on that.

Dr. ATKINS. I think the way it is structured for States that haven't been able to do managed care on the LTSS and behavioral health side, there is a way to get around that and kind of be able to do it even with a fee-for-service kind of structure in place there. So I think that is an important carve-out because a lot of States aren't yet in the position to be able to have aligned Medicare and Medicaid managed care plans.

But I think the time frames, as far as what I have seen, in the legislation seem reasonable.

Mr. WING. SCAN also believes that the movement to full integration for the D-SNPs is mission critical. Unless we have integration, there is no hope for savings, long-term savings, keeping people out of nursing homes for the State which is a big burden for the State. So I think it is 2021 and legislation and we support that. We think if there is a FIDE SNP at any stage, there is a lot of FIDE SNPs like SCAN in the United States, we think a 4-year time frame is very, very doable and essential.

Mr. HUDSON. Great. I appreciate that. Dr. Atkins, in your testimony, you know, what we have also heard from the GAO that there are not standardized measures for long-term services and supports that have been widely adopted or broadly used. However, it sounds like your association has initiated an effort to adopt quality measures that can meet the State requirements or yet not burdensome for plans. This sounds great to me, but I am wondering if you could tell me more about when you think the association will have more to report to us. Obviously, the more data points we have to deal with, the better.

Dr. ATKINS. Thank you for that question. I will say that we have adopted a quality framework which is a list of the indicators that we would feel we were able to report in a reasonable time frame. We will have to put all of this into effect, all the companies who participate will agree to put all of this into effect.

These are measures that we did not create. These are measures that have gone through the NQF process or are being developed by Mathematica for CMS or are generally out there in the home and community based consumer survey.

So there are existing measures that we believe that we can actually produce now out of our databases. So the process we are going through right now is to do what is called specification. We are actually digging down into each of our plans to see where the data is going to come from and how consistent we can get it to be across all of these.

Our purpose is not to do it unilaterally by ourselves, but to work with our States to encourage the States to essentially accept these measures that we would report as measures that are used in overseeing the quality, integrating with the quality reporting systems that they are going to have in place because it is a State function to report this.

Mr. HUDSON. Right. I think that is critical for being able to determine the impact on the beneficiaries.

Dr. ATKINS. We would be glad to come back and talk to you in a couple of months with some much more detail about where we are with it.

Mr. HUDSON. I think it would be great, Mr. Chairman. I hope we can encourage that and I will yield back the balance of my time if anybody else would like to use it. Thank you.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman for holding this hearing and to the witnesses, thank you for your wonderful testimony. You bring enormous expertise to the hearing room and we all appreciate it.

I am fascinated by the question of our colleague from Georgia about why does it have to be this way? Do we need a new title? Why do we have part of Medicare? Why is it in Medicaid? And I can't help but think of the President saying "Whoever knew that healthcare could be so complicated." So we are dealing with the complications here and these hearings are targeted to specific areas, but they also broaden and deepen our understanding of the system that we have and how we want to improve it and what is important to do.

What stands out to me today is how important Medicaid is, I mean how essential it is. And so the broader context in terms of what we are dealing with, whether some of us like it and some of us don't like it is that the House passed a bill that fundamentally restructures the Medicaid program by implementing per capita caps and block grants and the Senate is debating a lot of things, but we know that Medicaid is on the chopping block.

Now this discussion about reauthorizing, I think we should reauthorize. I think that we need to make some changes and you have brought some very good ideas to the table, but the reality is that I think anyway, Medicaid is hanging by a thread. I think it is hanging by a thread. Forget the ACA. Medicaid itself as an entitlement is hanging by a thread.

So my question, I guess I will start with Ms. Bella, is what would that do to dual eligibles? I mean it is my understanding that 70 percent of the SNP plans have dual eligibles in them, so can you talk about what if there is, in fact, an implementation of per capita caps or block grants in the Medicaid program, how does that affect what we are talking about today? We are talking about improving it, but the larger picture is that it is up to a 35 percent gouge of Medicaid itself.

Ms. BELLA. So I guess a couple of things. One, we are talking about improving it and improving it means we can put a full kind of cadre of Medicaid-funded services along with the medical piece.

Ms. ESHOO. I understand what those are. I worked on this years ago when I was a county supervisor for the dual eligibles. And we developed a capitated plan in the county.

You know what? I took care of my parents and they were blessed with a long life. And I know what is needed in the home. They are better off at home if, in fact, you can bring the kinds of services that they—the particular services that they need. So while they weren't enrolled in Medicaid, they were Medicare beneficiaries, they had the beneficiary of their daughter, too. But in terms of the care, I understand it.

Ms. BELLA. Right, so those services—

Ms. ESHOO. And the care for each one of them was unique.

Ms. BELLA. Right, those are the services that are at risk with a per capita or some sort of Medicaid block grant. And it is those services that are keeping people in these integrated programs out of the hospital and out of other places.

Ms. ESHOO. See, thank you for saying that. I hope everyone is listening to this. Because we are dealing with frail, elderly people that are far more vulnerable. I have always thought—I remember saying to the doctor when he said I think we need to take your father to the hospital and I said well, what are they going to do at Stanford Hospital that I can't do here at home for him? He said, you know, you have got a good point. So we kept him at home and in three and a half days, he was much better. But I think that in some ways we have got our heads in the sand here, because we are talking about how to do this, what it is, reauthorizing and meanwhile in the larger bubble, there is a wrecking ball that is going up against Medicaid. So we have got some choices here and I think we need to tell the truth about what is going on which is so frustrating to me. I am glad we are having the hearing, but you know what, we are pretending that everything is all right. And it is not because what is at hand is going to take a wrecking ball to what these people have come here to testify about. Thank you, and I will yield back.

Mr. BURGESS. The gentlelady's time has expired. The Chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions, please.

Mrs. BROOKS. Thank you, Mr. Chairman, and I, too, thank you for providing your expertise to all of us.

I have heard a lot of discussion today about the need for more integration coordination, but one policy area I know there is often typically a lot of bipartisan interest in is the issue of telehealth and it is something that—I represent a district that is urban, suburban,

but very rural as well. I know that one school in a smaller community of Elwood, Indiana, has begun some telehealth with the school nurse and I know that this is something that I think could have tremendous benefits to citizens throughout the country.

So I am interested in each of you commenting on the policy idea that many Medicare Advantage plans have expressed an interest in, and that is to allow Medicare Advantage plans to offer telehealth as part of their bid, so they don't have to use rebate dollars to provide it. They have an incentive to be efficient in their bids and this flexibility could be particularly helpful with the frail, disabled, or homebound beneficiaries and beneficiaries in rural areas that I just discussed.

So I wondered if you could please share with us, if you think it would be useful to give special needs plans this authority, at least for the next 5 years, and to see how this tool could boost the health outcomes for patients and what each of your thoughts are on telehealth and these types of plans.

Mr. Wing?

Mr. WING. I will start. I mentioned earlier that we have a pilot of behavioral health telehealth which we think is mission critical. And when you are dealing with the fully integrated D-SNPs, we are talking about a very vulnerable population and a lot of them, as you mentioned, are homebound. And so we need to figure out how do we bring the delivery system into their home?

In telehealth, the technology is there. The funding isn't, but the technology is there. And we are using it for telehealth, but for truly homebound members who don't have the financial wherewithal to go to a doctor, don't have the transportation to go to the doctor. They either have cognitive impairment or other reasons why they can't go to the doctor. We need to bring the delivery system there.

Now you can bring doctors to the home, but that is a very expensive proposition. Telehealth seems to hold the hope of bringing medical physicians, psychologists, psychiatrists, and other providers into the home at a fraction of the cost in real time. And oftentimes, these frail duals, they can't wait 15 days to get in to see a specialist. They need to see them now. So we are very supportive.

Mrs. BROOKS. Any particular reason why you are only focused on behavioral health?

Mr. WING. No. We are a small company. We happen to find this company out of Nashville and know that behavioral health, opioids is a really big issue of the senior population in aggregate. When you take the duals, it is a very pressing issue. I think 48 percent of our dually eligible have a clinical diagnosis of depression, 48 percent. When you see those numbers, you have to do something about it. And we can't bring a psychiatrist, a psychologist in a home. First of all, we don't even know the diagnosis yet. So we think telehealth is the right modality for behavioral health, but probably for a lot of other type of specialties.

Mrs. BROOKS. Thank you. Dr. Atkins?

Dr. ATKINS. I think Mr. Wing spoke earlier about the importance of eyes and ears in connecting the medical and nonmedical parts of the delivery system and that is critical. I think that we have to explore a lot of technology solutions that are going to enable us to be better connected in people in their homes who have these very

complex care needs. Telehealth certainly is going to be a major part of that.

Mrs. BROOKS. Ms. Bella, do you see any impediments to us advancing telehealth in Medicare Advantage plans?

Dr. ATKINS. No, especially if it is part of a broader push to recognize supplemental benefits generally that plans could be given more flexibility around when they are taking the financial risk.

Mrs. BROOKS. Actually, building on that issue regarding supplemental benefits, could you give us examples of supplemental benefit plans, benefits that plans provide and how they improve patient outcomes, other supplemental benefits?

Ms. BELLA. Sure, I think—Chris, do you want to answer?

Mr. WING. Well, again, if you take the FIDE SNP where we can provide these Medicaid type of benefits, you know, I mentioned I wrist card, solid flooring in the bathroom, solid flooring in the kitchen, guard rails in the toilet area and the shower that prevent the fall, a home- and community-based services, having a home health aide to help with bathing, cooking to prevent nursing home viable people being placed in custodial care. It is really being able for a Medicare Advantage plan to offer Medicaid-like benefits to prevent the reason for necessity for acute admission or even more importantly, going into long-term custodial care where they are never going to come back from. These are really demonstrated long time demonstrated benefits that really curtail costs, but they radically improve the quality of life for beneficiaries.

Mrs. BROOKS. Thank you. Thank you for those examples. I yield back.

Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady yield back. The Chair recognizes the gentlelady from California, Ms. Matsui, 5 minutes for questions, please.

Ms. MATSUI. Thank you, Mr. Chairman, and I want to thank the panelists here today. We are learning an awful lot and realize that there is so much more to learn here.

I have got to say that the future of special needs plans is so very important as we move forward because since their creation I guess in 2003, we have seen success in managing complex populations across Medicare and Medicaid, such as those dually eligible for programs and seniors with chronic conditions like diabetes and dementia and so forth.

But as we see the increase in population and look to see the quality of care that the individuals have gotten, I think it is important because sometimes it is not as successful and we really need to be very clear as we move towards full integration in Medicare and Medicaid options for the chronically ill and dual-eligible beneficiaries. The protection of beneficiary rights and the quality of care that beneficiaries receive should be the first consideration when evaluating any policy change. To that end, I think one of the most important things that could impact a beneficiary's experience is a unified appeals and grievance process.

Now I know that for many individuals, it can be overwhelming to understand how to appeal, doubly so if you are a person who happens to have both Medicare and Medicaid benefits.

All of our witnesses have highlighted the importance of a consistent and understandable appeals process for our beneficiaries, but I would like to dig a little deeper into this.

Mr. Wing, can you discuss how appeals and grievances work in the FIDE SNP, and how this is different from other types of SNPs?

Mr. WING. Well, I will talk about one of the solutions is we do suffer from the different rules for Medicare and Medicaid. We have to deal with that. I think Melanie Bella has been talking about that for years. It is very complex. It is confusing for the members, for the family, for the doctors and that confusion leaves people to go, I am not going to join.

Ms. MATSUI. Right.

Mr. WING. At SCAN, we have what we call for our fully integrated D-SNPs, we have basically concierge care. We want these people to stay with us, but when they are having a problem with an appeal or a referral or anything, we want them to have a one-on-one relationship with somebody in our call center that is not a bank. So everyone of our fully integrated D-SNP members have what we call a PAL, personal assistant line, where they develop a unique relationship with someone at our call center. If they have got a problem with coordinating appeals and grievances we are there for them. If they have got a problem with the delivery system, we are there for them. If they have got a problem with how we deliver care or home health aide services at home, we are there for them. And that is mission essential. These people, they have got a lot of special needs, complex needs. They need the system to come alongside them as opposed to them coming along aside the system.

Ms. MATSUI. OK. Ms. Bella, can you talk about this issue from the perspective of your former role as Director of Medicare and Medicaid Coordination Office? What barriers did you encounter?

Ms. BELLA. In the grievances and appeals specifically?

Ms. MATSUI. Yes.

Ms. BELLA. There are some legislative barriers and then there are some administrative barriers and so part of the—the language that is in the House bill will go a long way toward fixing, so in the Medicare-Medicaid programs there are different requirements about time frames, for example, and what level you have to go to, for example.

And so in CMS, in the demonstrations, we were able to integrate some of those things, but we just couldn't go quite far enough and we were still doing it under demonstration authority. Again, the language that you are considering today makes a huge step forward and then there are some administrative pieces where we can continue to wrap around that. That would streamline it even better and make it both protective of the beneficiary, but also make it easier for all parties to operate under.

Ms. MATSUI. OK. Thank you. Dr. Atkins, even with your associations, why diversity in membership? It seems like this is an important recommendation that has been agreed upon. Can you discuss why unified appeals are so important from the beneficiary perspective?

Dr. ATKINS. Well, certainly. I mean one of the more confusing aspects of the system is the different routes and different time frames and things that are involved in appeals and grievance under the

different programs. So I think it is critical that we work toward getting a single set of uniform set of rules.

We would, of course, love to see a common architecture in the program, a common architecture for integrated plans that would address a lot of these kinds of issues.

Ms. MATSUI. Right, right. I think it is really important as we talked about the unification of—and I think it is very, very difficult, as we know, in Medicaid and Medicare. But there is aspects here that I think I could see having some sort of unifying aspect of it where people aren't as confused as to what to do as we move forward. I see my time is gone. I yield back the balance.

Mr. BURGESS. The gentlelady yields back. The Chair thanks the gentlelady. The Chair observes that the Chair has actually delayed his time for questions to the end. We also have been joined by Mr. Costello, who is not on the subcommittee, but I believe the gentleman would like to seek time for questions. Is that correct?

Mr. COSTELLO. Yes, thank you, Mr. Chairman.

Mr. BURGESS. I will recognize the gentleman for 5 minutes for his questions.

Mr. COSTELLO. As a follow-up, to a line of inquiry that Mrs. Brooks had to you, Mr. Wing, could you share with me the certain types of specialty providers, be they medical or nonmedical, that you see most likely to begin or most likely to have the capacity to offer telehealth services?

Mr. WING. I thought you were going to go a different direction. I appreciate the question.

Mr. COSTELLO. You can take another direction.

Mr. WING. I thought you were going to ask me what is the specialty or type of provider that is going to make the most profound difference in the future.

Mr. COSTELLO. That was going to be my next piece of it.

Mr. WING. I like that question. I think it is going to be community health navigators. These people are \$14 or \$15 an hour, but going into the people's home, assessing what is going on with the social determinants. This is a low-cost, high-impact intervention. We would like to flood the market, especially for those who are nursing home certifiable, and make sure we are identifying the social determinants of health quickly, make sure the doctor knows. But I see no greater innovation. I don't think this is a medical problem that requires medical intervention. This is a social problem that requires a social solution and I think having an army, if you will, covering fully integrated D-SNPs or seniors who have Chronic Special Needs Plans, I think is going to be one of the most pronounced interventions, the most impactful interventions to improving quality and reducing costs that we are going to see over the next 5 to 10 years.

Mr. COSTELLO. Thank you. Ms. Bella, your testimony comments on how there are things that CMS and States can do to improve the coordination of benefits and delivery of services for dual eligibles, including those with disabilities. You know that State Medicaid manuals should move toward capitation of their LTSS and behavioral health benefits.

You also said though that they need assurance that if they go down this path, the future of D-SNPs is not uncertain. So to con-

firm, you are effectively saying that a longer extension would allow more planning and investment in infrastructure and policies that would better serve individuals with disabilities? Is that correct and could you expound upon that a little bit?

Ms. BELLA. Sure. I am actually saying that permanency would go the furthest because these have been sort of in limbo since 2003, meaning every few years people are wondering do we have to come back and argue for their case. And so Pennsylvania is a great example. Your State just spent several years putting together a managed LTSS program. They put in their Community HealthChoices Program. They have required all those participants to be D-SNPs. Tremendous amount of work. Tremendous amount of progress. And we want them to keep investing in that with already limited resources. They can't feel like it is at risk of going away. So if we want to get States to continue building these programs, they need the assurance of knowing that this program is permanent and stable.

Mr. COSTELLO. Thank you.

Dr. ATKINS. Could I add one thing to that which is that the MMP program, which is the demonstration program, has a time limit on it and we have a lot of people enrolled very successfully in MMP programs. It would be helpful for those people to know where they go when that demonstration ends.

Mr. COSTELLO. Thank you for your thoughts and thank you, Mr. Chairman.

Mr. BURGESS. Does the gentleman yield back?

Mr. COSTELLO. I do.

Mr. BURGESS. The Chair thanks the gentleman. The Chair recognizes himself for the balance of the time. Just checking to see if you are paying attention. Ms. Matsui, apparently not.

First off, thank you all for the very intriguing discussion this morning.

Mr. Wing, let me just start with, you mentioned right at the end here of this, something that I have thought for a long time, which is—you even used the term—“concierge medicine.” Yes, navigators are important. Yes, the home health aides are important. But you can have all the fingers in the world, but if you don't have a palm, it doesn't do you any good.

So I remember having this discussion with Dr. Berwick when he was CMS Director, many, many years ago, that when I voiced some of the same frustration that the gentleman from Georgia voiced this morning about not understanding why we have these programs that are sometimes difficult to comprehend and navigate, why there wasn't just one place and that, to me, would have been that position of the concierge or direct primary care or whatever you want to call the model.

So I was grateful to hear you mention that this morning. I do think that that is a direction that this subcommittee should explore. I have felt that for a long time.

And Ms. Bella, even the agency that you used to head up when we look at the enabling language in the Affordable Care Act, the establishment of a Federal coordinated healthcare office, that was the goal. And when I talked to Dr. Berwick and I said why don't we do a concierge doctor for these poor folks and actually take care

of them, his answer was we are going to set up a new Federal agency. I wasn't thrilled when he told me that. I probably had a reaction much like Buddy Carter voiced this morning, but at the same time I will also say that as your former office has matured over time, it does seem to be providing a valuable service to patients.

The reports that you generate at the end of every fiscal year—and I guess the most recent one I have is for Fiscal Year 2015, and you were probably involved in the generation of that report, were you not, Ms. Bella? So it is helpful. It is not just a recitation of things that were done. It actually has some meaningful insights and perhaps legislative direction that the legislative branch could pursue, so I think that is a good and positive development.

But again, Mr. Wing, when you mentioned the word concierge medicine, yes, I think that is right. When Don Berwick would complain, I got 20 percent of my folks spending 80 percent of my bucks and I need to do better with that. It seemed to lend itself in that direction. So I would be happy to hear your thoughts on that because this is the first time in all of these years of having these hearings that I have heard anyone actually mention that.

Mr. WING. Well, we believe the center of the universe really should be the doctor.

Mr. BURGESS. That is the right answer. Thank you.

Mr. WING. Well, it should be, but often again doesn't know what is going on in the community, so our people in the community are integrating via a laptop into the EMR with the doctor and we are trying to do the same thing through or provider integration efforts so that any encounter that we have with our PALS unit gets right back with the primary care physician. Primary care physicians armed with complete data will make complete decisions. Without complete decisions, they won't. And we need to arm them to do a better job.

Mr. BURGESS. And are you utilizing, of course, the day the Affordable Care Act was written the smartphone was in its infancy. The ability now that people have to connect even absent a navigator in the home, the fact that their smartphone can electronically transmit a daily weight, a blood pressure, a blood sugar, to some central facility.

Mr. WING. We are piloting—actually, some of our medical groups on their own are piloting, having a smartphone, but really, it is not really doing telemetry of health outcomes or bioreadings, but if you have a problem, here is a number to call. So they have a smartphone. Just call here. If you think you need to go to the ER, if you are uncertain, call us.

However, we spend a lot of time on the fully duals and these people have a lot of cognitive impairment. Oftentimes, they are socially isolated. Oftentimes they have multiple ADLs and multiple chronic conditions. Smart anything, I don't think this is going to solely be a technology answer. It is going to have to be a high touch. We need to have people there to come alongside to help them.

Mr. BURGESS. I don't disagree, but even as the gentlelady from California mentioned taking care of her parents, when I was in a similar situation, the ability to get that information to someone to help you make a decision.

Mr. WING. We are very supportive of that. We are very supportive of that.

Mr. BURGESS. Let me, again—fascinating panel, and I really appreciate all of you being here this morning. I am sorry Ms. Eshoo has already left. I am obligated to answer some of the charges that she made, so I have some stuff for the record, and I want to offer for the record an op-ed from February 7, 1997. The op-ed is almost old enough to vote itself. An op-ed from February 7, 1997, from the New York Times, “Making the Budget Bearable.” This was back in the Clinton administration. Part of the op-ed says, “The President offers an important reform of Medicaid, proposing to control future spending by placing a cap on the amount of Federal spending per enrollee and allowing States to place enrollees in managed care without going through the frustrating process of begging for Washington’s approval.” The New York Times recommending the per capita cap. That was an idea of a Democratic administration back in the 1990s.

Further evidence, Senator Murray from Washington State. Senator Murray speaking on the Congressional Record December 22, 1995: “Mr. President, I hold in my hand today a letter to President Clinton that is signed by all 46 members of the Democratic Caucus. This letter urges him to hold firm in our commitment to basic healthcare for children, pregnant women, and the elderly, and the disabled... . This letter supports a per capita cap approach to finding savings in the Medicaid program.” This was a problem 22 years ago. It is no less a problem today.

