

March 31, 2017

The Honorable Tom Price
Secretary
The U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Price:

The more than 11 million people dually eligible for Medicare and Medicaid are among the nation's most vulnerable citizens. Although most are served by fragmented systems of care, more than 700,000 of these individuals are now in programs that coordinate or integrate care across Medicare and Medicaid.

We represent a group of health plans participating in PRIDE (*P*romoting *I*ntegrated *C*are for *D*ual *E*ligibles), a national initiative that is building on recent efforts to integrate care and spreading successes to benefit the millions of dually eligible beneficiaries who still remain in fragmented systems of care. In this letter, we outline several opportunities for the new Administration to advance Medicare-Medicaid integration for dually eligible individuals.

A High-Need, High-Cost Population

Individuals eligible for both Medicare and Medicaid are often beset by various combinations of poverty, chronic disease, physical and cognitive disabilities, and social isolation. The majority of Medicare beneficiaries who receive Medicaid have three or more chronic conditions, such as diabetes, heart disease and depression. More than half of dually eligible beneficiaries require assistance with activities of daily living such as eating, bathing, or dressing, which are essential for living independently. In addition, more than half have a cognitive or mental impairment, such as dementia or a disabling behavioral health condition.

In 2012, the nation spent more than \$300 billion on care and services for dually eligible beneficiaries. Although these individuals represent only 20 percent of Medicare enrollees and 15 percent of Medicaid, they account for approximately one-third of expenditures in both programs. This high-need population – and, subsequently, associated program costs – will continue to grow as the Baby Boom generation ages. Further, the Centers for Medicare & Medicaid Services (CMS) anticipates that Medicaid enrollment for adults over age 65 will grow faster than any other enrollee category.

Integration Matters

Medicare and Medicaid have operated as separate programs since their inception in 1965 and, as a result, millions of dually eligible beneficiaries have received fragmented care at a great cost to them and to the nation. Dually eligible individuals receiving services through two programs with different administrative requirements and in separate delivery systems regularly face: (1) uncoordinated services; (2) poor provider communication; and (3) differing policies regarding reimbursement, beneficiary protections, and enrollment. These factors all contribute to poor health outcomes, cost-shifting, and avoidable spending.

Integrating care for this high-need population has become a priority for states, the federal government, health plans, providers, and other stakeholders, driven by expectations that integration will improve the quality of care and reduce costs. Defined broadly, *integration* refers to the blending or aligning of Medicare and Medicaid administrative processes and policies, and care management practices across medical, behavioral health, and long-term services and supports (LTSS) to make them work better together.

During the last several years, 12 states partnered with CMS’ Medicare-Medicaid Coordination Office to launch the Financial Alignment Initiative demonstrations, which have enrolled nearly 450,000 individuals. In addition, more than 20 states have comprehensive Medicaid managed LTSS programs, and many of these programs have strong linkages with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). Approximately 250,000 people are enrolled in fully aligned Medicare Advantage and Medicaid health plans. Early evaluation findings from integrated care models for dually eligible beneficiaries show:

- **Reduced inpatient and emergency department utilization:** A federal evaluation of Minnesota’s fully integrated D-SNP, Minnesota Senior Health Options, found that it decreased the number and duration of hospitalizations and decreased emergency department use.
- **Reduced spending:** Over its first 18 months, Washington’s managed fee-for-service Financial Alignment Initiative demonstration reduced Medicare spending by \$21.6 million relative to a comparison group, representing more than six percent shared savings for the state and CMS.
- **Improved beneficiary experience:** Under California’s capitated Financial Alignment Initiative demonstration, beneficiaries reported high overall satisfaction, attributed to better access to care, satisfaction with care coordination, and improved behavioral health services among other factors. A recent federal evaluation of Massachusetts’ capitated Financial Alignment Initiative demonstration showed high beneficiary satisfaction, including some who reported a “profound” impact on their services and quality of life.

The PRIDE Perspective

The PRIDE plans – **BlueCare Tennessee** (Tennessee); **CareSource** (Ohio); **Commonwealth Care Alliance** (Massachusetts); **Health Plan of San Mateo** (California); **Independent Care Health Plan** (Wisconsin); **Inland Empire Health Plan** (California); **UCare** (Minnesota); and **VNSNY CHOICE Health Plans** (New York) – each offer a Medicare-Medicaid Plan through Financial Alignment Initiative demonstrations and/or a D-SNP that provides all Medicaid services including LTSS.