As Margaret Thatcher once aptly observed, you can eventually run out of other people’s money. And that is a concern that, although this is an authorizing committee, not an appropriations committee, it is a concern that we should have as well. And I think one of the things that this panel helps us with today is understanding we need to be spending dollars wisely. It is not that we are not going to spend dollars, but we need to spend them wisely.

This is not a new concept of what is being debated in this committee this year and over in the Senate, even as we speak, not a new concept, one that was embraced by a Democratic administration 21 years ago, Democratic Senators 22 years ago, the New York Times 20 years ago. So it has been an interesting panel this morning. I want to thank you for being here.

Seeing that there are no further Members wishing to ask questions, I again want to thank our witnesses. We have received outside feedback from a number of organizations on these bills, so I would like to submit statements from the following for the record: Molina Healthcare, Avalere, the Healthcare Leadership Council, the National Association of Medicaid Directors, AHIP, the Association for Community Affiliated Plans, Bipartisan Policy Center, UPMC, and a letter from 12 advocacy groups on Special Needs Plans.

Additionally, I want to submit the New York Times editorial from 1997 and the Congressional Record statement from 1995. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Pursuant to committee rules, I remind Members they have 10 business days to submit additional questions for the record. I ask

the witnesses to submit their response within 10 business days upon receipt of the questions. Without objection, this subcommittee is adjourned.

[Whereupon, at 11:59 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

This morning we have a distinguished panel of witnesses to discuss the ways the committee can improve Special Needs Plans in Medicare Advantage as Congress looks to extend the authority for this program in the coming months. Special Needs Plans, or SNPs (pronounced “SNIPS”) are private healthcare plans providing Medicare benefits to some of our most vulnerable beneficiaries. These are elderly beneficiaries who are in care facilities, who have chronic conditions or diseases, and who are low-income and are enrolled in Medicaid.

As a committee with jurisdiction over both Medicare and Medicaid, we have a special obligation to thoughtfully examine this unique opportunity to not only extend the SNPs’ authority, but to make refinements to policy which can improve the ability of States and plans to provide needed care to millions of beneficiaries. As we embark on our effort, we recognize and appreciate the good bipartisan committee work that has preceded us—efforts by our colleagues in the Senate and in the House Ways and Means Committee.

Today, we complement previous efforts by hearing from experts and releasing draft legislation. Our bipartisan goal is to extend and enhance the program in a manner that encourages integrated, coordinated healthcare coverage.

We want to ensure healthcare plans and State Medicaid programs have the right incentives and proper tools to offer the best care to vulnerable patients. We also want to help ensure patients have the needed protections and help when navigating healthcare benefits and accessing care.

We welcome and need stakeholders’ feedback on how we can move forward on SNPs in a manner that improves care, enhances quality, and best serves millions of patients. I’d like to thank our witnesses for being here with us today, and I look forward to a productive discussion that will help us move forward on this critical issue.

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Thank you, Mr. Chairman, for calling this hearing to consider the extension of Special Needs Plans, an important subset of Medicare Advantage plans for some of our highest-need Medicare beneficiaries.

It is so important that our committee consider the extension of SNPs, as they are often called, and any related policy changes with the program closely. These types of plans serve some of our most complex and vulnerable patients: those that are institutionalized or have serious chronic illnesses, and those that are dually eligible for Medicare and Medicaid.

It is undeniable, also, that these types of Medicare plans have a unique interaction with Medicaid. And, as the chairman has heard me say so many times, the Energy and Commerce Committee has the critical responsibility and privilege of overseeing and protecting the Medicaid program. First and foremost, we should ensure that people who are dually eligible for both Medicare and Medicaid or living with a chronic illness have a seamless experience—regardless of what plan or combination of benefits they may elect to receive.

At times, this goal has been challenging, but I know that we have a good opportunity before us with the reauthorization of SNPs to continue to further that goal.

Today, I look forward to discussing how we can best continue to integrate benefits and provide high quality care to people that have chosen a SNP plan to provide their care. Our colleagues on the Ways and Means Committee and the Senate Finance Committee have both done excellent work over the past several months to further the growth and development of SNPs in the Medicare program. And now, I look forward to adding the voice of the Energy and Commerce Committee to that important work.

[E&C DISCUSSION DRAFT]115TH CONGRESS
1ST SESSION**H. R.** _____

To amend title XVIII of the Social Security Act to provide continued access to specialized Medicare Advantage plans for special needs individuals, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

M. _____ introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to provide continued access to specialized Medicare Advantage plans for special needs individuals, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Special Needs Plans
5 Reauthorization Act of 2017” or the “SNP Reauthoriza-
6 tion Act of 2017”.

1 **SEC. 2. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**
 2 **SPECIAL NEEDS INDIVIDUALS.**

3 (a) **EXTENSION.**—Section 1859(f)(1) of the Social
 4 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended—
 5 (1) by striking “and for periods before January
 6 1, 2019”; and

7 [(2) by adding at the end the following new
 8 sentence: “In the case of a specialized MA plan for
 9 special needs individuals described in clause (ii) or
 10 (iii) of subsection (b)(6)(B), the previous sentence
 11 shall apply for periods before January 1, 2024.”.]

12 **[(b) INCREASED INTEGRATION OF DUAL SNPs.—]**

13 **[(1) IN GENERAL.**—Section 1859(f) of the So-
 14 cial Security Act (42 U.S.C. 1395w–28(f)) is amend-
 15 ed—]

16 **[(A) in paragraph (3), by adding at the**
 17 **end the following new subparagraph:]**

18 **[(“(F) The plan meets the requirements**
 19 **applicable under paragraph (8).”; and]**

20 **[(B) by adding at the end the following**
 21 **new paragraph:]**

22 **[(“(8) INCREASED INTEGRATION OF DUAL**
 23 **SNPS.—]**

24 **[(“(A) DESIGNATED CONTACT.—The Sec-**
 25 **retary, acting through the Federal Coordinated**
 26 **Health Care Office established under section**

1 2602 of Public Law 111–148, shall serve as a
2 dedicated point of contact for States to address
3 misalignments that arise with the integration of
4 specialized MA plans for special needs individ-
5 uals described in subsection (b)(6)(B)(ii) under
6 this paragraph and, consistent with such role,
7 shall—】

8 【“(i) establish a uniform process for
9 disseminating to State Medicaid agencies
10 information under this title impacting con-
11 tracts between such agencies and such
12 plans under this subsection; and】

13 【“(ii) establish basic resources for
14 States interested in exploring such plans
15 as a platform for integration, such as a
16 model contract or other tools to achieve
17 those goals.】

18 【“(B) UNIFIED GRIEVANCES AND APPEALS
19 PROCESS.—】

20 【“(i) IN GENERAL.—Not later than
21 April 1, 2020, the Secretary shall establish
22 procedures, to the extent feasible as deter-
23 mined by the Secretary, unifying griev-
24 ances and appeals procedures under sec-
25 tions 1852(f), 1852(g), 1902(a)(3),

1 1902(a)(5), and 1932(b)(4) for items and
2 services provided by specialized MA plans
3 for special needs individuals described in
4 subsection (b)(6)(B)(ii) under this title
5 and title XIX. The Secretary shall solicit
6 comment in developing such procedures
7 from States, plans, beneficiaries and their
8 representatives, and other relevant stake-
9 holders. With respect to items and services
10 described in the previous sentence, appeals
11 procedures established under this clause
12 shall apply in place of otherwise applicable
13 appeals procedures.】

14 【“(ii) PROCEDURES.—The procedures
15 established under clause (i) shall be in-
16 cluded in the plan contract under para-
17 graph (3)(D) and shall—】

18 【“(I) adopt the provisions for the
19 enrollee that are most protective for
20 the enrollee and, to the extent feasible
21 as determined by the Secretary, are
22 compatible with unified timeframes
23 and consolidated access to external re-
24 view under an integrated process;】

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1 【“(II) take into account dif-
2 ferences in State plans under title
3 XIX to the extent necessary;】

4 【“(III) be easily navigable by an
5 enrollee; and】

6 【“(IV) include the elements de-
7 scribed in clause (iii), as applicable.】

8 【“(iii) ELEMENTS DESCRIBED.—Both
9 unified appeals and unified grievance pro-
10 cedures shall include, as applicable, the fol-
11 lowing elements described in this clause:】

12 【“(I) Single written notification
13 of all applicable grievances and appeal
14 rights under this title and title XIX.
15 For purposes of this subparagraph,
16 the Secretary may waive the require-
17 ments under section 1852(g)(1)(B)
18 when the specialized MA plan covers
19 items or services under this part or
20 under title XIX.】

21 【“(II) Single pathways for reso-
22 lution of any grievance or appeal re-
23 lated to a particular item or service
24 provided by specialized MA plans for
25 special needs individuals described in

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1 subsection (b)(6)(B)(ii) under this
2 title and title XIX.】

3 【“(III) Notices written in plain
4 language and available in a language
5 and format that is accessible to the
6 enrollee, including in non-English lan-
7 guages that are prevalent in the serv-
8 ice area of the specialized MA plan.】

9 【“(IV) Unified timeframes for
10 grievances and appeals processes,
11 such as an individual’s filing of a
12 grievance or appeal, a plan’s acknowl-
13 edgment and resolution of a grievance
14 or appeal, and notification of decisions
15 with respect to a grievance or ap-
16 peal.】

17 【“(V) Requirements for how the
18 plan must process, track, and resolve
19 grievances and appeals, to ensure
20 beneficiaries are notified on a timely
21 basis of decisions that are made
22 throughout the grievance or appeals
23 process and are able to easily deter-
24 mine the status of a grievance or ap-
25 peal.】

1 **【“(iv) CONTINUATION OF BENEFITS**
 2 PENDING APPEAL.—The unified procedures
 3 under clause (i) shall, with respect to all
 4 benefits under parts A and B and title
 5 XIX subject to appeal under such proce-
 6 dures, incorporate provisions under current
 7 law and implementing regulations that pro-
 8 vide continuation of benefits pending ap-
 9 peal under this title and title XIX.】

10 **【“(C) REQUIREMENT FOR UNIFIED GRIEV-**
 11 ANCES AND APPEALS.—For 2022 and subse-
 12 quent years, the contract of a specialized MA
 13 plan for special needs individuals described in
 14 subsection (b)(6)(B)(ii) with a State Medicaid
 15 agency under paragraph (3)(D) shall require
 16 the use of unified grievances and appeals proce-
 17 dures as described in subparagraph (B).】

18 **【“(D) REQUIREMENTS FOR FULL INTE-**
 19 GRATION FOR CERTAIN DUAL SNPS.—】

20 **【“(i) REQUIREMENT.—For 2021 and**
 21 subsequent years, a specialized MA plan
 22 for special needs individuals described in
 23 subsection (b)(6)(B)(ii) shall meet one or
 24 more of the following requirements for in-

1 tegration of benefits under this title and
2 title XIX:】

3 【“(I) Meet the requirements of a
4 fully integrated plan described in sec-
5 tion 1853(a)(1)(B)(iv)(II) (other than
6 the requirement that the plan have
7 similar average levels of frailty, as de-
8 termined by the Secretary, as the
9 PACE program).】

10 【“(II) Enter into a capitated
11 contract with the State Medicaid
12 agency to provide long-term services
13 and supports or behavioral health
14 services, or both.】

15 【“(III) To the extent the State
16 does not allow for or require such a
17 specialized MA plan to enter into a
18 capitated contract described in sub-
19 clause (II), enter into another type of
20 integration arrangement, as deter-
21 mined appropriate by the Secretary
22 after consultation with stakeholders,
23 such as by—】

24 【“(aa) entering into a con-
25 tract with the State that requires

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1 notifying the State in a timely
 2 manner of hospitalizations, emer-
 3 gency room visits, and hospital or
 4 nursing home discharges of en-
 5 rollees or otherwise requires shar-
 6 ing data that would benefit the
 7 coordination of items and serv-
 8 ices under this title and the State
 9 plan under title XIX; or】

10 【“(bb) being offered by a
 11 parent organization that also of-
 12 fers a Medicaid managed care
 13 plan that provides long term
 14 services and supports or behav-
 15 ioral health services to the same
 16 enrollees as under such special-
 17 ized MA plan.】

18 【“(ii) SANCTIONS.—For 2021 and
 19 subsequent years, if the Secretary deter-
 20 mines that a specialized MA plan fails to
 21 comply with clause (i), the Secretary may
 22 provide for the application against the
 23 Medicare Advantage organization offering
 24 the plan any of the remedies described in
 25 section 1857(g)(2).”】

1 **[(2) CONFORMING AMENDMENT TO RESPON-**
2 **SIBILITIES OF FEDERAL COORDINATED HEALTH**
3 **CARE OFFICE.—Section 2602(d) of Public Law 111–**
4 **148 (42 U.S.C. 1315b(d)) is amended by adding at**
5 **the end the following new paragraphs:]**

6 **["(6) To act as a designated contact for States**
7 **under subsection (f)(8)(A) of section 1859 of the So-**
8 **cial Security Act (42 U.S.C. 1395w–28) with respect**
9 **to the integration of specialized MA plans for special**
10 **needs individuals described in subsection**
11 **(b)(6)(B)(ii) of such section.]**

12 **["(7) To be responsible for developing regula-**
13 **tions and guidance related to the implementation of**
14 **a unified grievance and appeals process as described**
15 **in subparagraphs (B) and (C) of section 1859(f)(8)**
16 **of the Social Security Act (42 U.S.C. 1395w–**
17 **28(f)(8)).]**

18 **["(8) To be responsible for developing regula-**
19 **tions and guidance related to the integration or**
20 **alignment of policy and oversight under the Medi-**
21 **care program under title XVIII of such Act and**
22 **Medicaid program under title XIX of such Act re-**
23 **garding specialized MA plans for special needs indi-**
24 **viduals described in subsection (b)(6)(B)(ii) of such**
25 **section 1859.”.]**

1 (c) IMPROVEMENTS TO SEVERE OR DISABLING
2 CHRONIC CONDITION SNPs.—

3 (1) CARE MANAGEMENT REQUIREMENTS.—Sec-
4 tion 1859(f)(5) of the Social Security Act (42
5 U.S.C. 1395w-28(f)(5)) is amended—

6 (A) by redesignating subparagraphs (A)
7 and (B) as clauses (i) and (ii), respectively, and
8 indenting appropriately;

9 (B) in clause (ii), as redesignated by sub-
10 paragraph (B), by redesignating clauses (i)
11 through (iii) as subclauses (I) through (III), re-
12 spectively, and indenting appropriately;

13 (C) by striking “ALL SNPS.—The require-
14 ments” and inserting “ALL SNPS.—

15 “(A) IN GENERAL.—Subject to subpara-
16 graph (B), the requirements”; and

17 (D) by adding at the end the following new
18 subparagraph:

19 “(B) IMPROVEMENTS TO CARE MANAGE-
20 MENT REQUIREMENTS FOR SEVERE OR DIS-
21 ABLING CHRONIC CONDITION SNPS.—For 2020
22 and subsequent years, in the case of a special-
23 ized MA plan for special needs individuals de-
24 scribed in subsection (b)(6)(B)(iii), the require-

1 ments described in this paragraph include the
2 following:

3 “(i) The interdisciplinary team under
4 subparagraph (A)(ii)(III) includes a team
5 of providers with demonstrated expertise,
6 including training in an applicable spe-
7 cialty, in treating individuals similar to the
8 targeted population of the plan.

9 “(ii) Requirements developed by the
10 Secretary to provide face-to-face encoun-
11 ters with individuals enrolled in the plan
12 not less frequently than on an annual
13 basis.

14 “(iii) As part of the model of care
15 under clause (i) of subparagraph (A), the
16 results of the initial assessment and an-
17 nual reassessment under clause (ii)(I) of
18 such subparagraph of each individual en-
19 rolled in the plan are addressed in the indi-
20 vidual’s individualized care plan under
21 clause (ii)(II) of such subparagraph.

22 “(iv) As part of the annual evaluation
23 and approval of such model of care, the
24 Secretary shall take into account whether

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1 the plan fulfilled the previous year's goals
 2 (as required under the model of care).

3 “(v) The Secretary shall establish a
 4 minimum benchmark for each element of
 5 the model of care of a plan. The Secretary
 6 shall only approve a plan's model of care
 7 under this paragraph if each element of
 8 the model of care meets the minimum
 9 benchmark applicable under the preceding
 10 sentence.”.

11 (2) REVISIONS TO THE DEFINITION OF A SE-
 12 VERE OR DISABLING CHRONIC CONDITIONS SPECIAL-
 13 IZED NEEDS INDIVIDUAL.—

14 (A) IN GENERAL.—Section
 15 1859(b)(6)(B)(iii) of the Social Security Act
 16 (42 U.S.C. 1395w-28(b)(6)(B)(iii)) is amend-
 17 ed—

18 (i) by striking “who have” and insert-
 19 ing “who—

20 “(I) before January 1, 2022,
 21 have”;

22 (ii) in subclause (I), as added by
 23 clause (i), by striking the period at the end
 24 and inserting “; and”; and

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1 (iii) by adding at the end the fol-
2 lowing new subclause:

3 “(II) on or after January 1,
4 2022, have one or more comorbid and
5 medically complex chronic conditions
6 that is life threatening or significantly
7 limits overall health or function, have
8 a high risk of hospitalization or other
9 adverse health outcomes, and require
10 intensive care coordination and that is
11 listed under subsection (f)(9)(A).”.

12 (B) PANEL OF CLINICAL ADVISORS.—Sec-
13 tion 1859(f) of the Social Security Act (42
14 U.S.C. 1395w–28(f)), as amended by subsection
15 (b), is amended by adding at the end the fol-
16 lowing new paragraph:

17 “(9) LIST OF CONDITIONS FOR CLARIFICATION
18 OF THE DEFINITION OF A SEVERE OR DISABLING
19 CHRONIC CONDITIONS SPECIALIZED NEEDS INDIV-
20 VIDUAL.—

21 “(A) IN GENERAL.—Not later than De-
22 cember 31, 2020, and every 5 years thereafter,
23 the Secretary shall convene a panel of clinical
24 advisors to establish and update a list of condi-
25 tions that meet each of the following criteria:

1 “(i) Conditions that meet the defini-
2 tion of a severe or disabling chronic condi-
3 tion under subsection (b)(6)(B)(iii) on or
4 after January 1, 2022.

5 “(ii) Conditions that require prescrip-
6 tion drugs, providers, and models of care
7 that are unique to the specific population
8 of enrollees in a specialized MA plan for
9 special needs individuals described in such
10 subsection on or after such date and—

11 “(I) as a result of such special
12 needs individuals with such a condi-
13 tion having access to and being en-
14 rolled in such a plan, as compared to
15 access to and enrollment in other
16 Medicare Advantage plans under this
17 part, it is projected that such individ-
18 uals would improve health outcomes
19 with respect to such condition, that
20 such individuals would have reduced
21 overall costs under this title, and that
22 there would not be any increase in ex-
23 penditures under this title for such in-
24 dividuals; or

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1 “(II) have a low prevalence in the
2 general population of beneficiaries
3 under this title or a disproportionately
4 high per-beneficiary cost under this
5 title.

6 “(B) **【GAO】 STUDY ON HEALTH OUT-**
7 **COMES OF INDIVIDUALS ENROLLED IN SPE-**
8 **CIALIZED MA PLANS.**—Not later than the date
9 that is 3 years after the date of the enactment
10 of this paragraph, the **【Comptroller General of**
11 **the United States】** shall conduct a study and
12 submit to Congress a report on the extent to
13 which health outcomes can be compared across
14 specialized MA plans for special needs individ-
15 uals (as defined in section 1859(b)(6)) and
16 other Medicare Advantage plans under this part
17 across similar populations, using existing meas-
18 ures and that identifies any potential limita-
19 tions where new measures may need to be de-
20 veloped for such population.”.

21 (d) **QUALITY MEASUREMENT AT THE PLAN LEVEL**
22 **FOR SNPs AND DETERMINATION OF FEASIBILITY OF**
23 **QUALITY MEASUREMENT AT THE PLAN LEVEL FOR ALL**
24 **MA PLANS.**—Section 1853(o) of the Social Security Act

1 (42 U.S.C. 1395w-23(o)) is amended by adding at the end
2 the following new paragraphs:

3 “(6) QUALITY MEASUREMENT AT THE PLAN
4 LEVEL FOR SNPS.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), the Secretary may require reporting
7 of data under section 1852(e) for, and apply
8 under this subsection, quality measures at the
9 plan level for specialized MA plans for special
10 needs individuals instead of at the contract
11 level.

12 “(B) CONSIDERATIONS.—Prior to applying
13 quality measurement at the plan level under
14 this paragraph, the Secretary shall—

15 “(i) take into consideration the min-
16 imum number of enrollees in a specialized
17 MA plan for special needs individuals in
18 order to determine if a statistically signifi-
19 cant or valid measurement of quality at
20 the plan level is possible under this para-
21 graph;

22 “(ii) if quality measures are reported
23 at the plan level, ensure that MA plans are
24 not required to provide duplicative infor-
25 mation; and

1 “(iii) ensure that such reporting does
 2 not interfere with the collection of encoun-
 3 ter data submitted by MA organizations or
 4 the administration of any changes to the
 5 program under this part as a result of the
 6 collection of such data.

7 “(C) APPLICATION.—If the Secretary ap-
 8 plies quality measurement at the plan level
 9 under this paragraph—

10 “(i) such quality measurement may
 11 include Medicare Health Outcomes Survey
 12 (HOS), Healthcare Effectiveness Data and
 13 Information Set (HEDIS), Consumer As-
 14 sessment of Healthcare Providers and Sys-
 15 tems (CAHPS) measures and quality
 16 measures under part D; and

17 “(ii) the Secretary shall consider ap-
 18 plying administrative actions, such as rem-
 19 edies described in section 1857(g)(2), to
 20 the plan level.

21 “(7) DETERMINATION OF FEASIBILITY OF
 22 QUALITY MEASUREMENT AT THE PLAN LEVEL FOR
 23 ALL MA PLANS.—

24 “(A) DETERMINATION OF FEASIBILITY.—
 25 The Secretary shall determine the feasibility of

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19

1 requiring reporting of data under section
 2 1852(e) for, and applying under this subsection,
 3 quality measures at the plan level for all MA
 4 plans under this part.

5 “(B) CONSIDERATION OF CHANGE.—After
 6 making a determination under subparagraph
 7 (A), the Secretary shall consider requiring such
 8 reporting and applying such quality measures
 9 at the plan level as described in such subpara-
 10 graph.”.

11 (c) **GAO** STUDY AND REPORT ON STATE-LEVEL
 12 INTEGRATION BETWEEN DUAL SNPs AND MEDICAID.—

13 (1) STUDY.—The **Comptroller General of the**
 14 **United States** (in this paragraph referred to as the
 15 “**Comptroller General**”) shall conduct a study on
 16 State-level integration between specialized MA plans
 17 for special needs individuals described in subsection
 18 (b)(6)(B)(ii) of section 1859 of the Social Security
 19 Act (42 U.S.C. 1395w–28) and the Medicaid pro-
 20 gram under title XIX of such Act (42 U.S.C. 1396
 21 et seq.). Such study shall include an analysis of the
 22 following:

23 (A) The characteristics of States in which
 24 the State agency responsible for administering
 25 the State plan under such title XIX has a con-

1 tract with such a specialized MA plan and that
2 delivers long term services and supports under
3 the State plan under such title XIX through a
4 managed care program, including the require-
5 ments under such State plan with respect to
6 long term services and supports.

7 (B) The types of such specialized MA
8 plans, which may include the following:

9 (i) A plan described in section
10 1853(a)(1)(B)(iv)(II) of such Act (42
11 U.S.C. 1395w-23(a)(1)(B)(iv)(II)).

12 (ii) A plan that meets the require-
13 ments described in subsection (f)(3)(D) of
14 such section 1859.

15 (iii) A plan described in clause (ii)
16 that also meets additional requirements es-
17 tablished by the State.

18 (C) The characteristics of individuals en-
19 rolled in such specialized MA plans.

20 (D) As practicable, the following with re-
21 spect to State programs for the delivery of long
22 term services and supports under such title
23 XIX through a managed care program:

1 (i) Which populations of individuals
 2 are eligible to receive such services and
 3 supports.

4 (ii) Whether all such services and sup-
 5 ports are provided on a capitated basis or
 6 if any of such services and supports are
 7 carved out and provided through fee-for-
 8 service.

9 (E) As practicable, how the availability
 10 and variation of integration arrangements of
 11 such specialized MA plans offered in States af-
 12 fects spending, service delivery options, access
 13 to community-based care, and utilization of
 14 care.

15 (F) Barriers and opportunities for making
 16 further progress on dual integration, as well as
 17 recommend legislation to expedite or refine
 18 pathways toward fully integrated care.

19 (2) REPORT.—Not later than 2 years after the
 20 date of the enactment of this Act, the **【Comptroller**
 21 **General】** shall submit to Congress a report con-
 22 taining the results of the study conducted under
 23 paragraph (1), together with recommendations for
 24 such legislation and administrative action as the
 25 **【Comptroller General】** determines appropriate.

1 **SEC. 3. EXPANDING SUPPLEMENTAL BENEFITS TO MEET**
 2 **THE NEEDS OF CHRONICALLY ILL MEDICARE**
 3 **ADVANTAGE ENROLLEES.**

4 (a) IN GENERAL.—Section 1852(a)(3) of the Social
 5 Security Act (42 U.S.C. 1395w-22(a)(3)) is amended—

6 (1) in subparagraph (A), by striking “Each”
 7 and inserting “Subject to subparagraph (D), each”;
 8 and

9 (2) by adding at the end the following new sub-
 10 paragraph:

11 “(D) EXPANDING SUPPLEMENTAL BENE-
 12 FITS TO MEET THE NEEDS OF CHRONICALLY
 13 ILL ENROLLEES.—

14 “(i) IN GENERAL.—For plan year
 15 2020 and subsequent plan years, in addi-
 16 tion to any supplemental health care bene-
 17 fits otherwise provided under this para-
 18 graph, an MA plan, including a specialized
 19 MA plan for special needs individuals de-
 20 scribed in subsection (b)(6) of section
 21 1859, may provide supplemental benefits
 22 described in clause (ii) to a chronically ill
 23 enrollee (as defined in clause (iii)).

24 “(ii) SUPPLEMENTAL BENEFITS DE-
 25 SCRIBED.—

1 “(I) IN GENERAL.—Supplemental
 2 benefits described in this clause are
 3 supplemental benefits that, with re-
 4 spect to a chronically ill enrollee, have
 5 a reasonable expectation of improving
 6 or maintaining the health or overall
 7 function of the chronically ill enrollee
 8 and may not be limited to being pri-
 9 marily health related benefits.

10 “(II) AUTHORITY TO WAIVE UNI-
 11 FORMITY REQUIREMENTS.—The Sec-
 12 retary may, with respect to supple-
 13 mental benefits provided to a chron-
 14 ically ill enrollee under this subpara-
 15 graph, waive the uniformity require-
 16 ment, as determined appropriate by
 17 the Secretary.

18 “(iii) CHRONICALLY ILL ENROLLEE
 19 DEFINED.—In this subparagraph, the term
 20 ‘chronically ill enrollee’ means an enrollee
 21 in an MA plan that the Secretary deter-
 22 mines—

23 “(I) has one or more comorbid
 24 and medically complex chronic condi-
 25 tions that is life threatening or signifi-

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1 cantly limits the overall health or
 2 function of the enrollee;
 3 “(II) has a high risk of hos-
 4 pitalization or other adverse health
 5 outcomes; or
 6 “(III) requires intensive care co-
 7 ordination.”.

8 (b) **【GAO】** STUDY AND REPORT.—

9 (1) STUDY.—The **【Comptroller General of the**
 10 United States**】** (in this subsection referred to as the
 11 **【“Comptroller General”】**) shall conduct a study on
 12 supplemental benefits provided to enrollees in Medi-
 13 care Advantage plans under part C of title XVIII of
 14 the Social Security Act, including specialized MA
 15 plans for special needs individuals described in sec-
 16 tion 1859(b)(6) of such Act (42 U.S.C. 1395w-
 17 28(b)(6)). Such study shall be conducted in con-
 18 sultation with the Centers for Medicare & Medicaid
 19 Services and Medicare Advantage plans as necessary
 20 and, to the extent data is available, shall include an
 21 analysis of the following:

22 (A) The type of supplemental benefits pro-
 23 vided to such enrollees, the total number of en-
 24 rollees receiving each supplemental benefit, and
 25 whether the supplemental benefit is covered by

1 the standard benchmark cost of the benefit or
2 with an additional premium.

3 (B) The frequency in which supplemental
4 benefits are utilized by such enrollees.

5 (C) The impact supplemental benefits have
6 on—

7 (i) indicators of the quality of care re-
8 ceived by such enrollees, including overall
9 health and function of the enrollees;

10 (ii) the utilization of items and serv-
11 ices for which benefits are available under
12 the original Medicare fee-for-service pro-
13 gram option under parts A and B of such
14 title XVIII by such enrollees; and

15 (iii) the amount of the bids submitted
16 by Medicare Advantage Organizations for
17 Medicare Advantage plans under such part
18 C.

19 (2) REPORT.—Not later than 5 years after the
20 date of the enactment of this Act, the **Comptroller**
21 **General** shall submit to Congress a report con-
22 taining the results of the study conducted under
23 paragraph (1), together with recommendations for
24 such legislation and administrative action as the
25 Comptroller General determines appropriate.

Fixing the 5 Percent

"Super-users" with complex medical needs make up a small fraction of U.S. patients, but they account for half of the nation's overall health-care spending. Now, innovative efforts are providing better care at lower costs.



Elaina Nataro / Katie Martin / The Atlantic

KAREN WEINTRAUB AND RACHEL ZIMMERMAN

JUN 29, 2017 | HEALTH

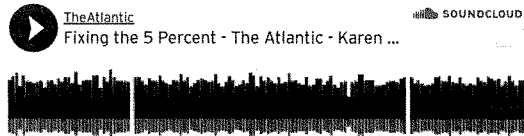
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AN OVERSIZED POSTER of the *Seinfeld* character Kramer watches over Phil Rizzuto's daily routine. When Rizzuto, named for the famous New York Yankees shortstop, swallows his 6 a.m. pills, Kramer is looming over him, looking quizzical. Same for the 9 a.m., noon, 6 p.m., and midnight doses, each fistful of pills placed in a carefully labeled Dixie cup. "I live on medication," he says.

7/28/2017

The 5 Percent: The Super-Users and Health-Care Spending - The Atlantic

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Rizzuto's daily life in Haverhill, Massachusetts, is a litany of challenges: His aides have to hoist his paralyzed legs from his bed to his motorized wheelchair and back again; keep the bag that collects his urine clean; tend to the gaping wound on his backside, which developed when he was left to lie still in bed too long; and help him avoid the panic that could claim anyone in his situation—that last one is particularly difficult since Rizzuto's obsessive-compulsive disorder drives him to want to do everything for himself.

After more than a year of emergency and rehabilitative care following a devastating car accident, Rizzuto moved into a YMCA-run housing complex in this gritty New England town. But he still endured constant medical emergencies. "I was back and forth and in and out of the hospitals so much, it was like I didn't know I had an apartment here," the 56-year-old says, sitting in his small studio. His open wound kept getting infected; his diaphragm, weakened by his injury and his inability to quit smoking, left him gasping for breath; his urine-collection bag slipped out; his demons kept getting the better of him. The government eventually covered the cost of his care, but the relentless need for medical attention was exhausting and demeaning.

Then he opted into a Massachusetts health-care program called One Care that focuses on people with complex medical needs who are on Medicare. One Care provides 71 hours of aide support a week, a twice-weekly visit from a massage therapist, twice-monthly psychiatric care, a wheelchair support group, and a nurse practitioner who oversees and coordinates Rizzuto's care. If he struggles between

visits—or just wants to talk—she’s available by phone, even on weekends and after hours. Now, his life has a routine and a discipline that keeps emergencies at bay. “The difference it’s made ...” he says, unable to fully express his gratitude. He estimates his hospital visits have dropped at least 75 percent since the One Care program took charge of his health. “I would hate like hell to not have them.”

The program that has helped Rizzuto is part of a nationwide movement to improve care for people struggling with very complicated medical needs—so-called *super-users*—the 5 percent of patients who account for about half of the country’s health-care spending. (Surgeon and *New Yorker* writer Atul Gawande outlined the problem and one solution in a definitive 2011 piece about the Camden Coalition of Healthcare Providers.) Some of these super-user programs say they provide cost savings of as much as 20 to 40 percent after a few years, as well as provide the kind of advantages offered to Rizzuto: fewer stressful hospital visits, better mental and physical health, and the satisfaction of being treated like a person instead of a package of problems. The program accomplishes this by shifting the focus of medical care. Instead of responding to complications, the care team tries to prevent them. “You can’t even get to the medical issue until you’ve figured out: Do they have a place to sleep, do they have housing they’re not going to lose, do they have food in their refrigerator, do they have a refrigerator?” says Christopher Palmieri, the president and CEO of the nonprofit Commonwealth Care Alliance, which manages 80 percent of One Care patients, including Rizzuto.

Despite its successes, this care movement, which doesn’t go by any catchy name—one doctor gave it the clunky title “high-impact, relationship-based primary care”—is scattered among a handful of states and is advancing only very slowly across the country. There is general agreement that these programs must address a range of social and pragmatic needs, like transportation, housing, nutrition, isolation, emotional well-being, and medical problems. But the details of each program are different. “Everyone’s trying their home brew,” says Dr. Harlan Krumholz, a cardiologist and health-care researcher at Yale University and Yale-New Haven Hospital.

The one thing all of the super-user care programs have in common is a mantra that could have come from Cosmo Kramer himself: Stay the hell out of the hospital. Hospitals, these folks argue, often make sick people sicker. They're sources of infection to vulnerable patients. They're disorienting. They run costly tests and look for issues that are better left alone. Super-users, says Krumholz, "represent a failure of the system."

MEDICAL CARE IS DANGEROUS," says Dr. Rushika Fernandopulle, the co-founder and CEO of Iora Health, a leading practitioner of a more holistic approach to health. Fernandopulle says a big part of his company's business model involves fighting to keep people out of the hospital—not just because it's expensive, but because the care they will get puts them at higher risk for other problems. Medicare patients saw roughly a 40 percent drop in hospitalizations after Iora took over their care, Fernandopulle says.

"We put far more into hospital care than we do keeping people from having to be in the hospital."

For Fernandopulle, one patient in particular illustrates this phenomenon of snowballing medical care. That patient was an 80-year-old woman, fairly healthy but with hypertension and arthritis, who one day saw red in the toilet after urinating. She told her primary-care doctor, who sent her to a urologist; the urologist worried it might be cancer and ordered a catheter inserted. Before the procedure, a nurse asked the octogenarian if she ever felt weak or dizzy. (Of course she did—think about it.) When the woman said yes, a heart monitor was ordered: It showed a dip in her overnight heart rate. A cardiologist then scheduled the woman for a pacemaker.

"This is what I mean by the vortex," Fernandopulle says, noting that inserting a pacemaker would be risky and provide no clear benefit. The woman's condition might be explained in a much more low-tech way: a beet salad, for example, could be the culprit behind the red pee, and a prescribed medication might trigger the

heart irregularity. “I called the cardiologist and politely declined the pacemaker for this patient,” Fernandopulle says. Part of the problem is that, while each doctor gets paid for each procedure he or she performs, usually no one gets paid for taking a step back and using common sense to think about what would genuinely help the patient.

“The health-care system as a whole is out of balance,” says Dr. Donald Berwick, the former head of the Centers for Medicare and Medicaid Services under President Obama. “We put far more into hospital care than we do keeping people from having to be in the hospital.” Hospital stays cost more than anything else in the health-care system; an average inpatient admission runs nearly \$2,000 a day, and an intensive-care stay can easily cost \$7,000 a day. In 2012, a typical hospital stay topped \$10,000, according to the federal Agency for Healthcare Research and Quality. Caring for an Iora patient, on the other hand, typically costs about \$3 a day and can reduce hospitalizations by 40 to 50 percent, Fernandopulle says. All of the physicians and advocates we interviewed who support this type of high-needs care are quick to note that their goal isn’t to deprive people of medical care. If someone doesn’t get needed heart surgery, they will end up in worse shape; no one will benefit. Their aim is appropriate, Goldilocks care: not too much, not too little.

Cory Sevin, a senior director with the Institute for Healthcare Improvement, a policy center in Cambridge, Massachusetts, says providing more appropriate treatment is also better for the caregiver. Kim Tremblay, a nurse practitioner with the Commonwealth Care Alliance, says that while the work is intense, she has enjoyed managing Rizzuto’s health team for three years and watching him slowly improve. “We give a lot to these patients,” she says. “We get a lot back.”

The model hinges on establishing strong, trusting relationships—but that doesn’t always come easily. “Some patients jump on board; sometimes it takes six months to establish a connection,” Tremblay says, recalling one patient who refused to talk to her for nearly five months before finally accepting help. She has become profoundly invested in her patients’ care. “Every time we send someone to the

hospital, it's stressful," for both the patients and caregivers, Tremblay says. "We send someone in [and] we kind of shudder, *Are they going to come out better?*"

ONE BIG CHALLENGE to providing care for patients with complex needs is finding them. Commonwealth Care, for instance, has struggled to identify people who will benefit from its program. Any Massachusetts resident who receives both Medicare and Medicaid is eligible to join One Care. Commonwealth Care Alliance, which serves most of these patients, had to hire extra staff to track down potential clients. When Commonwealth Care started four years ago, 43 percent of these potential clients were considered "unreachable," for reasons like having an unknown address. Today, that rate has shrunk to 32 percent.

Why is it so hard to track down needy patients? Some people are so isolated and disengaged that they're largely invisible. Others patients are expensive and challenging today but might soon recover. And still others are doing fine now but might have a setback that throws them off balance for months. In fact, 60 to 80 percent of patients who are super-users now won't be a year from now, Sevin says, and different people will be.

There are also people who will be perennially expensive—because their disease requires a costly drug, for instance. And there are those who will be expensive for a short time—say, for the few months after an organ transplant. There's no point in wasting time trying to bring either group's medical expenses down.

Fernandopulle says the only effective way to identify people at risk for super use is to ask them two questions: "How do you think your health is?" and "How confident are you in managing your health?"

"If they answer, 'Poor, poor,' they are at huge risk," he says.

ON A RECENT SWELTERING day, Rizzuto met his wheelchair support group at a small zoo in suburban Boston. Keeping cool in the above-90-degree heat wasn't easy for Rizzuto. Paralysis robs people of their ability to regulate body temperature. One of Rizzuto's aides, Bill Regan, came prepared with

water, ice packs, sandwiches, and a spray bottle that he frequently spritzed on Rizzuto's face and legs.

Rizzuto says these interactions with other people in wheelchairs help lift his mood, though on this trip he seemed more focused on watching a brown bear, several snakes, and tiny, hyperactive cotton-topped tamarins. He never could have made it around the zoo without a motorized wheelchair—though it took Rizzuto a year to convince the state to buy it for him. One of the first things Commonwealth Care Alliance does when signing on a new One Care client is to assess the person's equipment needs, Tremblay says.

One Care is a partnership between Massachusetts's Medicaid agency and the federal Centers for Medicare and Medicaid, and it focuses solely on patients ages 21 to 64 with multiple, complex medical and behavioral issues. (An older program, Senior Care Options, takes the same approach for patients over 65.) Most of Commonwealth Care's 13,500 One Care clients earn less than \$20,000 a year; some are homeless; the majority of them have a serious mental illness or substance-use disorder, as well as multiple other chronic health conditions.

This high-touch care approach is beginning to save money, says Palmieri. A report last year by the Commonwealth Fund found that among 4,500 members of One Care, patients enrolled for 12 continuous months had 7.5 percent fewer hospital admissions and 6.4 percent fewer emergency-room visits. For those enrolled in the program for at least 18 months, hospital admissions dropped 20 percent, the study found.

“Most health-care systems are still operating in an environment where reducing emergency-department and inpatient use hurts the bottom line.”

Although each model of high-touch care is different, the basics are the same: focusing on prevention, ensuring basic needs are met, reducing unnecessary treatment, and building relationships with patients. At Stanford University, for

example, one young man with severe anxiety and obsessive-compulsive disorder required constant reassurance (in addition to his multiple medications) from doctors and emergency departments. In a traditional care system, emergency-room staff might roll their eyes and quickly send him on his way. Instead, Dr. Alan Glaseroff, the co-founder of Stanford's Coordinated Care program to treat high-needs university employees and their family members, gave the 19-year-old his phone number. At first, whenever his anxiety or OCD took control, the young man called Glaseroff or another care coordinator as many as seven times a day.

But slowly, over the course of three years, the man learned to think before he called. If he saw spots in his eyes, he'd wait for a few minutes to see if they went away. He was taught to use mindfulness techniques, and if the symptom persisted, he would run through a checklist to see if it was really something to be concerned about. He ended up calling the clinic every two to three weeks, rather than multiple times a day, and learned not to lean on the clinic's staff for minor issues. "Now, he hardly needs us," Glaseroff says.

Creating viable long-term plans like this means far fewer emergencies. In fact, in its first three years, the Stanford program cut emergency-room visits for its 253 patients by 59 percent, hospital admissions by 29 percent, and total cost per patient by 13 percent, says Glaseroff, who teaches this model of care in two-day workshops across the country. According to the study, the Stanford practice saved the university \$1.8 million and now has nearly twice as many patients.

The secret to the cost-savings, Glaseroff says, is for patients to use hospitals and doctors only when absolutely necessary and to rely for most of their care on empathetic—and relatively inexpensive—medical assistants, who check in with each patient about once a week. In the past four years, in an industry known for its high burnout and turnover, not one of his practice's care coordinators has left, Glaseroff says. "They're not allowed to diagnose and treat, but they're really good at the people stuff," he says. "The core is being given responsibility for people, not for tasks."

Patients in the program have responsibilities as well as rights, Glaseroff says. They are expected to show up for their medical appointments and to come on time out of fairness to others. They're told to call the clinic if they can before heading to the emergency room and then wait a few minutes for a call back, Glaseroff says. They are expected to do their part to engage with their care coordinator, even if the medical system hasn't always treated them well in the past. "It's patient self-management—what people do within their chronic illness 365 days a year—that matters the most," he says.

FOR THE HIGH-TOUCH model to work financially, large numbers of patients have to stick around long enough to recoup the upfront investment in their care. Today, there are only a few pools of people stable enough to sustain this model: people who work for major employers, like Stanford University, and those insured by the federal government.

Iora provides health care to workers at large, stable employers like the Dartmouth College Employees, the New England Carpenters Benefits Fund, a union trust, and members of Medicare Advantage plans, like Humana and Tufts Health Plan. This gives them a big group of customers with high needs and the corporate muscle to avoid being pushed around by hospitals that don't want to lose patients, Fernandopulle says.

If he loses customers to other insurance carriers in the first year or two, he'll have all the upfront costs and none of the savings. A five-year time horizon allows Iora to recoup its upfront investment and get ahead of problems—controlling diabetes before it leads to a heart attack, for instance, says Fernandopulle, whose company oversees care for about 20,000 patients in eight states.