Our plans have significant expertise in the diverse medical, behavioral health and LTSS needs of our dually eligible members. We believe that the key to care management for this population is the ability to combine Medicare and Medicaid financing streams and services into an integrated benefit structure that allows the plans to address individuals’ full range of needs. This is critical to avoiding further medical or functional decline that would require admission to a hospital or nursing facility or services that are more intensive. Our plans are pursuing innovations made possible by integrated models to improve quality, better coordinate care, and/or reduce utilization or unnecessary spending, including:

- **Delivery system innovations.** One plan, with nearly 70 percent of its membership having a behavioral health condition, created Crisis Stabilization Units (CSUs) to accommodate members who need short-term intensive behavioral health and medical services. Early findings show that nearly 90 percent of CSU stays were diversions from more costly inpatient admissions, and on average CSU lengths of stay were shorter.
- **Efforts to increase value.** A plan established a value-based reimbursement initiative with nursing facilities that tied incentive payments to quality metrics required by the state. Another plan developed nursing facility “report cards” to motivate quality improvement efforts related to hospital readmission rates, outcomes for individuals with behavioral health conditions, and others.
- **Inpatient care reductions.** One plan recently partnered with a provider of in-home medical care for its members with five or more chronic conditions in order to divert emergency department visits, prevent hospital readmissions, and extend individuals’ ability to remain in their homes. Another plan launched a community paramedicine program to accomplish similar goals. A third plan partnered

with community-based organizations to support member transitions out of institutions, significantly improving quality of care and member satisfaction, and reducing costs.

Policy Considerations

Based on our experience with integrated care models, we suggest three policy options for the Secretary’s consideration that, if pursued by the Department of Health and Human Services, would help sustain momentum toward advancing integrated care for dually eligible beneficiaries. The following options support key goals of improving health outcomes and reducing unnecessary spending and overall program costs for this high-need population:

1. **Establish permanent integration platform(s).** Neither Medicare-Medicaid Plans nor D-SNPs have permanent authority to continue operation. Some Financial Alignment Initiative demonstrations have been extended through 2020, but, without rulemaking for permanence, states and plans face an uncertain future thereafter. Current SNP authorization expires after December 31, 2018. This uncertainty limits both states and health plans’ willingness to invest in these programs by, for example, signing contracts and committing new resources for integrated programs.

We request the Secretary's support for establishing permanent platforms for integration, which would accelerate advancements in integrated care for dually eligible beneficiaries. Both the Medicare Payment Advisory Commission (MedPAC) and the Senate Finance Committee have expressed support for the Financial Alignment Initiative demonstrations and/or permanent reauthorization of the SNP program. They and others have also been highly supportive of the Medicare-Medicaid Coordination Office’s efforts and other mechanisms for engaging states, health plans, and other key stakeholders in improving these programs.

2. **Continue to support collaboration and communication between the states and CMS.** A strong state-federal partnership is essential to making integrated care programs work. During the last few years, CMS and states have made substantial progress in expanding collaboration, such as establishing regular communication mechanisms between the federal government, states, and health plans to oversee Financial Alignment Initiative demonstrations, and creating opportunities for stakeholders to comment on Medicare Advantage policies that impact Medicare-Medicaid enrollees.

The effects of this collaboration are felt at the delivery system level. We hope that the Secretary will continue to support efforts that facilitate coordination between states and the federal government and address remaining Medicare and Medicaid program misalignments. Continued focus on streamlining requirements around plan and provider reporting requirements, care management, and member materials could ease some of the financial and human capital costs to health plans that also often create burdens for providers. We also encourage the Secretary to support Medicare Advantage policies that promote beneficiary enrollment into aligned Medicare-Medicaid integrated care plans.

3. **Continue to examine and evaluate program policies that address specific population characteristics of the dually eligible population.** PRIDE plans appreciate CMS’ recognition that health plans that serve a high proportion of dually eligible beneficiaries are more likely to have enrollees with behavioral health conditions, functional limitations, and other considerable challenges related to low-income status. A study released in December 2016 by The Office of the Assistant Secretary for Planning and Evaluation found that dual beneficiary status was the most significant predictor of poor health outcomes among Medicare beneficiaries. We hope that the Secretary will continue efforts to re-evaluate risk adjustment and Medicare Star Ratings methodologies to develop a

meaningful framework to better align resources and accurately measure quality of care for health plans that cover a disproportionate number of dually eligible beneficiaries.

We appreciate the opportunity to describe our efforts to improve care and lower costs for the dually eligible population and to present these options for your consideration. The federal government, states, and health plans have collaborated in unprecedented ways in recent years to build a strong foundation for integrated care platforms, but there is still much work ahead to extend the benefits of integrated care to millions of additional dually eligible individuals. We remain committed to staying the course toward integrated care to improve health outcomes and reduce unnecessary costs for the enrollees we serve.

Sincerely,



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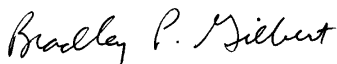
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