Iora and another company with a similar approach, Landmark Health, also provide care to people on Medicare Advantage—a government-funded, privately run program. About a third of people on Medicare now belong to Medicare Advantage programs, which were created by the Affordable Care Act. The Trump administration and Republicans have proposed huge cuts to Medicaid over the next decade. It's unclear, however, whether such cuts would paralyze efforts at

innovation or provide more urgency to reduce health-care spending. “It is a bipartisan issue that the current costs of health care are unsustainable,” Yale’s Krumholz says, “whether driven by empathy for those who are disadvantaged and suffering or by economic imperative.”

But there are also built-in disincentives to this kind of high-touch care. One of the most obvious is that hospitals make money on patients. If they succeed in decreasing readmissions, they also limit their own earnings. Despite efforts to replace fee-for-service care with so-called global payments, “the fact is that currently most health-care systems are still operating in an environment where reducing emergency-department and inpatient use hurts their bottom line,” says Dr. Seth Berkowitz, a primary-care doctor at Massachusetts General Hospital who studies how addressing patients’ social needs improves their health and lowers costs.

Moreover, the model is challenging to scale, because all health care is local. State laws, hospital structures, and needs differ from place to place. What works in Florida doesn’t work in Washington state, and vice versa, notes Fernandopulle, whose frequent-flyer miles attest to his attempts to learn about new markets.

Slowly, though, these scattershot efforts may be coalescing into a larger movement. Fernandopulle says it’s getting easier for companies like his to raise money in the private sector. Other factors seem to be coming together, too. Technology allows health-care companies to more easily identify people at risk of becoming super-users, track their progress, and standardize some of their treatments. There’s broad public consensus, gaining momentum in recent years, that health-care costs need to come down, says Dr. J. Michael McGinnis, the executive officer of the National Academy of Medicine, an advisory body formerly known as the Institute of Medicine. “Now the issue is not whether; it’s how.”

Rizzuto is lucky that he was treated for his 2012 car accident in Massachusetts. If he’d had to recover in neighboring New Hampshire, where someone else’s road rage landed him in a ditch and then in a month-long coma, he’d probably still be making near-weekly trips to the emergency room. The crash left his spine broken in

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two places and exacerbated his post-traumatic-stress disorder and a concussion that still makes him feel like “I have some scramble with my brain.”

The paralysis has left him with limited control of the outer three fingers on each hand—restricting his ability to play his beloved guitar—and he can’t breathe deeply enough or with enough control to sing anymore. His core muscles are weak, too, Rizzuto says, explaining why his torso wobbles uncontrollably as he speaks. “I’m so close to being a quadriplegic, it’s crazy,” he says. Rizzuto lifts his t-shirt to reveal small, circular burn marks dotting his chest. He knows he needs to quit smoking—and will have to before his upcoming surgery to close the wound on his back, but it has been a struggle. Rizzuto says he often spaces out with a cigarette between his fingers and doesn’t notice he’s doing himself damage until it’s too late. “There’s just so much to get used to,” he says.

But he has also come to terms with his current life. Despite everything that has happened, he still has his adult twin sons, a daughter, a granddaughter, a safe place to live, and caregivers who really care. And so he goes on living the best life he can. He even hopes to start talking to high-school kids about his experiences. “I’m very fortunate,” Rizzuto says. “I don’t know why. Maybe it’s because I’m supposed to do something with this stupid accident that happened to me.”

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**Integrated Healthcare Model Outperforms Traditional Fee-for-Service in
 Caring for Individuals with Medicare and Medicaid**

*New Independent Study from Avalere Health Shows SCAN Health Plan
 Achieving Superior Results in Key Clinical Areas in Caring for “Dual Eligibles”*

(LONG BEACH, CA – April 2, 2012) — A new Avalere Health study released today shows that SCAN’s integrated care model, which provides coordinated care for dual eligibles through the Medicare Advantage program, results in fewer hospital stays or readmissions than a group of similar beneficiaries receiving care under traditional fee-for-service. According to the study, healthcare quality can be improved and considerable dollars can be saved by delivering coordinated, integrated care to “dual-eligible” individuals. Dual eligible refers to those individuals who qualify for both Medicare and Medicaid/Medi-Cal.

The study is particularly significant as federal and state budgets continue to be depressed while the nation grapples with how to care for an aging society. Because dual eligibles are more likely than other Medicare beneficiaries to go into and stay longer in the hospital, the ability to avoid hospitalization has meaningful budgetary implications. If the fee-for-service program was able to achieve those lower rates of hospital care, the Medicare program would realize considerable savings.

Avalere Health compared 30-day all-cause hospital readmission rates between California dual eligibles in traditional Medicare vs. those enrolled in SCAN Health Plan, the nation’s fourth largest not-for-profit Medicare Advantage plan. The study found that SCAN’s dual eligible members had a hospital readmission rate that was 25 percent lower than those in fee-for-service. It also found that SCAN performed 14 percent better than Medicare fee-for-service on the “prevention quality indicator (PQI) overall composite”—keeping people out of the hospital to begin with—as established by the Agency for Healthcare Research and Quality, the lead federal

(More)

SCAN/Avalere Health*Page 2*

agency charged with improving the quality, safety, efficiency and effectiveness in healthcare services.

“We have long believed that integrated care can mean better care if individuals are carefully tracked, if care is coordinated, and if members are directed into the types of programs that allow them to age well,” said Chris Wing, president and CEO of SCAN Health Plan. “This study reaffirms this belief and provides to federal and statewide policymakers a path to follow if they are serious about improving care and controlling costs.”

The Avalere study looked at HEDIS 30-day all-cause hospital readmission rates for more than 5,500 SCAN dual-eligible enrollees and an equivalent number of fee-for-service dual eligibles in California with similar medical conditions. This methodology was designed to help ensure that similar risk profiles were being compared across SCAN dual eligibles and fee-for-service dual eligibles. Comparing “apples to apples” on hospitalization rates, SCAN outperformed traditional Medicare fee-for-service in 9 of the 12 individual PQI measures that compose the overall composite. When comparing risk-adjusted readmission rates, SCAN had lower rates for all 12 clinical conditions analyzed in the study, scoring 40 percent better in pneumonia, 29 percent better in diabetes, and 25 percent better in neurological disorders.

“SCAN has been able to achieve these results by effectively integrating care for these members through a team-oriented case management approach,” said Wing. “For 35 years we have been focused exclusively on helping seniors and others on Medicare, with a strong commitment to those who need us the most, including these dual eligibles who are all in Medicare Special Needs Plans that tailor care plans around the patient.”

Concurrent with the improvement of health status for these dual-eligible individuals, the study also showed the potential for additional cost savings in caring for this population. Based on the results of a matched cohort analysis, if California Medicare fee-for-service dual eligibles had the same hospitalization and readmissions rates as SCAN’s dual eligibles, there could be 1,320 fewer hospitalizations and 1,773 fewer readmissions. This would result in approximately \$50 million in annual cost savings to Medicare fee-for-service in California.

“Better coordinated care for low-income elderly patients is a critical imperative for federal and state governments,” said Bonnie Washington, senior vice president of Avalere. “This study shows that well-developed care-management models can result in measurable differences

(More)

SCAN/Avalere Health*Page 3*

in quality, hospitalization and rehospitalization – and cost savings – for a vulnerable population in need of close care coordination.”

Dual eligibles, including seniors and disabled adults with acute needs, are the most vulnerable beneficiaries served by Medicare and Medicaid, but federal and state governments face unsustainable growth in costs for caring for these individuals. Medicare costs associated with this population totaled \$127 billion in 2010 and were approximately twice the average spent on non-dual Medicare beneficiaries. In Medicaid, dual eligibles account for 46 percent of total spending but only 18 percent of the program’s enrollment in 2008. In addition to high healthcare costs, dual eligibles have complex needs: 40 percent of duals under age 65 are disabled, and 57 percent live with cognitive or mental impairments.

For 35 years SCAN Health Plan has been focusing exclusively on the unique needs of seniors and others on Medicare. The company currently has nearly 130,000 Medicare Advantage members in California and Arizona. Further information may be obtained at scanhealthplan.com.

Avalere Health is an advisory-services company. Its core purpose is to create innovative solutions to complex healthcare problems. Based in Washington, DC, the firm delivers research, analysis, insight, and strategy for leaders in healthcare business and policy. Avalere’s experts span 160 staff drawn from the federal government (e.g., CMS, OMB, CBO and Congress), Fortune 500 healthcare companies, top consultancies and nonprofits. The firm offers deep substance in areas ranging from healthcare coverage and financing to the changing role of evidence in healthcare decision making. Its focus on strategy is supported by a rigorous, in-house analytic research group that uses public and private data to generate quantitative insight. Through events, publications and interactive programs, Avalere also translates real-time healthcare developments into actionable information. Learn more at avalerehealth.net.

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July 26, 2017

The Honorable Michael Burgess
2125 Rayburn House Office Building
Washington DC 20515

The Honorable Gene Green
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Green:

As Interim President and CEO of Molina Healthcare, Inc., I am writing to thank you for holding a hearing to examine legislation to reauthorize Medicare Advantage Special Needs Plans (SNPs) and improve the quality of care for vulnerable seniors and individuals living in poverty or with a chronic illness.

Molina Healthcare ("Molina") has been serving the poor and underserved who are insured through government-sponsored healthcare programs for close to four decades, engaging in Medicaid markets in 30 states and Puerto Rico. Molina Healthcare serves more dually eligible individuals in our Medicare-Medicaid Plans (MMPs) than any other insurer in the country. We have been serving the neediest members of the Medicare Advantage program through our Dual Eligible Special Needs Plans (D-SNPs) for close to a decade with current membership at approximately 43,000 beneficiaries. Today, we are one of the ten largest health insurers in the country, serving more than 4.5 million low-income members in 12 states and Puerto Rico.

We strongly support efforts to reauthorize SNPs. D-SNPs have proven to more effectively serve individuals who will have the most significant cost implications and challenges impacting Medicare and Medicaid over the next few years. With years of experience serving these vulnerable members, we have seen the positive outcomes of the SNP program firsthand. Delivering health care through SNPs has led to better management of chronic conditions, lower admission and readmission rates, and cost efficiencies that the federal government and states desperately need.

As the Committee process moves forward, we appreciate the bipartisan support for the program and request that you support permanent reauthorization for all types of SNPs, particularly D-SNPs. The constant uncertainty of reauthorization creates many issues for health plans and their state partners as they have to allocate time and resources to the program without the security of knowing how long the program may continue. Giving SNPs permanency will allow for the continuation and growth of this successful integration platform.

Molina supports the integration of Medicare and Medicaid benefits for the most vulnerable beneficiaries either through MMPs or D-SNPs. In order for integration in D-SNPs to be successful, it is imperative that consideration be given to additional opportunities to support states and plans efforts to move forward with desired integration that recognizes the uniqueness of each state's health care system and dually eligible population.

Again, thank you for your interest in reauthorizing SNPs. We look forward to continuing our work with you on issues related to the Medicare Advantage program and its impact on the most vulnerable beneficiaries.

Sincerely,


Joseph White
Interim President and CEO



To: Peter Begans, SVP Public & Government Affairs, SCAN Health Plan
From: Dianne Munevar, Edward Drozd
Date: March 30, 2012
Re: Analysis of SCAN Health Plan's Dual Eligible Population: Technical Specifications

SCAN Health Plan asked Avalere Health ("Avalere") to conduct a study comparing hospitalization and 30-day all-cause readmission rates between SCAN Health Plan's Medicare-Medicaid dual-eligible Medicare Advantage (MA) plan members to similar dual eligibles continuously enrolled in the original Medicare fee-for-service (MFFS) and MediCal in 2009 and 2010. Avalere used 2009 and 2010 claim-level data from SCAN Health Plan's Medicare Advantage (MA) plan and from the Centers for Medicare & Medicaid Services (CMS) to compare rates of potentially preventable hospitalizations and for 30-day all-cause readmissions. The data were drawn from 2009 and 2010 data since these are the latest years for which fee-for-service Medicare data are available. The analyses featured a matched cohort design, where each SCAN Health Plan dual eligible in the analysis was matched to the most similar MFFS dual-eligible beneficiary in California, based on similar risk profiles. Using the matched sample, Avalere also estimated the potential cost-savings that MFFS could achieve if hospitalization and readmission rates for dual-eligible MFFS beneficiaries were the same as the rates for SCAN dual eligibles. Results of the analysis can be found on the Avalere Health website at www.avalerehealth.net.

This memo presents details of Avalere's approach to conducting these analyses. The first section describes the data sources. The next four sections describe the technical approach to the matched cohort design, potentially preventable hospitalizations and readmissions, and program cost-savings analyses. The final two sections present the assumptions and limitations behind these analyses and a brief conclusion.

Data Sources

To compute the Medicare outcomes and cost-savings, Avalere used the Medicare five percent Standard Analytical Files (SAFs), a random sample of MFFS beneficiaries, from 2009 and 2010. California MFFS (CA-MFFS) dual eligibles were identified as beneficiaries who were enrolled in MediCal for at least one month in 2010, and were continuously enrolled in MFFS for all of 2009 and 2010, or until death in 2010. Avalere used the 2009 Medicare SAFs as the data source for risk-adjustment purposes. To compute the SCAN Health Plan outcomes, Avalere used all-provider encounter, claim-level data provided by SCAN for 2009 and 2010. The analyses were conducted on dual eligibles that were enrolled in SCAN Health Plan's Medicare-MediCal (Medi-Medi) plan for at least one month in 2010, and were continuously enrolled in SCAN Health Plan for all of 2009 and 2010, or until death in 2010.

To construct the matched cohorts, enrollees in both groups were limited to California residents, age 18 or older, continuously enrolled in either SCAN Health Plan or original Medicare Parts A and B for the full 24 months of 2009 and 2010 (or until death in 2010), and were dual eligible for at least one month in 2010. The resulting sample of SCAN Health Plan's dual eligible enrollees (5,552 members) was compared to a similar size sample of CA-MFFS beneficiaries with similar risk profiles.

Matched Cohort Analysis

The matched cohort analysis used a propensity score matching (PSM) model, a two-step quasi-experimental analysis designed to identify and compare two cohorts, simulating a randomized control trial where one cohort is identified as the "treatment group" and receives the intervention (in this case, "SCAN's management of its dual-eligible population") while the other group is considered the "control group" and does not receive the intervention (in this case, "CA-MFFS").

The first step of the analysis involves a logistic regression which includes all SCAN Health Plan and CA-MFFS dual eligibles satisfying the above criteria. This regression estimates the likelihood of each enrollee being in the SCAN Health Plan group (an indicator for SCAN Health Plan dual eligible was the dependent variable) using the following patient-level characteristics, listed below, as explanatory variables:

- Resident of California

- Age ranges (Under 65, 65-74, 75-84, 85+)
- Dual eligibility duration in 2009 and 2010 (Number of months)
- Gender
- Clinical condition group (see below for detailed information)
- Psychiatric/substance abuse hospitalization in the past year
- Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software (CCS) categories
- CMS Hierarchical Condition Categories (HCCs)
- Acute inpatient hospital utilization in 2009
- Post acute care (PAC) utilization in 2009 (limited to skilled nursing facilities and home health agencies, since inpatient rehabilitation facilities are included as acute inpatient hospitals)

Clinical condition groups were created by mapping enrollees' prior year inpatient and outpatient claims (excluding DME and hospice) into AHRQ HCUP CCS Level 3 condition categories and then combining and aggregating up to a total of 23 condition groups. The 23 clinical condition groups used in this analysis are:

- Bacterial infections
- Behavioral health and substance abuse disorders
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Cancer
- Diabetes
- Gastrointestinal disorders
- Hematologic disorders
- Major acute coronary events (MACE)
- Musculoskeletal disorders
- Neurological disorders
- Other cardiovascular disorders
- Other conditions and factors influencing health care

- Other endocrine, immunity, and metabolic disorders
- Other ill-defined conditions and factors' influencing health care
- Other injuries and poisoning
- Other respiratory disorders
- Pneumonia
- Renal failure
- Skin disorders
- Stroke and transient ischemic attack (TIA)
- Traumatic injury

The second step of the analysis matches each SCAN Health Plan dual eligible with a single CA-MFFS dual eligible who most resembled the SCAN Health Plan dual eligible on these dimensions. This was accomplished using a propensity score generated by the logistic regression. The PSM matching featured a 1:1 match, without replacement, using a caliper (maximum propensity score distance) of 0.3. These criteria excluded 32 SCAN dual eligibles—less than 1 percent of the original SCAN sample—and 43,184 CA-MFFS dual eligibles—89 percent of the original CA-MFFS sample.

Potentially Preventable Hospitalizations

To identify potentially preventable hospitalizations, Avalere used the AHRQ Prevention Quality Indicators (PQI) Overall Composite, which identifies potential issues of access to, and quality of, ambulatory care in a given geographic area, that may have an impact on hospitalizations for particular conditions. The overall composite measure consists of twelve individual PQI measures, each equal to the number of hospitalizations (acute admissions) for a particular ambulatory care-sensitive condition (ACSC) per 100,000 persons. The twelve individual PQI measures are:

- Diabetes Short-Term Complications Admission Rate (PQI 1)
- Diabetes Long-Term Complications Admission Rate (PQI 3)
- Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5)
- Hypertension Admission Rate (PQI 7)

- Congestive Heart Failure (CHF) Admission Rate (PQI 8)
- Dehydration Admission Rate (PQI 10)
- Bacterial Pneumonia Admission Rate (PQI 11)
- Urinary Tract Infection Admission Rate (PQI 12)
- Angina Without Procedure Admission Rate (PQI 13)
- Uncontrolled Diabetes Admission Rate (PQI 14)
- Asthma in Younger Adults Admission Rate (PQI 15)
- Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)

Avalere used the Medicare inpatient SAFs and SCAN's all-encounter and claims data, limited to specific types of bill (TOBs) to identify acute inpatient hospital claims. TOBs were limited to inpatient hospitals (11x), religious nonmedical hospitals (41x), and critical access hospitals (85x). For a complete list of administrative specifications, please see AHRQ's website at http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.

30-Day Plan All-Cause Hospital Readmissions

To measure readmissions, Avalere used the Healthcare Effectiveness Data and Information Set (HEDIS) 30-Day Plan All-Cause Readmission (PCR) rate measure, maintained by the National Committee for Quality Assurance (NCQA). The HEDIS 30-day PCR rate estimates the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days of hospital discharge.

Before estimating the readmission rate, Avalere identified acute inpatient hospital stays using TOBs 11x, 41x, and 85x. Claims were then combined to create a complete acute inpatient stay where overlapping claims had the same admission and discharge dates, including claims for consecutive stays where the patient was not discharged until the last claim. Furthermore, diagnosis and discharge information from hospital-to-hospital transfers was included with the transfer source stay when the discharge date of the transferring hospital was the same as the admission date of the receiving hospital. Index stays were identified as all acute inpatient stays where there were no other acute inpatient discharges in the 30 days prior to the index admission date. Readmissions were identified as any acute inpatient stay for any diagnosis with an admission date within 30 days of a previous index discharge date (excluding transfers).

This measure is risk-adjusted for patient demographics (age and gender), medical severity identified with CMS' Hierarchical Condition Categories (CMS-HCCs), and surgeries that occurred during the index acute inpatient stay. Applying the risk-adjustment methodology, Avalere computed the "average adjusted rate"—the readmission rate expected based on national average readmission patterns and the demographics and case mix severity of the population measured. The lower the observed rate is relative to the expected rate, the better the readmission performance relative to national all-Medicare norms.

For a complete list of administrative specifications, please check NCQA's website at <http://www.ncqa.org/tabid/1250/Default.aspx>.

Medicare Program Expenditure Savings

The Medicare program savings (cost) analyses attempt to measure how much the original MFFS program would save if the PQI hospitalization and HEDIS 30-day all-cause readmission rates were the same as those for SCAN Health Plan. These estimates focus on cost-savings for MFFS dual eligibles who most resemble those identified in the SCAN Health Plan sample for use in this analysis.

For hospitalization savings, Avalere compared the hospitalization rate for each of the twelve PQI measures that comprise the overall composite between the SCAN and CA-MFFS matched cohorts to determine the difference in the number of hospitalizations between the groups and to determine the number of potential hospitalizations saved in each PQI condition. Then, Avalere estimated the Medicare-only average total cost of hospitalizations within each PQI condition, for the CA-MFFS matched cohort using the 2009 and 2010 Medicare SAFs five percent sample. Average total costs include some cases where hospital payments were \$0 and where, in some cases, average payment differences were negative for cases where SCAN Health Plan's dual eligibles had higher hospitalization rates than CA-MFFS for three PQI measures¹.

The average total cost was multiplied by the number of potentially avoided hospitalizations to estimate the total amount that Medicare could save on the CA-MFFS dual eligibles.

¹ Angina Without Procedure Admission Rate (PQI 13), Hypertension Admission Rate (PQI 7), and Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5)

For readmission cost-savings, Avalere first multiplied the HEDIS 30-day PCR rate ratio of the observed readmission rate to the expected ("observed-to-expected") rate for SCAN Health Plan by the expected rate for CA-MFFS dual eligibles in the analysis sample and then subtracted this quantity from the actual observed CA-MFFS rate. To determine the number of potential readmissions saved, Avalere then multiplied the rate difference described above by the number of matched cohort CA-MFFS hospitalizations. Avalere then estimated the Medicare-only average total cost of readmissions for the CA-MFFS matched cohort using the 2009 and 2010 Medicare SAFs. The average total cost was multiplied by the number of potentially avoided readmissions to estimate the total amount that Medicare would save on the CA-MFFS dual eligibles if CA dual eligibles had readmission rates that were equivalent to SCAN's dual eligibles.

Lastly, because Avalere only used a five percent sample of CA-MFFS beneficiaries, Avalere multiplied the total cost-savings estimate for potentially avoided hospitalizations and readmissions by 20 to account for potential annual savings across the California dual eligible population who may have similar risk profiles as the SCAN dual eligibles identified in the analyses.

Assumptions and Limitations

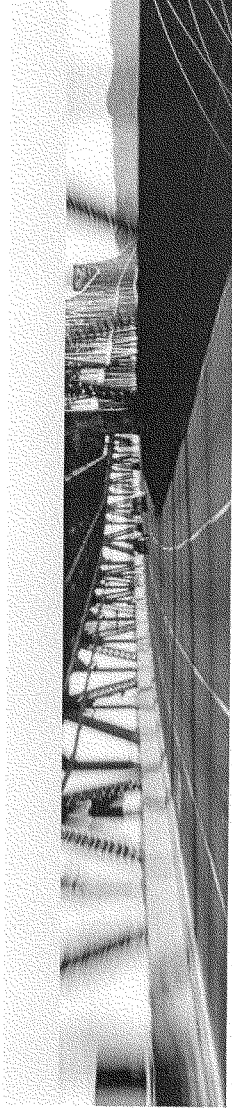
- All analyses used the Medicare five percent SAFs; no state Medicaid data was used for these estimates.
- Since the propensity score match analysis was limited to 1:1 matches and the analysis successfully matched nearly all SCAN dual eligible enrollees to one CA-MFFS dual eligible per SCAN dual, the model may have excluded from consideration some CA-MFFS dual eligibles whose risk profiles were similar to those of the SCAN "treatment group".
- The PQI analysis assumes some of these hospitalizations could have been avoided. Likewise, the analysis is limited to the hospitalizations that occurred within the twelve individual PQI measures, and therefore does not account for other hospitalizations in

other conditions distinct from those conditions included in the twelve individual PQI measures that may have been avoided.

- For the risk-adjustment methodology for the HEDIS PCR rate, Avalere used the "Medicare Advantage and SNP Product Lines" risk-adjustment weights for estimating the expected readmission rate for both samples.
- Estimated costs were based on the total average cost of hospitalizations and readmissions in the CA-MFFS matched sample. Avalere did not model which specific hospitalizations or readmissions, and associated costs, could have been more easily avoided.
- Cost-savings analyses for hospitalizations and readmissions were estimated separately so savings from avoided readmissions in 2010 do not account for reduced hospitalizations.

Conclusion

As stated above, this analysis was conducted to estimate the difference in hospitalization and readmissions rates between SCAN Health Plan's dual eligibles and CA-MFFS dual eligibles. Additionally, SCAN Health Plan asked Avalere to estimate the potential cost-savings if CA-MFFS dual eligibles had the same hospitalization and readmission rates as SCAN's dual eligibles. For detailed findings, please see the presentation titled, "Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions", located on the Avalere Health website, www.avalerehealth.net.



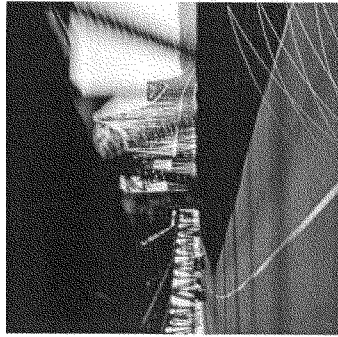
Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions

March 2012

Avalere Health LLC

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1 Project Overview & Key Findings

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The intersection of business
strategy and public policy

1 Avalere Analysis Found that SCAN's Dual Eligibles Outperform CA-MFFS on the PQI Overall Composite and the HEDIS 30-Day Plan All-Cause Readmission Rate

PQI Overall Composite Key Findings

- SCAN's dual eligibles scored better than CA-MFFS dual eligibles on ARHQ's Prevention Quality Indicators (PQI) Overall Composite¹, demonstrating a 14 percent lower hospitalization rate
 - » SCAN's duals were hospitalized less than CA-MFFS across the majority of the PQI measures including, but not limited to, congestive heart failure (CHF), dehydration, bacterial pneumonia, and adult asthma

HEDIS 30-Day Plan All-Cause Readmission Rate Key Findings

- SCAN's dual eligibles had an observed readmission rate that was 28 percent lower, and a risk-adjusted readmission rate 25 percent lower, than a similar cohort of CA-MFFS dual eligibles when comparing HEDIS 30-day Plan All-Cause Readmission (PCR) Rates
- Among SCAN's dual eligibles who are eligible to receive Home and Community-Based Services (HCBS), the HEDIS observed readmission rate is 15.7 percent—almost 25 percent lower than the risk-adjusted expected readmission rate of 20.6 percent

Cost-Savings Analysis Key Findings

- If CA-MFFS dual eligibles had the same readmission and hospitalization rate as SCAN's dual eligibles, there would be 1,320 fewer hospitalizations², 1,773 fewer readmissions, for a total of \$50 million in annual cost-savings

¹ Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit. (Medicare-Medicaid Coordination Office, September 28, 2011)

² Agency for Healthcare Research and Quality. The composite measure is comprised of 12 individual measures. See Appendix for list of all individual PQI measures.

³ Healthcare Effectiveness Data and Information Set.

⁴ The cost-savings analysis was based on the matched cohort. Those who may be additional CA-MFFS duals for whom SCAN may be able to achieve cost-savings, however, those additional beneficiaries were not included in this analysis due to the design of the matched cohort model.

⁵ Cost-analysis for hospitalizations and readmission rates were based on PQI hospitalization rates and HEDIS PCR rates.

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1 Avalere Compared Quality and Outcomes for SCAN Health Plan's Dual Eligible Members Versus California's Dual Eligible Beneficiaries in Fee-for-Service Medicare

- SCAN Health Plan asked Avalere Health to compare performance on quality measures between SCAN's dual-eligible enrollees¹ and Medicare Fee-for-Service (MFFS) dual eligibles in California, along these two measures:
 1. AHRQ Prevention Quality Indicators (PQI) Overall Composite² which measures potentially avoidable hospitalizations and is used to measure access to and quality of ambulatory care in a given geographic area
 2. HEDIS³ 30-day Plan All-Cause Readmission (PCR) Rate which estimates the number of acute inpatient stays followed by an acute readmission for any discharge within 30 days of hospital discharge
- Avalere made comparisons on 2009 and 2010 data from a matched cohort of SCAN's dual-eligible enrollees and Medicare FFS (MFFS) dual eligible beneficiaries in California
 - » Medicare Standard Analytic Files (SAFs) from 2009 and 2010 were used to compute outcomes for the CA-MFFS dual eligibles; all-provider encounter data for 2009 and 2010 were provided by SCAN to compute outcomes for the SCAN dual eligibles
- SCAN also asked Avalere to estimate the potential cost-savings⁴ if CA-MFFS duals had the same hospitalization⁵ and readmissions⁶ rate as SCAN's dual eligibles

¹ Dual-eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit (Medicare-Medicaid Coordination Unit, Dual Eligible Special Enrollment Period or Medicaid Buy-In program).

² The composite measure is comprised of 12 individual measures. See Appendix for list of all individual PQI measures.

³ Healthcare Effectiveness Data and Information Set.

⁴ The cost analysis was based on the CA-MFFS identified in the matched cohort; there may be additional CA-MFFS duals for whom SCAN may be able to provide data.

⁵ The cost analysis for hospitalizations and readmissions rates were based on PQI hospitalization rates and HEDIS PCR rates.

1 Avalere Analysis Found that Medicare Could Have Saved \$50 Million in 2010 if CA-MFFS Dual Eligibles Had the Same Hospitalization and Readmission Rates as SCAN's Dual Eligibles

If CA-MFFS duals¹ had the same hospitalization and readmission rates as SCAN's dual eligibles, there could be 1,320 fewer hospitalizations and 1,773 fewer readmissions, for a total of \$50 million in annual cost-savings

- Avalere's analysis used a matched cohort model where each SCAN dual-eligible member is matched with a single CA-MFFS dual-eligible beneficiary based on a set of patient-level demographic and clinical characteristics, as well as utilization of acute inpatient and post acute services in the prior year
- Avalere estimated cost-savings using the same matched cohorts used in the hospitalization and readmissions analysis and:
 - » Compared the rates of hospitalization and readmissions between the cohorts to estimate the difference in the number of hospitalizations and readmissions
 - » Multiplied the difference in the number of hospitalizations by the average total cost of hospitalizations for those enrollees who were hospitalized; similarly, multiplied the difference in the number of readmissions by the average total cost of hospitalizations for those enrollees who were readmitted

¹The cost-savings estimate was based on the results of the matched cohort analysis which used a propensity score match model limited to matching one CA-MFFS dual eligible to each SCAN dual eligible, thereby excluding from consideration some CA-MFFS dual eligibles whose risk profiles were similar to those of the SCAN cohort

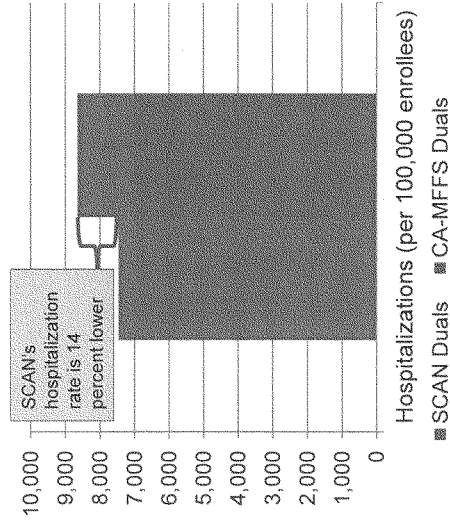
NOTE: For details regarding the methodology and/or assumptions and limitations, please see the Appendix

SCAN's Dual Eligibles Score Better on the PQI Overall Composite Score with a 14 Percent Lower Hospitalization Rate

SCAN Performs Better than CA-MFFS on Select PQI Individual Measures

- SCAN's dual eligibles have lower hospitalization rates than CA-MFFS enrollees on each of the following PQI measures:
 - Congestive Heart Failure (CHF) (PQI 8)
 - Uncontrolled Diabetes (PQI 14)
 - Diabetes Short-Term Complications (PQI 1)
 - Diabetes Long-Term Complications (PQI 3)
 - Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)
 - Dehydration (PQI 10)
 - Bacterial Pneumonia (PQI 11)
 - Urinary Tract Infection (PQI 12)
 - Adult Asthma (PQI 15)
- CA-MFFS dual eligibles have lower hospitalization rates for the following three PQI measures:
 - Angina Without Procedure (PQI 13)
 - Hypertension (PQI 7)
 - Chronic Obstructive Pulmonary Disorder (COPD) (PQI 5)

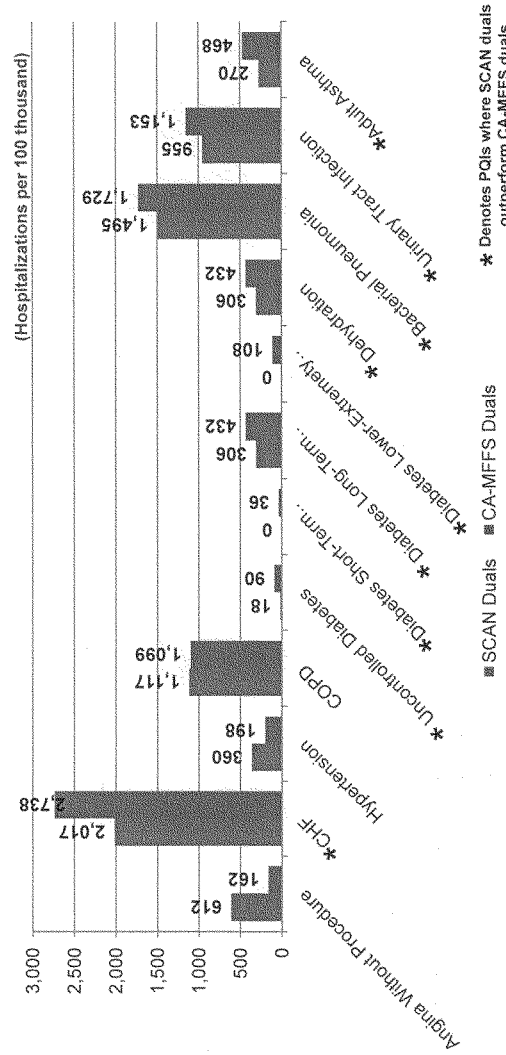
Comparison of SCAN's PQI Overall Composite with CA-MFFS, 2010



NOTE: For details regarding the methodology and limitations for this analysis, please see the Appendix

1 SCAN's Dual Eligibles Score Better on Most of the Twelve PQI Individual Measures¹

Comparison of PQIs for SCAN and CA-MFFS Dual Eligibles, 2010



¹ The PQI Overall Composite measure consists of 12 individual measures. SCAN outperforms CA-MFFS on 9 of the 12 measures, with the exception of Angina Without Procedure (PQI 13), Hypertension (PQI 7), and Chronic Obstructive Pulmonary Disease (COPD) (PQI 15).

NOTE: For details regarding the methodology and limitations for this analysis, please see the Appendix

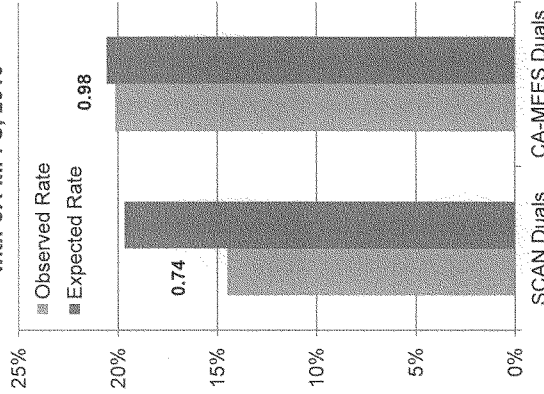


1 SCAN Also Scores Better on the HEDIS PCR Rate With a 25 Percent Lower Risk-Adjusted Readmission Rate

SCAN Performs Better than CA-MFFS for Several Conditions

- SCAN's dual eligibles have a lower observed readmission rate than expected based on SCAN's patient severity compared to CA-MFFS dual eligibles
 - » SCAN's dual eligibles have a 14.5 percent observed readmission rate versus 20.1 percent for CA-MFFS
 - » SCAN's dual eligibles have a 0.74 observed-to-expected readmission rate ratio¹ versus 0.98 for CA-MFFS—demonstrating a 25 percent lower risk-adjusted readmission rate
- Also, among SCAN's dual eligibles who are eligible to receive Home and Community-Based Services (HCBS), the HEDIS observed readmission rate is 15.7 percent—almost 25 percent lower than the risk-adjusted expected readmission rate of 20.6 percent

Comparison of SCAN's HEDIS PCR Rate with CA-MFFS, 2010



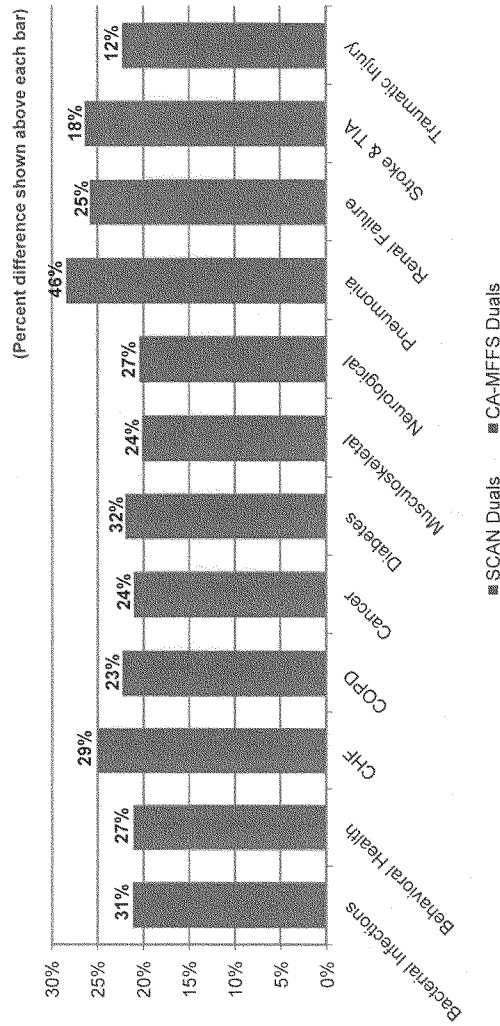
SCAN Duals CA-MFFS Duals

¹ The observed-to-expected readmissions rate ratio compares a plan's observed rate to the plan's expected readmission rate, which accounts for differences in the populations' medical severity and prior utilization of health care services

NOTE: For details regarding the methodology and limitations for this analysis, please see the Appendix

1 SCAN Duals Have Lower HEDIS Observed Readmission Rates than CA-MFFS for Twelve Select Medical Conditions¹

Comparison of SCAN's Observed Readmission Rates with CA-MFFS, for Twelve Select Conditions, 2010



¹ Condition groups were created by mapping enrollees' prior year inpatient and outpatient claims (excluding DME and hospice) into AHRQ H-CUP Clinical Condition Software (Level 3 condition groups and then combining and aggregating up to a total of 23 condition groups; the Avalere analysis was limited to these 12 condition groups since the remaining 11 condition groups are generally "other" conditions such as "other cardiovascular disorders" which are less well defined. See Appendix for full condition group list.

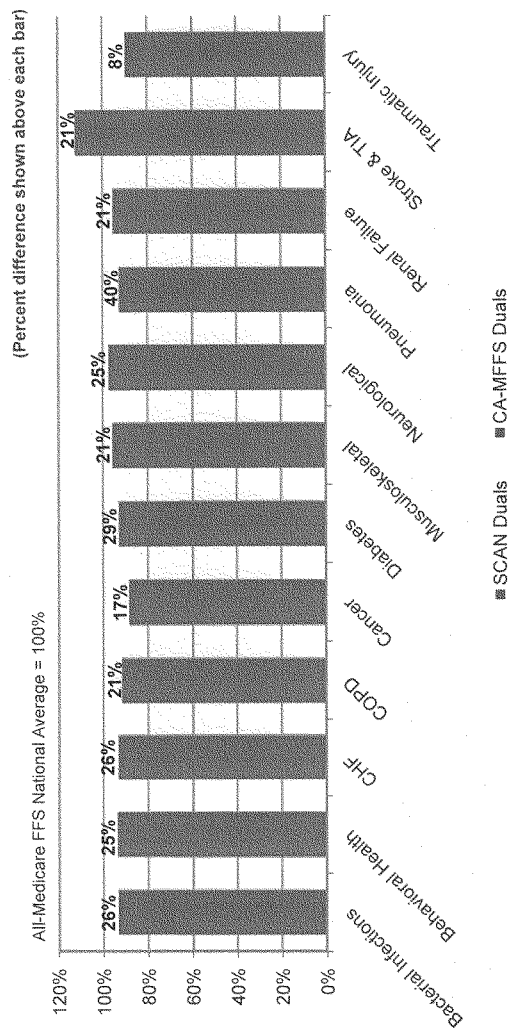
NOTE: For details regarding the methodology and limitations, please see the Appendix.

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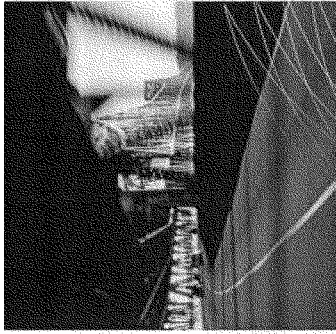
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1 SCAN Duals Have Lower HEDIS Risk-Adjusted Readmission Rates than CA-MFFS for Twelve Select Medical Conditions¹

Comparison of Risk-Adjusted Readmission Rates for SCAN and CA-MFFS Dual Eligibles Relative to the All-Medicare National Average, for Twelve Select Conditions, 2010



¹ Condition groups were created by mapping enrollees' prior year inpatient and outpatient claims (excluding DME and hospice) into AHRQ H-CUP Clinical Condition Software Level 3 condition groups and then combining and aggregating up to a total of 23 condition groups. The Avalere analysis was limited to these 12 condition groups since the remaining 11 condition groups are generally "other" conditions such as "other cardiovascular disorders" which are less well defined. See Appendix for full condition group list. NOTE: For details regarding the methodology and limitations, please see the Appendix.



2 Background

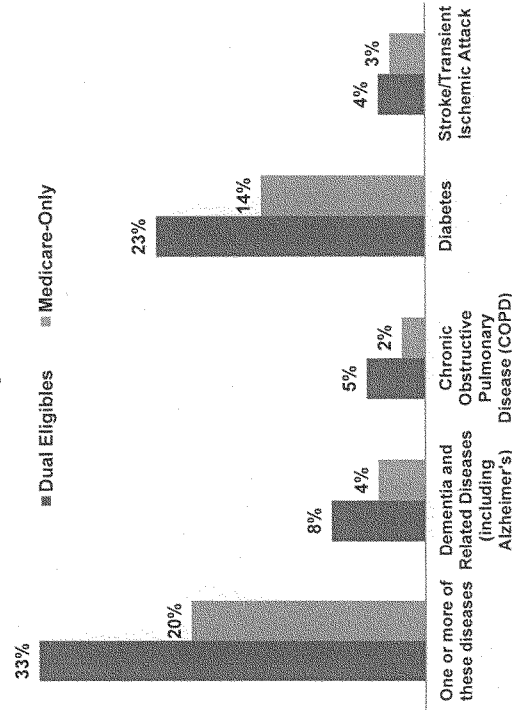


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strategy and public policy

2 Dual Eligibles Tend to Have Poorer Health Status and Are More Frail Than Medicare-Only Beneficiaries

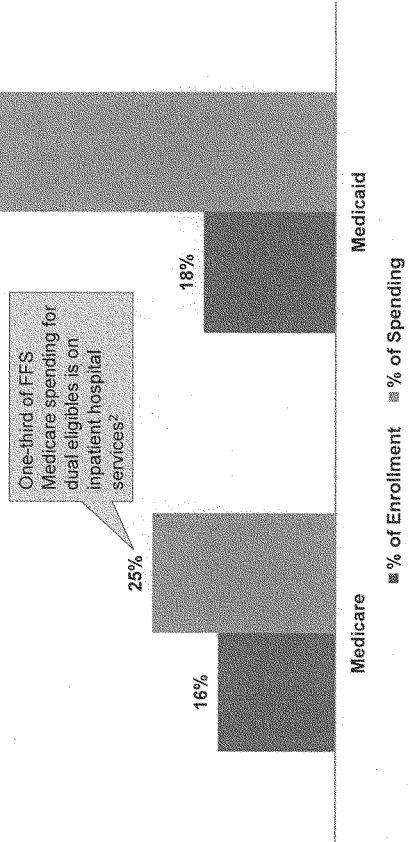
Prevalence of Selected Chronic Conditions in Dual Eligibles and Medicare-Only Beneficiaries, 2008



Source: Avalere Analysis of 2008 Medicare Claims Data

2 Dual Eligibles Have Complex Needs and Account for a Disproportionate Share of Medicare and Medicaid Spending

Comparison of Duals Percent of Enrollment Versus Percent of Spending, 2008^{1,2}



The cost of potentially avoidable hospitalizations for dual eligibles was projected to be \$7-\$8 billion in 2011³

¹ MedPAC Report to the Congress, Aligning Incentives in Medicare, Chapter 5: Coordinating the care of dual eligible beneficiaries, June 2010, page 131

² Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006

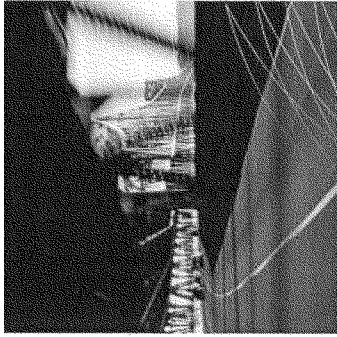
³ Segal, M. Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations. CMS Policy Insight Brief, 2011

2 SCAN Health Plan's Care Management Model¹ Assesses and Coordinates Care for Dual Eligible Members

- SCAN operates a Dual Eligible Special Needs Plan (D-SNP) with 6,674² enrollees in 2011
 - » SCAN has a long history of serving dual-eligible beneficiaries, including for 20 years as a Social HMO (S/HMO) Demonstration
- SCAN's care management model employs an integrated social and medical approach to the management of dual-eligible members; programs include:
 - » Care management team with case managers to oversee the coordination of services across providers, community-based and institutional care settings, and organizations that offer services to the member
 - » Information tailored to members, support and assistance necessary to more actively manage their own care; and
 - » Provider support to use evidence-based practice guidelines

¹ SCAN Health Plan Internal Resources, SCAN Health Plan, Model of Care: An innovative approach for federal policy makers seeking the best and most cost effective ways to care for vulnerable populations

² Kaiser Family Foundation, (2011) Special Needs Plans: Availability and Enrollment



3 Appendix



The intersection of business
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3 Avalere Utilized Medicare Standard Analytic Files (SAFs) and SCAN's All-Provider Encounter Data

Data sources

- To compute the Medicare outcomes and cost-savings, Avalere used Medicare Standard Analytic Files (SAFs) from 2009 and 2010
 - » CA-MFFS dual eligibles were identified as beneficiaries who were enrolled in MediCal for at least one month in 2010, and were continuously enrolled in MFFS for all of 2009 and 2010, or until death in 2010
 - » Used the 2009 Medicare SAFs as the data source for risk-adjustment purposes
 - » Demographic, clinical condition, psychiatric/substance abuse DRG hospitalization, and acute inpatient and post acute care utilization data from 2009 and 2010 were used to select a matched cohort of CA-MFFS beneficiaries
- To compute the SCAN outcomes, Avalere used all-provider encounter data provided by SCAN for 2009 and 2010
 - » The analysis was conducted on dual eligibles that were enrolled in SCAN's Medi-Medi plan for at least one month in 2010, and were continuously enrolled in SCAN for all of 2009 and 2010, or until death in 2010

¹ For detailed assumptions and limitation of this particular methodology, please see the Technical Memorandum

3 Avalere Conducted a Matched Cohort Analysis to Compare Quality Outcomes For SCAN Dual Eligibles Versus CA-MFFS Dual Eligibles

Data Sources

- Medicare Standard Analytic Files (SAFs) from 2009 and 2010 were used to compute outcomes for the CA-MFFS dual eligibles
- All-provider encounter data for 2009 and 2010 were provided by SCAN to compute outcomes for the SCAN dual eligibles

Matched Cohorts

- Enrollees in both groups were limited to California residents, age 18+, continuously enrolled in either SCAN or Medicare Part A or B for the full 24 months of 2009 and 2010 (or until death in 2010), and were dually eligible for at least one month in 2010
- A sample of SCAN's dual-eligible enrollees (5,552 members) were compared with a similar size sample of CA-MFFS with similar risk profiles
 - » Individuals were matched based on a set of patient-level characteristics including age ('18+), gender, clinical condition¹, psychiatric/substance abuse hospitalization in the past year, and the prior year's acute hospital and post-acute care utilization
 - » Each SCAN dual eligible was matched to the CA-MFFS dual eligible who most resembled the SCAN dual eligible on these dimensions

¹ Condition groups were created by mapping enrollees' prior year inpatient and outpatient claims (excluding DME and hospice) into AHRQ H-CUP Clinical Condition Software Level 3 condition groups and then combining and aggregating up to a total of 23 condition groups; the Avalere analysis was limited to these 12 selection conditions since the remaining 11 condition groups are generally "other" conditions such as "other cardiovascular disorders" which are less well defined. See Appendix for full condition group list.

NOTE: For details regarding the methodology and limitations, please see the Appendix.

3 Avalere Used AHRQ's Methodology to Compute the PQI Overall Composite Measure and Estimated the HEDIS PCR Rate Based on NCQA's Methodology

- The AHRQ PQI Overall Composite measures potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs), which are intended to reflect issues of access to, and quality of, ambulatory care in a given geographic area
- The HEDIS 30-day PCR Rate estimates the number of acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days of hospital discharge
 - » This measure is risk-adjusted for patient demographics (age and sex), medical severity identified with CMS' Hierarchical Condition Categories (CMS-HCCs) and survey that occurred during the index acute inpatient stay
- The cost analysis estimates a one-year savings of how much MFFS could save if CA's MFFS dual eligibles had the same PQI hospitalization and HEDIS readmissions rates as SCAN's dual eligibles

NOTE: For more detailed information about the methodology used to construct the matched cohorts, HEDIS 30-Day All-Cause Readmissions Rates, the PQI Overall Composite and individual measures, and the cost-saving analysis, please see the Appendix



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Page 19

3 Cost-Savings¹ Estimates Simulate Hospital and Readmissions Rates for CA-MFFS Dual Eligibles Equal to SCAN's Rates

Potential Cost-Savings Associated with Reduced Hospitalizations

- Compare the PQI Overall Composite hospitalization rate between SCAN dual eligibles and the CA-MFFS dual eligibles matched to them to determine the difference in the number of hospitalizations between the matched cohorts
- Estimate average cost of hospitalizations, using the 2009 and 2010 Medicare SAF's, and multiply by the number of hospitalizations avoided to estimate the total amount that Medicare would save on the CA-MFFS dual eligibles matched to SCAN's dual eligibles

Potential Cost-Savings Associated with Reduced Readmissions

- Compare the HEDIS 30-day PCR rate and the observed-to-expected ratio between SCAN dual eligibles and the CA-MFFS dual eligibles matched to them to determine the difference in the number of readmissions between the matched cohorts
- Estimated the average cost of readmissions, using the 2009 and 2010 Medicare SAF's, and multiply by the number of avoided readmissions to estimate the total amount that Medicare would save on the CA-MFFS dual eligibles matched to SCAN's dual eligibles

¹ For detailed assumptions and limitation of this particular methodology, please see the Appendix

3 Assumptions and Limitations

General Limitation

- All analyses used the Medicare 5 percent SAFs; no state Medicaid data was used for these estimates
 - » The results of the cost-savings analysis were multiplied by 20 to account for potential savings across the entire California dual eligible population who could have been matched to SCAN dual eligibles based on similar risk profiles

Propensity Score Match Model Limitation

- Since the propensity score match analysis was limited to 1:1 matches, the model may have excluded from consideration some CA-MFFS dual eligibles whose risk profiles were similar to those of the SCAN "treatment group"

PQI Overall Composite Limitation

- Analysis assumes some of these hospitalizations could have been avoided, and likewise, does not account for other hospitalizations that may have been avoided

¹ For detailed assumptions and limitation of this particular methodology, please see the Technical Memorandum

3 Assumptions and Limitations (continued)

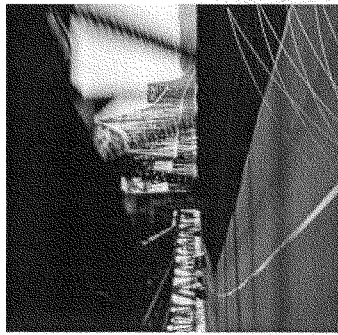
HEDIS 30-day All-Cause Plan Readmission Rate Limitation

- For the risk-adjustment methodology for the HEDIS PCR rate, Avalere used the "Medicare Advantage and SNP Product Lines" risk-adjustment weights for estimating the expected readmission rate for both samples

Cost-Savings Limitations

- Avalere used the PQI hospitalization rates and HEDIS PCR rates to estimate the potential reduced hospitalizations and readmissions, however, there may be other conditions in addition to the twelve PQI-related conditions
- Estimated costs were based on the total average cost of hospitalizations and readmissions in the CA-MFFS matched sample
 - » Avalere did not model which specific hospitalizations or readmissions and associated costs would be avoided
- Cost savings from avoided readmissions in 2010 do not account for reduced hospitalizations (an avoided hospitalization cannot have an associated readmission)

¹ For detailed assumptions and limitation of this particular methodology, please see the Technical Memorandum



4 Requests for Additional Information

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4 Requests for Additional Information

For additional information, please contact:

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BIPARTISAN POLICY CENTER

Bipartisan Policy Center Comments for the Record
House Energy and Commerce Committee Health Subcommittee Hearing:
“Examining the Extension of Special Needs Plans”
July 26, 2017

The Bipartisan Policy Center (BPC) appreciates the opportunity to submit comments for the official record at today’s House Energy and Commerce Health Subcommittee hearing on legislation to improve and extend the Medicare Advantage (MA) Special Needs Plans (SNPs) program. BPC commends the bipartisan collaboration of Energy & Commerce Committee and Ways & Means Committee Members and staff to examine the SNP program and improve coordination of care for the vulnerable individuals it serves. BPC’s Health Project has released numerous recommendations to improve quality and value in the U.S. health care system and the financing and delivery of long-term services and supports (LTSS). In September 2016, BPC released a report on improving care for individuals dually-eligible for Medicare and Medicaid.¹ This report examined and provided recommendations on the reimbursement and the integration of services for programs that serve dual-eligible beneficiaries, including MA Special-Needs Plans, the Program of All-Inclusive Care for the Elderly (PACE), and Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative demonstration.

Barriers to Integration in Dual-Eligible Special Needs Plans (D-SNPs)

Common challenges for high-need patients are exacerbated for dual-eligible individuals – who are a diverse population of low-income elderly patients and individuals with disabilities. Lack of care coordination is particularly serious for this population, 69 percent of whom have four or more chronic conditions. BPC analysis in its 2016 report found that, on average, full-benefit dual-eligible beneficiaries have risk scores that are 50 percent higher than the average risk score for all other Medicare beneficiaries. They often require a greater need for care coordination and assistance with activities of daily living (ADLs) due to higher medical acuity and significant cognitive and functional impairments. To address this, D-SNPs were introduced as a program within Medicare Advantage as a means of better coordinating Medicare and Medicaid benefits for dual-eligible individuals. However, multiple enrollments, cost-sharing, and other administrative requirements continue to impede the coordination of benefits in D-SNPs. For example, D-SNP-enrolled dual-eligible individuals typically receive separate cards, member handbooks, and provider directories—one for Medicare benefits and one for Medicaid benefits. Though one managed care organization administers the entirety of the benefits, individuals in D-SNPs are technically enrolled in two separate plans. Most Medicaid managed care plans enrolling dual-eligible beneficiaries do not cover the full range of Medicaid benefits to which dual-eligible individuals are entitled, making it difficult, if not impossible, to fully align and integrate services. Indeed,

¹ Bipartisan Policy Center. *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*. September 2016. Available: <https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.

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bipartisanpolicy.org | 202-204-2400 | @BPC_Bipartisan | Washington, D.C. 20005

the most common benefits excluded are behavioral health services and some or all of Medicaid LTSS covered by the state. BPC analysis found that full-benefit dual-eligible beneficiaries with multiple chronic conditions and depression have on average 80 percent higher Medicare spending than those without depression. Evidence shows that targeting treatment to patients likely to benefit from interventions is a necessary element of a successful care model, however the lack of alignment of benefits and administration of services across the continuum of care in D-SNPs warrants continued effort to improve the coordination of care for those who need it most.

Whether or not full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible individuals will likely vary based on the care delivery model and state implementation, but there is potential for improved quality and greater value. As Congress considers the extension of SNPs, BPC appreciates this opportunity to highlight several recommendations from the 2016 report on improving the integration of care for dual-eligible individuals.

Permanently authorize Medicare Advantage Dual-Eligible SNPs

D-SNPs were intended to permit better coordination of care between the Medicare and Medicaid programs for dual-eligible beneficiaries by allowing plans to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan. However, as discussed above, the delivery and administration of benefits in D-SNPs continue to face barriers to integration. Consistent with current legislation from the Senate Finance Committee-approved *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017*, BPC recommends the permanent extension of D-SNPs. BPC recommends that all plans should meet the requirements of Fully Integrated Duals Special-Needs Plans, which fully integrate clinical health services, behavioral health, and LTSS by January 1, 2020 to improve the coordination of care and integration of benefit structures.

Authorize the Department of Health and Human Services (HHS) secretary to align the Medicare and Medicaid grievance and appeals processes.

The grievance and appeals processes for Medicare have different rules and timelines than those processes for Medicaid. These differences can cause confusion, and it can be time consuming for beneficiaries to navigate the two processes. The HHS secretary does not currently have the authority to align these processes, although the administration has sought this authority in fiscal year (FY) 2015, 2016, and 2017 budget proposals. BPC's recommendation to unify the grievance and appeals processes for dual-eligible individuals is consistent with the Energy & Commerce Committee's draft *Special Needs Plans Reauthorization Act of 2017*, H.R. 3168 on SNP authorization, and provisions in the Senate *CHRONIC Care Act of 2017* (S. 870). BPC recommends that the MA standards for grievances and appeals should be the minimum standard, but as under Medicaid, claims should be "paid while pending appeal."

The HHS secretary should ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers.

Multiple enrollments, cost-sharing, and other administrative requirements are barriers to the coordination of benefits and are confusing to beneficiaries. A single enrollment and administrative process would be less confusing to beneficiaries, would reduce administrative complexities at the plan and provider levels, and would require the alignment of enrollment dates, out-of-pocket costs, contact numbers, and claims submission processes in the Medicare and Medicaid programs.

Align Oversight of Programs Serving Dual-Eligible Beneficiaries within the Centers for Medicare and Medicaid Services

To better serve dual-eligible individuals, Congress should consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office. Congress directed HHS to establish an office responsible for integrating care for dual-eligible beneficiaries; however, existing agencies within CMS retain regulatory authority over programs serving dual-eligible beneficiaries. Consolidating this authority will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries, as well as state implementation. Reimbursement structures would include SNPs, PACE, and current and future demonstrations. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs through an entity that has the authority to address those needs. This new structure would also be in line with the Administration's Executive Order on cross-cutting reforms designed to create a lean, more effective, efficient, and accountable government.

Treating persons with complex medical conditions is especially challenging when patients have low incomes. Although many plans and providers understand how best to treat patients with chronic conditions, the current fragmented reimbursement and administrative structures under Medicare and Medicaid create barriers to the integration of services. While federal and state policymakers, health plans, and providers have much to learn about the delivery and integration of clinical health services, behavioral health services, and LTSS, evidence suggests potential for improving quality, value, and patient satisfaction.

We encourage Congress to continue its thoughtful, open, and bipartisan process to ensure the extension of SNPs will improve the coordination of care and health outcomes for these vulnerable populations. BPC appreciates the opportunity to provide comments. Please do not hesitate to contact us if you have any additional questions.



July 26, 2017

The Honorable Michael C. Burgess, M.D.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Burgess:

Thank you for your work on the Medicare Advantage (MA) Special Needs Plans (SNPs). As the Subcommittee on Health prepares to hold a hearing on this important issue, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable, high quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC supports stabilizing the Medicare program for beneficiaries using tools that have been developed and used successfully in the private sector. Like employer-sponsored health insurance, MA gives beneficiaries access to affordable care. These plans include catastrophic coverage, as well as early intervention and care coordination services.

MA benefits are especially valuable to the 2.4 million people enrolled in a SNP. These plans enroll beneficiaries who are dually-eligible for Medicare and Medicaid (D-SNPs), reside in a nursing home (I-SNPs), or have a chronic condition (C-SNPs). SNPs give beneficiaries access to care plans and provider networks that are designed especially for their health conditions. By coordinating care and providing access to supplemental benefits, these plans improve the health of Medicare beneficiaries and reduce costs for taxpayers.

The SNPs must be reauthorized this year, preferably in the early fall to give the Centers for Medicare and Medicaid Services (CMS) to implement the program. HLC urges the

Subcommittee to reauthorize the SNPs until at least 2024 and to consider permanently reauthorizing them. This reauthorization would encourage broader replication of best practices and care delivery, and SNP enrollees would be guaranteed continued access to high quality and cost effective care.

HLC also urges the Subcommittee to enact a proposal similar to the bill introduced in the last Congress, H.R. 4212, the "Community-Based Independence for Seniors Act." This legislation would establish a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program to provide home and community-based care to low-income Medicare beneficiaries who are unable to perform two or more activities of daily living. The CBI-SNP program would improve the care of these beneficiaries and eliminate the need for them to spend down their income and assets to qualify for Medicaid. They would instead be provided with home and community-based long-term care services and supports. This would enable beneficiaries to remain at home, where they want to be, and reduce their Medicare and Medicaid costs.

Thank you again for your leadership on the SNPs. HLC looks forward to continuing to work with you in a constructive collaboration to develop an optimal 21st century Medicare program. If you have any questions, please do not hesitate to contact Debbie Witchev at (202) 449-3435.

Sincerely



Mary R. Grealy
President



March 28, 2017

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Greg Walden
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20510

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Chairman Walden, and Ranking Member Pallone:

On behalf of the nation's Medicaid Directors, we write to request that your Committees work to provide states with the certainty that key federal programs will continue to be authorized and funded. Specifically, we request:

1. The timely passage of legislation to fund the Children's Health Insurance Program (CHIP); and
2. Permanently reauthorizing Medicare Advantage Duals Special Needs Plans (D-SNPs), with consideration of lifting the administrative moratorium on "seamless conversion" between Medicaid managed care plans and D-SNPs.

It is critical that states be assured of the federal government's commitment to continuing its support of these programs, as states must make budgetary and operational decisions in the coming months which hinge on this commitment. Ensuring predictability for the future Medicaid landscape is key to maximizing the planning occurring now, as state legislatures are convened.



The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, which provides a vital health care safety net for more than 72 million Americans. In most states, the Medicaid agency also retains responsibility for administering CHIP, either in combination with the Medicaid program or as a standalone program.

The Medicaid program often makes up the largest budget item in a state, with program and policy decisions exerting a significant effect on both the state's and Medicaid's budgetary outlook in a given year. Consequently, as state legislatures convene and make state funding decisions which must be in place for a year or two years, depending on the legislature's schedule, it is imperative that state policymakers be fully informed of the federal landscape for Medicaid and CHIP in order to make the most appropriate decisions for their state. Programmatic uncertainty or changes in federal programs after a legislature has made these decisions may necessitate special sessions to address disruptions in service delivery, funding gaps, or other unanticipated consequences.

In the spirit of minimizing the potential for this disruption, Medicaid Directors request that Congress take timely action in this period of debate and reform discussion to provide states with certainty that the federal commitment to CHIP and the D-SNP programs will remain in place going forward.

Timely CHIP Funding is Key for State Budgetary and Operational Certainty

CHIP is a program with a record of success and bipartisan support since its creation in 1997. With federal support of CHIP, which is administered either separately or in conjunction with Medicaid at state option, the nation has seen steady improvements in health insurance coverage and access to services for children. The program also provides coverage for pregnant women, allowing access to prenatal care services which can improve long-term health outcomes for children. Financing of the CHIP program allocates a certain amount to states for each year of the program, with states drawing down the allocated funds based on a federal match specified by Congress and the administration. Medicaid agencies or agencies responsible for administering CHIP shape their budget requests to state legislatures based on this allotment and the funds needed to meet match requirements.

Currently, Congress has funded CHIP through September 2017, while the ACA requires states to maintain current eligibility levels for children through September 2019. While the September 2017 funding expiration date may suggest ample time to act to appropriate new funds for the program at the federal level, the reality for states is markedly different. The funding structure for CHIP described above necessitates budget decisions in the next few weeks, without a clear sense of whether program funding will still be in place. Further, as the program nears the end of



its Congressional funding, states will be required to notify current CHIP beneficiaries of the termination of their coverage. This process may be required to begin as early as July in some states. Additionally, states will need to begin significant administrative and operational work to wind down CHIP and its associated programs, at substantial cost, should a timely renewal of the program not be forthcoming.

We recommend Congress act swiftly to appropriate funding for CHIP to mitigate these concerns, and note the support of both HHS Secretary Tom Price and CMS Administrator Seema Verma for an eight-year reauthorization of the program. Providing states with certainty around the federal government's commitment to CHIP will ensure the program's prior successes are sustained. Additionally, we request Congress consider how the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which is also set to have its federal funding expire in September 2017, may factor into the future of children's health coverage, and note the bipartisan support for this program expressed by federal policymakers in a March 15 House Ways and Means Subcommittee on Human Resources hearing.

Permanent D-SNP Reauthorization Promotes Medicare-Medicaid Integration Efforts

Medicaid Directors also seek a timely and permanent reauthorization of the Duals Special Needs Plans (D-SNP) program in order to promote further programmatic and budgetary predictability for states. Dually eligible Medicare-Medicaid beneficiaries represent one of the most complex and fragile populations in the nation, with significant care needs. Integrated managed care plans such as D-SNPs present one solution to ensuring coordination of benefits across the Medicare and Medicaid programs. Sufficient coordination often does not occur, making care delivery for this population more costly and complex than necessary.

D-SNPs are currently authorized through December 31, 2018. While the need for reauthorization is not as pressing as CHIP, Medicaid Directors recommend a permanent reauthorization of the D-SNP program. Permanency for D-SNPs will facilitate states building a comprehensive, long-term strategy around these plans to drive further improvements for the dually-eligible population.

Additionally, we request that Congress, either independently or as part of a D-SNP reauthorization, work with the Centers for Medicare and Medicaid Services (CMS) to sustain and promote the use of "seamless conversion" as Medicaid beneficiaries become eligible for Medicare. Seamless conversion is the method by which an individual who is enrolled in a non-Medicare Advantage plan is able, upon gaining Medicare eligibility, to enroll in a Medicare Advantage plan from that same issuer. In the context of Medicaid, the non-Medicare Advantage Plan is a Medicaid managed care plan. Seamless conversion into an aligned D-SNP for new Medicare beneficiaries provides for improved coordination of Medicaid and Medicare benefits.



This practice has received scrutiny in other contexts, but we believe seamless conversion for the dual eligible population is categorically different from commercial coverage to Medicare transitions. Unlike commercial plans, there is typically significant overlap in the network for Medicaid managed care and D-SNP plans, which can provide for greater continuity of services and providers. States can also leverage federally required Medicare Improvements for Patients and Providers Act (MIPPA) agreements with the state Medicaid agency to establish minimum network overlap and continuity of care requirements and to require issuers have procedures to ensure case managers, care coordination, and other critical care management activities remain in place during the seamless transition, thereby promoting continuity of care for this vulnerable population. Moreover, aligned enrollment for Medicare and Medicaid benefits provides for improved coordination of critical care transitions and benefits across programs, including long-term services and supports. Unlike other Medicare members, dual eligible beneficiaries can opt out of a D-SNP plan at any time, thus providing flexibility if the beneficiary decides a different plan or original Medicare is preferred.

Currently, two states are able to use seamless conversion to promote care and coverage continuity for dual eligible members, but CMS has placed a blanket moratorium on seamless conversion due to concerns around individuals transitioning from private coverage to Medicare Advantage. We believe the data in these two states will show seamless conversion is having a positive impact for dual eligible beneficiaries, based on the very low volume of opt-outs and dis-enrollments. Over time, we anticipate data will also demonstrate that these aligned arrangements in which Medicaid and Medicare services can be delivered in a coordinated way can improve the quality and efficiency of care delivery across both programs.

Available evidence already suggests integrated Medicare-Medicaid managed care plans improve care for their beneficiaries. In the *Minnesota Managed Care Longitudinal Data Analysis*¹, which compared service utilization in a fully-integrated managed care program to a model in which Medicare and Medicaid benefits are managed separately, members in fully integrated managed care plans were:

- 48% less likely to have a hospital stay, with 26% fewer stays overall;
- 6% less likely to have an outpatient ED visit, with 38% fewer visits overall; and
- 2.7 times more likely to have a primary care physician visit, but if so, had 36% fewer visits.

NAMD encourages Congress to analyze this moratorium in the context of the Medicaid program compared to other coverage sources, noting the ability for state Medicaid agency oversight to

¹ Available at <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>



leverage seamless conversion as an effective tool to align coverage and access to services for the vulnerable duals population.

We appreciate your consideration of these requests, and stand ready to provide additional information or other assistance.

Sincerely,

A black rectangular box redacting the signature of Christian L. Soura.

Christian L. Soura
Director
South Carolina Department of Health and
Human Services
President, NAMD

A black rectangular box redacting the signature of Judy Mohr Peterson.

Judy Mohr Peterson
Med-QUEST Division Administrator
State of Hawaii
Vice President, NAMD

cc: Seema Verma, Administrator, Centers for Medicare and Medicaid Services

July 20, 2017

The Honorable Greg Walden
Chairman
Committee on Energy & Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy & Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy & Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Committee on Energy & Commerce
United States House of Representatives
Washington, DC 20515

Dear Chairman Walden, Ranking Member Pallone, Subcommittee Chairman Burgess,
and Subcommittee Ranking Member Green:

We, the undersigned organizations, representing Special Needs Plans, health care providers, advocates and Medicare beneficiaries, write to convey our strong support for Medicare Advantage Special Needs Plans (SNPs), and the specialized care they deliver to more than 2.4 million high-need, high-cost Medicare beneficiaries.

With current SNP authorization expiring at the end of 2018, we remain committed to working this year in a bipartisan manner with Congress and the Administration to permanently authorize all SNPs to ensure that they are stable, accessible, high quality, cost effective, and financially viable for the millions of Medicare beneficiaries who depend on SNPs for their care.

Knowing that beneficiaries with chronic conditions are among Medicare's most costly and fastest-growing patient groups, Congress prudently created SNPs in the Medicare Modernization Act of 2003 (MMA, P.L. 108-173). Congress has continued to reauthorize the program since 2003 because the capitated, or fixed dollar amount per member, per month system in Medicare Advantage incentivizes not only the appropriate level of care and better care management for chronic conditions, but also has the capacity to create value-based models of care that provide specialized medical services for these beneficiaries.

Today, SNPs serving beneficiaries who are dually-eligible for Medicare and Medicaid (D-SNPs), have certain chronic conditions (C-SNPs), or receive long-term care in an institutional setting such as a Skilled Nursing Facility (I-SNPs) have all been highly successful in targeting clinical programs to more effectively care for high-risk beneficiaries who have multiple chronic conditions or complex medical problems. These specialized models of care better coordinate benefits and services for the SNP enrollee population, and include care management tools, such as care managers, interdisciplinary teams, specialized provider networks, and quality improvement plans that can better enable data sharing across health plans and providers.

According to the Centers for Medicare & Medicaid Services (CMS), I-SNPs perform well on quality measures, and have proven success in lowering hospital readmission rates.^{1 2} D-SNPs had the most performance measures with a statistically significant improvement from 2012-2013.³ A 2012 study found beneficiaries in C-SNPs had lower rates of hospitalizations and readmissions than their peers in FFS Medicare.⁴ A Commonwealth Fund Case

¹ MedPAC. "Medicare Advantage special needs plans." MedPAC. N.p., Mar. 2013. [Web](#).

² MedPAC. "Report to Congress: Medicare and the Health Care Delivery System." Page 269. MedPAC. N.p., June 2017. [Web](#).

³ National Training Program. "Centers for Medicare & Medicaid Services." [www.seiservices.com](#). CMS, 11 Aug. 2015. [Web](#).

⁴ Robb Cohen, Jeff Lemieux, Jeff Schoenborn, Teresa Mulligan, "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients," Health Affairs, January 2012 vol. 31 no. 1 110-119.

Study found in 2015, CareMore plan beneficiaries had 20 percent fewer hospitalizations, while delivering Medicare benefits more efficiently. The CareMore plan has an I-SNP, D-SNP, and C-SNP.⁵

As Congress works to build on these achievements for current and future high-need, high-cost beneficiaries, we firmly believe that several key principles should guide legislative efforts. SNP reauthorization should include provisions that provide for:

- **Stability Through Permanency**—Permanently authorizing all SNPs will provide states, health plans, and providers with a stable environment to allow for care continuity for beneficiaries, and for greater planning of and investment in the successful care models that SNPs provide to high-need beneficiaries.
- **A Workable Pathway Toward Integration**—We agree that integration of Medicare and Medicaid services in D-SNPs is an important goal for states, plans, and beneficiaries. Specific consideration should be given to ensuring states and plans have multiple pathways to work together to tailor integration. In addition, legislation should state explicitly that plans should not be penalized for state decisions that might impede integration.
- **Strengthening the Role of the Medicare-Medicaid Coordination Office**—The MMCO plays a vital leadership role for CMS, states, and plans in advancing dual integration in general. For integration to be successful over time, the MMCO should be given regulatory and guidance authority for aligning the spectrum of Medicare and Medicaid policies and procedures for plans charged with integrating benefits and services for dually eligible beneficiaries.
- **Benefit Flexibility**—We are supportive of policies that allow Medicare Advantage plans—including SNPs—to most efficiently and effectively meet the needs of chronically ill beneficiaries. This includes policies expanding the type of supplemental benefits plans can offer these beneficiaries, as well as expanding the use of Value-Based Insurance Design (VBID), which is currently being tested by the Center for Medicare and Medicaid Innovation (CMMI). These policies will allow SNPs to better tailor medical and social services for their high-need enrollees.

Thank you for your consideration of these principles as you work to further policies that will better enable Medicare Advantage SNPs to provide high quality care over the long term and focus on prevention, coordinated care, better management of chronic conditions, and new provider payment models that reward value over volume and meet the needs of complex patients.

We appreciate the thoughtful work and stakeholder engagement offered by the committees of jurisdiction. We stand ready to work with you to ensure continuity, affordability, and peace of mind for the millions of Medicare beneficiaries who depend on SNPs for their care.

Sincerely,

AIDS Healthcare Foundation
Alliance of Community Health Plans
America's Health Insurance Plans
Association for Community Affiliated Plans
Better Medicare Alliance
Blue Cross Blue Shield Association

Healthcare Leadership Council
Meals on Wheels America
National Alliance on Mental Illness
National Coalition on Health Care
National Minority Quality Forum
SNP Alliance

cc: The Honorable Paul Ryan, Speaker, U.S. House of Representatives
The Honorable Nancy Pelosi, Minority Leader, U.S. House of Representatives

⁵ Martha Hostetter, Sarah Klein, and Douglas McCarthy. "CareMore: Improving Outcomes and Controlling Health Care Spending for High-Needs Patients." www.commonwealthfund.org. N.p., Mar. 2017. [Web](#).



STATEMENT FOR THE RECORD

**Submitted to the
House Energy and Commerce Committee
Subcommittee on Health**

Examining the Extension of Medicare Advantage Special Needs Plans
July 26, 2017

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
Suite 500, South Building
Washington, D.C. 20004

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate the committee's interest in reauthorizing and strengthening Medicare Advantage (MA) Special Needs Plans (SNPs). We also thank the committee for strongly supporting the broader MA program. Earlier this year, more than 340 members of Congress addressed letters to the Centers for Medicare & Medicaid Services (CMS), expressing support for the MA program.

Because of the great value that SNPs deliver for the American people, we encourage Congress to permanently reauthorize all SNPs including plans for beneficiaries who are dually eligible for both Medicare and Medicaid (D-SNPs), those for beneficiaries with specified chronic conditions (C-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Our nation's health plans remain committed to the physical and financial well-being of America's seniors, and we are eager to work with Congress and the administration on new ways to ensure that every dollar spent serving Medicare beneficiaries delivers real value for the American people.

SNPs are Essential for Medicare Beneficiaries

SNPs serve as an essential safety net for approximately 2.4 million of our nation's most vulnerable seniors. To qualify for SNPs, seniors must be: (1) dually eligible for both Medicare and Medicaid; (2) have severe or disabling chronic conditions; or (3) qualify for an institutional level of care.

These individuals have serious health concerns, and health plans that participate in the SNP program tailor their benefits and services to address their unique needs. Beneficiaries who enroll in SNP plans can become more healthy through the use of coordinated care, disease management, and other initiatives designed to ensure high-quality, integrated care.

Research findings demonstrate that such innovations translate into better health. A *Health Affairs* study found that beneficiaries with diabetes who were enrolled in a Medicare Advantage SNP had "lower admission rates, shorter average lengths-of-stay in the hospital, lower

readmission rates, slightly lower rates of hospital outpatient visits, and slightly higher rates of physician office visits than their fee-for-service counterparts.” Specifically, the study indicated that SNP enrollees had 9 percent lower hospital admission rates and 19 percent fewer hospital days, and 7 percent more office visits than beneficiaries in traditional Medicare.¹

While SNP enrollment has nearly tripled – from 900,000 in 2007 to 2.4 million enrollees today – the quality of care has increased dramatically. The average Medicare Star Rating of SNPs, determined by CMS and awarded annually according to relative plan performance on a robust series of quality measures, increased from 3.59 in 2013 to 4.07 in 2017.

SNPs have also proven to be cost effective. Even with all of the additional benefits that enrollees receive through a SNP program, the cost to taxpayers is the same as for beneficiaries in the Medicare fee-for-service (FFS) program. Indeed, according to the Medicare Payment Advisory Commission (MedPAC), Medicare payments to SNPs in 2017 will equal 100 percent of Medicare FFS costs.²

Our Recommendations for Permanently Reauthorizing and Strengthening SNPs

Permanent reauthorization is good policy, and it makes good fiscal sense. SNPs have existed for more than ten years, are popular with beneficiaries, have improved quality ratings, and cost no more than Medicare FFS. Moreover, in 2017, the Congressional Budget Office estimated that permanent SNP reauthorization (as part of S. 870) would only increase federal spending by \$123 million over 10 years, in comparison to a 2015 estimate of \$600 million to extend the program by three years (as part of H.R. 2).³

SNPs were first authorized by the Medicare Modernization Act of 2003 (MMA) and implemented in 2006. In the intervening years, Congress has passed seven short-term extensions:

¹ Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use among Diabetes Patients. *Health Affairs* Vol. 31, No. 1: 110-119. January 2012. <http://content.healthaffairs.org/content/31/1/110.abstract>

² Report to Congress: Medicare Payment Policy, Chapter 13, Medicare Payment Advisory Commission, March 2017. http://medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0

³ Preliminary Estimate: S. 870, Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, Congressional Budget Office, May 16, 2017. <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s870withmodifications.pdf>

1. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 subsequently extended the SNP program from December 31, 2008, to December 31, 2009. (2008 to 2009)
2. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) lifted the Medicare, Medicaid, and SCHIP Extension Act of 2007 moratorium on approving new SNPs and MIPPA extended the SNP program through December 31, 2010. (2009 to 2010)
3. Section 3205 of the Patient Protection and Affordable Care Act (ACA) extended the SNP program through December 31, 2013. (2010 to 2013)
4. Section 607 of the American Taxpayer Relief Act of 2012 (ATRA) extended the SNP program through December 31, 2014. (2013 to 2014)
5. Section 1107 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) extended the SNP program through December 31, 2015. (2014 to 2015)
6. Section 107 of the Protecting Access to Medicare Act of 2014 extended the SNP program through December 31, 2016. (2015 to 2016)
7. Section 206 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018. (2016 to 2018)

Continuing to reauthorize SNPs only on a short-term basis creates unnecessary disruption and hinders innovation for greater value for beneficiaries and taxpayers. Without permanent reauthorization, plans and state Medicaid programs cannot invest in longer-term initiatives such as devoting the resources necessary to integrate Medicaid benefits and coordinate care with D-SNPs. In a September 2012 report, the Government Accountability Office recognized that this uncertainty created challenges for plans and states.⁴ Permanent reauthorization would increase our members' commitment to creating larger-scale innovative programs to deliver better care at a lower cost for these Americans.

In addition to supporting permanent reauthorization of SNPs, we also have joined other stakeholders in recently addressing a letter to committee leaders highlighting other priorities:

- A Workable Pathway Toward Integration: We agree that integration of Medicare and Medicaid services in D-SNPs is an important goal for states, plans, and beneficiaries. Specific consideration should be given to ensuring that states and plans have multiple pathways to work together to tailor integration. In addition, legislation should state explicitly that plans should not be penalized for state decisions that might impede integration.

⁴ Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance, Government Accountability Office, September 2012. <http://www.gao.gov/assets/650/648291.pdf>

- Strengthening the Role of the Medicare-Medicaid Coordination Office (MMCO):
The MMCO plays a vital leadership role for CMS, states, and plans in advancing dual integration in general. For integration to be successful over time, the MMCO should be given regulatory and guidance authority for aligning the spectrum of Medicare and Medicaid policies and procedures for plans charged with integrating benefits and services for dually eligible beneficiaries.
- Benefit Flexibility: We support policies that allow MA plans – including SNPs – to most efficiently and effectively meet the needs of chronically ill beneficiaries. This includes policies expanding the type of supplemental benefits plans can offer these beneficiaries, as well as expanding the use of Value-Based Insurance Design (VBID), which is currently being tested by the Center for Medicare and Medicaid Innovation. These policies will allow SNPs to better tailor medical and social services for their high-need enrollees.

Thank you for considering our recommendations. We also have provided the committee with additional recommendations on technical changes that would help to further improve care for those who rely on SNPs. We look forward to working with the committee as you advance legislation to reauthorize and strengthen SNPs.



ACAP
Association for Community
Affiliated Plans

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Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

July 24, 2017

The Honorable Greg Walden, Chairman
House Energy and Commerce Committee
2124 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Ranking Member
House Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

Sent via Email

Chairman Walden and Representative Pallone:

As the House Energy and Commerce Committee considers legislation regarding the reauthorization of Medicare Advantage Special Needs Plans (SNPs), I am writing to offer ACAP's policy recommendations for the D-SNP program. For the purposes of this letter we will be basing our comments on H.R. 3168, the "*Special Needs Plans 3 Reauthorization Act of 2017*" as passed by the Ways and Means Committee on July 13 of this year. On behalf of the Association for Community Affiliated Plans, the 60 Safety Net Health Plans, and the 20 million Americans served by them, we are grateful for the opportunity to explain the policy recommendations and to propose the corresponding legislative language.

Permanent Authorization of D-SNPs

Although we are pleased that H.R. 3168 provides for longer than a short-term reauthorization, ACAP strongly supports permanent authorization of D-SNPs. D-SNPs have been reauthorized numerous times, but only in a series of short-term extensions. The benefit of D-SNPs to enrollees is that they can tailor their care management, provider interventions, and partnerships with community-based organizations to the unique needs of their dual-eligible enrollees. We believe that the lack of permanent authorization destabilizes the program for beneficiaries, states, health plans, and providers. ACAP supports permanent authorization of D-SNPs because doing so would provide certainty to plans, beneficiaries, and states and would foster longer term partnerships and investments in care management and integration with Medicaid.

Suggested technical revision:

- In HR 3168, Section 1, strike clause (a)(2).
- Revise Section 1, clause (a) (1) so that it reads: (a) EXTENSION.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by 16 striking “and for periods before January 1, 2019”.

Adjust the Star Ratings Program to adjust for Dual Eligible Status

The Star Ratings system is central to CMS's goal of improving the quality of services provided to Medicare beneficiaries and the system helps beneficiaries compare plan quality and determine plan bonus payments. However, the December 2016 ASPE report to Congress shows that dual status is a significant predictor of low Star Ratings, independent of plan or provider performance. Unfortunately, this suggests that the current Star Rating system fails to adequately account for dual eligible and disability status, producing a structural disadvantage for plans that serve dual-eligible beneficiaries. Because of that, ACAP believes that Congress should require CMS to develop a meaningful, long-term solution that



accurately measures and compares quality of care for plans with high enrollment of dual-eligible beneficiaries. This will not only help to create an accurate “apples-to-apples” measure to help facilitate true comparison among the quality of the unique D-SNP plans, but it will also not penalize plans that choose to serve Dual Eligibles from being penalized for issues more related to the uniqueness of the population than the quality of the plan itself.

Suggested technical revision:

- Insert in Section 2 the new subsection (2) (on page 21, line 7)”
- (f) ENSURING APPROPRIATE QUALITY MEASUREMENT FOR SPECIAL NEEDS PLANS SERVING DUAL ELIGIBLES. – (1) Not later than the 2020 Medicare Advantage plan year, the Secretary shall revise the Medicare Advantage Star Rating system so that the quality measures used in the system, and the methodology for developing the quality ratings, result in accurate quality measurement for plans that enroll individuals dually eligible for Medicare and Medicaid and individuals with disabilities. (2) In developing revisions to the Star Rating system, the Secretary shall (A) take into account stakeholder feedback before implementing the revisions to the Star Rating system, (B) consider peer grouping Dual Eligible Special Needs Plans, adjusting individual measures, revising the measure set used for Dual-Eligible Special Needs Plans so that all measures used are applicable and appropriate for individuals dually eligible for Medicare and Medicaid, and (C) account for the impact of social determinants of health on quality measurement.

Apply the frailty adjuster at the beneficiary level to all LTSS recipients.

The CMS-HCC risk-adjustment model does not adjust for frailty. For that reason, PACE providers and Fully-Integrated Dual Eligible SNPs (FIDE-SNPs) receive a frailty adjuster. The frailty adjuster is calculated based on these plans’ average level of frailty and is applied at the plan level, as opposed to the beneficiary level. PACE providers and FIDE-SNPs are permitted to receive the frailty adjuster because they directly furnish LTSS services. All other plans, including D-SNPs and MMPs, are excluded from receiving the frailty adjuster. In making this distinction about which plans are eligible for the frailty adjuster, CMS is equating frailty with use of LTSS services.

Medicare spending is higher for LTSS users than it is for non-LTSS users. A recent report by MedPAC and MACPAC found that Medicare per user spending was much higher for LTSS users - \$31, 921 for institutional LTSS users, \$22,438 for HCBS state plan users, and \$19, 172 for HCBS waiver users – while per user spending for non-LTSS Medicare beneficiaries was much lower (\$14,089 per user).¹ These additional costs are incurred not only by PACE providers and FIDE-SNPs, but also by D-SNPs, MMPs, and other plans that enroll LTSS users. But because D-SNPs, MMPs, and other plans are not eligible for the frailty adjuster, Medicare payments to these plans do not account for the additional costs associated with LTSS utilization. Because D-SNPs and MMPs exclusively enroll dual eligibles, many of whom are LTSS users, the lack of a frailty adjuster results in fewer resources for these plans.

To be equitable and to appropriate pay plans that care for LTSS users, we believe that Congress should require CMS to apply the frailty adjuster at the beneficiary level for all LTSS users (both institutional and

¹ MedPAC and MACPAC. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. January 2017.



HCBS users) and apply that adjustment to LTSS users enrolled in D-SNPs, MMPs, and other MA plans. This would more appropriately pay plans for the additional Medicare costs associated with LTSS users and would provide D-SNPs and MMPs additional resources to manage the LTSS population.

Suggested technical revision:

- Section 1853(a)(1)(B)(iv) of the Act should be amended to allow CMS to apply the frailty adjuster at the individual level for beneficiaries that receive institutional or community-based long-term care services and supports.
- In addition, ACAP supports language that provides that no later than the 2020 plan year, the Secretary must develop the methodology for applying the frailty adjuster at the individual level for all Medicare Advantage enrollees that receive long-term care services and supports. These changes to the risk-adjustment methodology are not required to be done in a budget neutral manner.

Again, thank you for the opportunity to submit our comments on helping to develop D-SNP legislation that will be considered in the House Energy and Commerce Committee. As always, please do not hesitate to contact Christine Lynch, ACAP's Vice President for Medicare, at clynch@communityplans.net if we can be of any assistance.

Sincerely,



Margaret A. Murray
President and Chief Executive Officer



July 25, 2017

UPMC Health Plan
Legal Services Department
U.S. Steel Tower
600 Grant Street, 55th Floor
Pittsburgh, PA 15219
T 412-454-7823
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House Energy and Commerce Committee, Subcommittee on Health
Attn: Josh Trent, Deputy Chief Counsel and Rachel Pryor, Health Policy Advisor
U.S. House of Representatives
Submitted Electronically (Josh.Trent@mail.house.gov, Rachel.Pryor@mail.house.gov)

Re: Comments on Special Needs Plan (SNP) reauthorization

Dear Chairman Burgess, Vice Chairman Guthrie, and Ranking Member Green:

On behalf of UPMC Health Plan and the UPMC Insurance Services Division (collectively, "UPMC") and the over three million individuals we serve, thank you for the opportunity to provide feedback on the approach that the House Energy and Commerce Committee intends to take with respect to the extension of Special Needs Plan (SNP) authorization. Having recently testified before the Senate Finance Committee in support of a reauthorizing bill, I and UPMC Health Plan support your Committee in its consideration of this important legislation and its intent to improve health care services for Medicare beneficiaries with chronic health care needs. We appreciate your thoughtful consideration of the issues that this legislation seeks to address.

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medical Special Needs Plans (SNPs), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers' compensation coverage products. Our MA Plan, UPMC *for Life*, serves approximately 160,000 members combined through the MA Part C/D and SNP programs. Through our Medicaid managed care organization, UPMC *for You*, we provide coverage to more than 400,000 enrollees across 40 Pennsylvania counties, and our behavioral health managed care organization, Community Care Behavioral Health, manages mental health and substance abuse services for almost one million Medical Assistance enrollees in Pennsylvania. In January 2018, UPMC will expand its portfolio to include Pennsylvania's Community HealthChoices, a Managed Long-Term Services and Supports (MLTSS) program that is expected to serve more than 360,000 individuals who are disabled, placed in nursing homes, or dually eligible for Medicare and Medicaid. We are committed to playing a role in the evolution of MLTSS and other promising, cost- and quality-improving efforts both in Pennsylvania and elsewhere. It is with this commitment in mind that we offer for your consideration the following comments on the current Discussion Draft.

While we are strongly supportive of the legislation and its intent, we nonetheless have some concerns regarding the following provision, which permits a SNP to satisfy otherwise applicable "full integration" requirements where it is:

"(bb) being offered by a parent organization that also offers a Medicaid managed care plan that provides long term services and supports or behavioral health services to the same enrollees as under such specialized MA plan."
(7/25/2017 Discussion Draft, Page 9 Lines 10-17)

We understand that the intent of this provision is to allow Plans operating separately contracted SNP and MLTSS or behavioral health managed care organization (BH-MCO) to qualify as fully integrated SNPs. We support this characterization and thank your colleagues in the House Ways & Means Committee for including it in their version of this legislation. That said, we are nonetheless concerned that the currently drafted language could be read to limit such a grant of “fully integrated” status to those Plans whose MLTSS or BH-MCO programs serve *all* of the Plan’s SNP enrollees. In States like Pennsylvania, SNP and MLTSS or BH-MCO programs can operate in geographically diverse areas that in some cases vary on a county-by-county basis. As such, while a Pennsylvania SNP operating alongside a commonly owned BH-MCO is likely to serve some or most of the same enrollees, it may also be the case that the State’s approach to contracting requires the SNP to coordinate services with a different, unaffiliated BH-MCO for a subset of SNP members. Importantly, this is only one example, and we expect that other States may face similar changes based on their unique approach to contracting Medicaid managed care services.

We recognize the importance of balancing the need for flexibility in recognition of varied State approaches, while still limiting the grant of “fully integrated” status to those Plans operating a SNP that truly integrates care and management for beneficiaries. We also recognize that this provision will likely be subject to interpretive guidance and rulemaking, and acknowledge that the nature of the subject provision also provides the Secretary of Health and Human Services with some degree of flexibility in establishing the qualifications for Plans to claim “fully integrated” status. As such, we ask the Committee to consider adopting a minor adjustment to the foregoing language that will help guide agency rulemaking without seeking to be overly prescriptive. We recommend the following adjustment to the terms of the Discussion Draft:

“(bb) being offered by a parent organization that also offers a Medicaid managed care plan that provides long term services and supports or behavioral health services to substantially the same enrollees as under such specialized MA plan.”

Thank you again for your efforts to support and strengthen SNPs and for your consideration of these comments. We firmly believe that passage of this bipartisan legislation will enable States like Pennsylvania, and Plans like ours, to advance innovative, quality-driven care delivery models that better serve medically vulnerable and chronically ill individuals. We would be happy to provide any additional information or data in support of the Committee’s efforts in this regard, and look forward to continued collaboration and dialogue on this important topic.

Sincerely,



John G. Lovelace
President
Government Programs and *Individual Advantage*
UPMC Health Plan

The New York Times

Opinion

Making the Budget Bearable

FEB. 7, 1997

The basic outlines of President Clinton's budget for 1998 were largely set the moment he made election-year concessions to the Republicans to balance the budget by the year 2002, cut taxes and ax welfare spending. But now that he must live within these tight confines, Mr. Clinton has mostly made sound, compassionate decisions to mitigate the worst harshness.

His budget plan would remove the cruelest parts of the welfare law by reinstating the right of childless adults to collect food stamps if they are unemployed and unable to find work. The plan would also allow legal immigrants who become disabled after they arrive in the United States to collect cash assistance and Medicaid coverage. It would provide health coverage for many uninsured children and extend health insurance for millions of workers between jobs.

In education, the area he highlighted in his State of the Union address, Mr. Clinton would raise spending by a hefty \$50 billion over five years. The budget would put one million children by 2002 into Head Start, the effective preschool program for low-income families. That needed move would still leave another million eligible children out of the program. Unfortunately, the bulk of Mr. Clinton's education spending would be doled out indiscriminately to families in tuition tax credits totaling about \$35 billion. These will not boost college enrollment very much, and will not even leave money in the pockets of middle-class families once universities react, as they almost certainly will, by raising tuition.

By contrast, Mr. Clinton would spend less than \$2 billion next year in additional funding for Pell grants, the proven way to help poor families send young people to college who could not otherwise attend. Now that the election is behind it, the Administration should not resist if some in Congress want to skip the tuition tax cuts and apply the money to tuition grants.

The President offers an important reform of Medicaid, proposing to control future spending by placing a cap on the amount of Federal spending per enrollee and allowing states to place enrollees in managed care without going through the frustrating process of begging for Washington's approval. But if Mr. Clinton's fiscal record is measured largely on the basis of what he does on Medicare, he risks a failing grade. He has proposed no long-term solution, rejecting an emerging consensus for turning Medicare into a competitive system like the one that provides a choice of health plans for every Federal employee.

Mr. Clinton's five-year plan concentrates about two-thirds of its spending cuts in the last two years, thus ducking difficult decisions. But for next year he has made mostly sensible calls. His budget would pay some of the money that the United States owes the United Nations and the World Bank for assistance to poor countries, boost money for lending institutions in urban ghettos and maintain spending on scientific research. These and other proposals look like a politically realistic basis for compromise with Congress in the year after budget parameters were set by a foolish competition to promise both a quick end to deficits and broad-scale tax cuts.

S 19184

CONGRESSIONAL RECORD — SENATE

December 22, 1995

about that ad is similar to the one that I have just represented?

Mr. ROCKEFELLER addressed the Chair.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. In responding to the Senator from Massachusetts, it is really a matter, I think, of fundamental shock as well as distortion of truth that these ads are portraying. What we have been doing in the course of this particular year 1995 is looking at Medicare and Medicaid all by themselves without any sort of thought about comprehensive health care reform at all, which means it is like you are trying to take a gigantic system and just reorganize one part of it.

What Mrs. Clinton was talking about a year or more ago in this television ad, she was in the process of leading an effort, along with the President and the rest of us, which did not succeed, to try to reform health care as a whole and to really give a chance for Medicare and Medicaid to take their proper role within a reformed total health care system in the private sector.

So to the Senator from Massachusetts, I would say he is absolutely right. All of those cuts she was talking about were being plowed right back into Medicare, into senior citizens in the form of prescription drugs and long-term care. Because there were tremendous efforts being made to control costs in the private sector, there was not any of the cost-shifting involved that we are seeing in the debate this year because it was comprehensive health care, cost control within the private sector, plus the fact that you were not going to have, back then, the situation of doctors refusing to see patients, Medicare patients because perhaps the fee would not be adequate, or you certainly would not have seniors being forced into HMO's and other things. So the choosing of the doctor, the fact that the money was all being put back into Medicare really makes the perpetrators of this ad a rather shameful lot, and it is a tremendous disservice to Mrs. Clinton, who did everything that a human could possibly do to try to make health care better for all Americans.

Mr. KENNEDY. Mr. President, I thank the Senator, and I particularly wish to thank my friends and colleagues, the floor managers, Senator LUGAR and Senator PELL. This matter which is before the Senate now is extremely important, and I am grateful to them for their courtesy in letting us address the Senate briefly on this matter.

I thank the Chair.

Mr. BINGAMAN addressed the Chair. The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. I ask unanimous consent that I be allowed to speak as if in morning business for up to 6 minutes.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

WORKABLE GOVERNMENT

Mr. BINGAMAN. Mr. President, we are now in the seventh day of the second Government shutdown of the year. This is the longest partial shutdown of our Government in the almost 207 years of our Nation's history.

The commonly held view is that the shutdown results from differences in policy between the Republican-controlled Congress and the President. The Republicans want their economic projections used to calculate the deficit reduction needed to get to a balanced budget. The President wants to ensure that reasonable funding levels are maintained for Medicare, Medicaid, education, environmental enforcement, and so on.

This commonly held view is wrong. In fact, this crisis in government is not caused by differences between the President and Congress on policy matters. It is caused by the new and radical view that Republican congressional leaders have taken about Congress' constitutional duties and prerogatives.

For the first time in our Nation's history, the congressional government and keep it closed in order to extort concessions from the President on policy issues. House Majority Leader RICHARD K. ARMEY, this week, announced that the House will not send President Clinton a bill reopening the full Government—even temporarily—until there is "a bill for him to sign" that balances the budget in 7 years.

This decision by Congress to shut down the Government until it gets its way is new. No previous Congress has interpreted the Constitution as granting it that right. In a recent interview with the Wall Street Journal, Mr. GINGRICH referred to this newfound right as "the key strategic decision made on election night a year ago."

Mr. GINGRICH stated: If you are going to operate with his [the President's] veto being the ultimate trump, you have to operate within a very narrow range of change. * * * You had to find a trump to match his trump. And the right not to pass money bills is the only trump that is equally strong.

So, for the first time in our national life we have congressional leadership that believes it has the constitutional right to close the Government and keep it closed until Congress prevails. The immediate disagreement is about a whole tangle of budgetary issues, but if Congress has the right to close the Government in this disagreement, presumably it has that right whenever the President has the temerity to stand his ground on any issue. If the closing of Government is an inherent right of the Congress, then all powers of the President are necessarily subordinated.

Those who wrote our Constitution never intended that the Congress have any such right as is now claimed. They set out a system of checks and balances among the branches of government and provided a method of resolving differences including a right of the President to veto legislation and the right of Congress to override that veto.

But underlying all these checks and balances between the branches of government, those who wrote the Constitution assumed an obligation and desire on the part of all to maintain what Justice Jackson referred to as a "workable government." (343 U.S. 379, 635 (1952)).

When our Founders embarked upon the task of bringing to life the constitutional system devised in Philadelphia in 1787 and approved by the State ratifying conventions, it was the legislative branch of our new Government which they called on to commence proceedings under the Constitution.

Pursuant to that call, the Congress met in New York in 1789, organized itself, and provided for the counting of the Presidential electoral votes and the inauguration of the President. The Congress then passed legislation to establish the great departments of the executive branch, to provide for the organization of the judicial branch, and to furnish appropriations to enable all the branches of our new National Government to perform their constitutional functions.

It would be, Mr. President, frankly unimaginable to our Nation's Founders that our branch, the first branch of government, whose duty it was to bring to life the Framers' plan, would ever think that it was within its purview to disable that plan by refusing to perform the Congress' primary constitutional responsibilities.

But the Republican leaders of Congress today are doing just that—refusing to perform the Congress' primary constitutional responsibilities. They believe they have "the right not to pass money bills" and can use that so-called right as the "ultimate trump," as Mr. GINGRICH puts it, in their disagreements with the President.

Mere policy differences, no matter how important, are not at the core of the present Government crisis. There have been many times in our history when policy differences between Congress and the President were great and were strongly held. The real cause of this crisis is the inflated and radical view taken by Republican congressional leaders concerning the rights of the Congress under the Constitution. What they claim as a right is instead an unprecedented abuse of power. Until a majority of each House of Congress recognizes this, the "workable government" which the Founding Fathers contemplated will remain at risk.

Thank you Mr. President, and I yield the floor.

Mrs. MURRAY addressed the Chair. The PRESIDING OFFICER. The Senator from Washington.

Mrs. MURRAY. Thank you, Mr. President.

FUNDING FOR MEDICAID

Mrs. MURRAY. Mr. President, I hold in my hand today a letter to President Clinton that is signed by all 46 members of the Democratic Caucus. This

December 22, 1995

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letter urges him to hold firm to our commitment to basic health care for children, pregnant women, the elderly, and the disabled in this country. This letter supports a per capita cap approach to finding savings in the Medicaid Program.

Mr. President, I ask unanimous consent to have that letter printed in the RECORD at the end of my statement.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

(See exhibit 1)

Mrs. MURRAY. Mr. President, this letter shows unity and it demonstrates support for President Clinton in his negotiations on this vital matter. As you heard the eloquent Senator from West Virginia describe yesterday, sometimes we have to look beyond partisanship and do what needs doing as Americans. As you heard our respected colleague say, we need to look beyond partisanship, toward compromise if we want to succeed in creating a balanced budget.

This letter is partisan in that it is signed by all Democrats. But it is my feeling that as Americans every Member of the Senate should have an opportunity to endorse the position described in this document. As Americans we all must do our very best for our children in this Nation, and that is what this letter is about.

As the Senators from Nebraska and North Dakota discussed yesterday with the release of the Senate Democratic budget, we can balance the budget in 7 years using the most conservative CBO estimates without hurting our children.

This letter I hold in my hand reflects just one part of that commitment. I do not think my colleagues across the aisle are advocating the block grants so that we will intentionally hurt children in this country. I will simply tell you the reaction of people at the State and local level who actually provide Medicaid services to children is overwhelmingly negative.

They can see from the grassroots level what it will mean to design a Medicaid program, and they do not want drastic funding cuts, and they do not want a block grant, because it fundamentally will not work.

Groups representing almost every decisionmaker and provider in this country have come out against the Medicaid block grant proposal. The Conference of Mayors, the National Association of County Officials, the National Conference of State Legislatures, the Democratic Governors Association, the American Hospital Association, and most other medical provider organizations, and all child advocacy groups, all have rallied in opposition to this bad idea.

I heard yesterday from Mayor Norm Rice of Seattle and the Mayors Association, who are sending a letter of their own to the President. The block grant has been condemned by anyone who has thought about how it will affect this country's children and other

vulnerable populations. Tonight there will be a child within a few blocks from this building who will need the help of a caring health care professional, and Medicaid will pay for the care.

Marion Wright Edelman uses a phrase that sums up what we are talking about when it comes to Medicaid and children, "protection of last resort." We have to guarantee that protection. It is a moral commitment, and it is within our grasp. We can balance the budget but we can do it without giving in to mindless partisanship and we can do it without sacrificing our basic commitments.

EXHIBIT 1

U.S. SENATE,
Washington DC, December 13, 1995.
President WILLIAM J. CLINTON,
The White House,
Washington, DC.

DEAR Mr. PRESIDENT: We are writing to express our strong support for the Medicaid per-capita cap structure in your seven-year budget. We have fought against Medicaid block grants and cuts in the Senate, and we are glad you acknowledge the importance of our position.

We support a balanced budget. We are glad you agree with us that we can balance the budget without undermining the health of children, pregnant women, the disabled, and the elderly.

The savings level of \$54 billion over seven years included in your budget will require rigorous efficiencies and economies in the program. However, after consulting with many Medicaid Directors and service providers across the country, we believe a reduction of this level is possible to achieve without dramatic limits on eligibility or cuts to essential services. States will need flexibility to achieve these savings, and you have taken steps toward granting it in your bill.

We were encouraged that your Medicaid proposal does not pit Medicaid populations against one another in a fight over a limited pot of federal resources.

We were further encouraged to hear Chief of Staff Panetta relay your commitment to veto any budget not containing a fundamental guarantee to Medicaid for eligible Americans.

We commend you on the courage you have exercised in making these commitments to Americans eligible for Medicaid. There is a bottom line when it comes to people's health: do not allow the current Congressional leadership to further reduce our commitment to Medicaid beneficiaries.

Your current proposal is fair and reasonable, and is consistent with what we have advocated on the Senate floor. We urge you in the strongest possible terms to hold fast to these commitments in further negotiations. We are prepared to offer any assistance you may need in this regard.

Sincerely,
Bob Graham; John Breaux; Jay Rockefeller; Herb Kohl; Patrick Leahy; Frank R. Lautenberg; Ted Kennedy; Tom Daschle; Patty Murray; Barbara Boxer; David Pryor; Barbara A. Mikulski; Max Baucus; Paul Simon; Kent Conrad; Wendell Ford; Harry Reid; Paul Wellstone; Richard H. Bryan; Ernest Hollings; Dianne Feinstein; Tom Harkin; Byron L. Dorgan; Chris Dodd; J. Bennett Johnston; Joe Lieberman; Paul Sarbanes; Carol Mosely-Braun; John Glenn; Jeff Bingaman; Carl Levin; Bill Bradley; John F. Kerry; Bob Kerrey; Joe Biden; Daniel K. Akaka; Dale Bumpers; Daniel Inouye; Chuck

Robb; J. James Exon; Howell Heflin; Claiborne Pell; Russ Feingold; Daniel P. Moynihan; Sam Nunn; Robert C. Byrd.

Mr. FEINGOLD addressed the Chair. The PRESIDING OFFICER. The Senator from Wisconsin.
Mr. FEINGOLD. Thank you, Mr. President.

HEALTH CARE

Mr. FEINGOLD. Let me first of all express my appreciation to the Senator from Massachusetts and the Senator from West Virginia who just spoke about the advertisement that I also saw this morning with regard to Mrs. Clinton and her health care financing proposals as opposed to those of the leadership in the Congress of this session.

To suggest that the President's proposal last year was in any way the same in terms of cuts to Medicare and Medicaid is truly absurd. In fact, I want to emphasize that one of the very significant things that the President's plan would have done is provide for the first time a national home- and community-based long-term care program, to help people stay in the community, and I think save the country a lot of money in both the Medicare and Medicaid budget.

To suggest that somehow Mrs. Clinton's proposal was in any way, shape or form like what we are seeing today with the slash-and-burn approach to Medicaid and Medicare is, to me, very unfortunate and very distorting and, again, suggests that there is no limit in reference to the actual facts in these situations.

I don't know how the American people are supposed to know who to believe. That is the comment I get most often now at home. "Who do you believe?" And when you are willing to put an ad on the television that suggests that a program that was proposed by the President last year is essentially the same as the Medicare and Medicaid cuts proposed today, I just get the feeling that people will not have any idea who is telling the truth in Washington. I think we all suffer because of that.

CONFEREES HAVE FAILED TO PROTECT FREE SPEECH RIGHTS OF INTERNET USERS

Mr. FEINGOLD. Mr. President, on another matter, 2 weeks ago I came to the Senate floor to urge my colleagues who are telecommunications conferees not to adopt potentially unconstitutional legislation in our efforts to protect children on the Internet. I was concerned about the substantial chilling effect this legislation would have on constitutionally protected speech. The media had just reported recently an online service provider's censorship of the word "breast" because it was vulgar, supposedly, despite the fact that that term merely refers to a part of the anatomy.