

June 5, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius,

I am writing on behalf of the Medicaid Health Plans of America (MHPA) to express our strong support for the Department of Health and Human Service's (HHS) unprecedented efforts to strengthen health care services and improve the quality of life for more than 9 million Americans dually eligible for both Medicaid and Medicare. We also believe that the Capitated Financial Alignment Demonstration (CFAD) initiative is an integral part of the Department's overall strategy for better integrating care and improving health outcomes for Medicare-Medicaid enrollees (MMEs). We therefore urge you to implement the pilot program as quickly as possible to allow this population to realize the same benefits of an integrated care delivery system already afforded to millions of non-dual Medicaid beneficiaries.

As you may know, MHPA is the leading association solely focused on representing the common interests of Medicaid health plans. Our 108 member plans serve more than 14 million beneficiaries in 33 states and the District of Columbia. MHPA represents both non-profit and for profit plans, ranging from large multi-state insurance corporations to small community-based plans. We believe that Medicaid managed care has proven to be a highly successful model for coordinating care for low-income and culturally diverse populations and our plans are eager to expand this model to include Medicare-Medicaid enrollees.

MHPA does not think HHS is moving too quickly to implement Capitated Financial Alignment Demonstrations. Rather, we believe the existing payment silos and fragmented fee-for-service (FFS) delivery systems are failing Medicare-Medicaid enrollees and are fiscally unsustainable for both the federal and state governments. According to an analysis by the Urban Institute, the combined cost of Medicare and Medicaid care for this population in 2007 exceeded total Medicare expenditures for all other Medicare beneficiaries, a group four times as large. I offer the following additional thoughts on the urgent need for transformation of the current structure of care and the benefits of integration:

Current Care Delivery System, Income and Health Status, and Cost of Care for MMEs

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

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

At the present time, Medicaid-Medicare enrollees represent just 15% of the Medicaid population, but account for 39% of total Medicaid spending. In Medicare, they represent 16% of enrollees and 27% of program costs. Total federal and state spending on this population now exceeds \$300 billion. Almost two-thirds of Medicaid spending for this population is for long-term care. As you know, while nursing home care is a Medicaid entitlement benefit for individuals meeting state income eligibility criteria, in most states access to home and community-based services, which is an optional service, is generally more restricted. The Urban Institute analysis of 2007 data also showed that total per capita Medicare and Medicaid spending on Medicare-Medicaid enrollees averaged \$29,868, more than four times per capita spending on other Medicare beneficiaries. As a society, we can and must do a better job of providing elderly and disabled Medicare-Medicaid enrollees higher quality and more cost-effective health care.

New Integration and Alignment Initiatives

Through the Medicare-Medicaid Coordination Office (MMCO), and in partnership with the Center for Medicare and Medicaid Innovation (CMMI), HHS has launched several innovative programs to better integrate Medicare and Medicaid services, align administrative requirements, quality measures, and consumer protections, and to improve health outcomes for Medicare-Medicaid enrollees. These include the state demonstrations focused on the integration of care and financial alignment, the collection and sharing of Medicare data with states to improve care coordination, and a separate demonstration to reduce avoidable hospitalizations for nursing facility residents.

The MMCO is not only helping to implement each of these important initiatives, but also serves as an advocate for the well-being of Medicare-Medicaid enrollees and is giving clear focus to their health care concerns and social needs. MHPA member plans are engaging with states and CMS on these integration and alignment activities and we believe they will dramatically improve health care for Medicare-Medicaid enrollees.

Structure and Planning Process for Capitated Financial Alignment Demonstrations

This model is one of two approaches MMCO is testing to integrate all Medicare and Medicaid services and to make care delivery more cost effective. Three-way contracts between CMS, states, and health plans will provide a single, blended capitation payment to fully cover a range of Medicare and Medicaid services, including prescription drugs and long-term care services and supports.

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

While administrative processes and requirements will be streamlined and simplified, the CFAD demonstrations generally incorporate and build upon Medicare beneficiary protections. MMCO is also requiring transparency for the planning process that each state seeking to implement a financial alignment demonstration must undertake. Every proposal must document how stakeholders have been engaged and must be posted for public comment at least once by a state sponsor for 30 days. Following submission by a state of its final proposal to CMS, the plan is posted for another 30-day comment period.

To date, 20 states have issued draft capitated proposals and/or submitted final capitated plans to CMS. A number of these states have made adjustments to their CFAD plans after receiving input from interested stakeholders and the general public. Just last week, CMS also publicly released information on the rate setting process, baseline projections and savings assumptions, and risk adjustment criteria it plans to use for the CFAD demonstrations.

Plans seeking to participate in state demonstrations must submit applications and detailed information on benefits, including drug formularies, models of care, networks, and marketing materials under uniform timelines established by CMS. Their participation must also be jointly approved by states and CMS. We encourage CMS and states to engage with plans as early as possible to ensure timely and successful implementation of

the CFAD demonstrations. We also applaud CMS for collecting Medicare data that can be shared with states and urge that this process be expedited to facilitate benefit design, development of models of care, and rating setting.

Enrollment Considerations

For the CFAD demonstrations, CMS is allowing states to use passive enrollment for their integrated plans, but is also requiring them to allow individuals to “opt out” of the integrated program either prior to enrollment or anytime afterward. We strongly agree that extensive outreach and education will be required to ensure that Medicare-Medicaid enrollees are fully aware of their options and rights, but also believe that once a person chooses to enroll, a state should generally be able to require participation for some reasonable period of time before Medicare-Medicaid enrollees can make an informed decision about whether to stay in the plan, switch to another plan, or opt back into the FFS system. We also think states and plans should be able to provide additional supports and services beyond those already available through Medicare and Medicaid as incentives for participation, as well as non-nominal incentives such as coupons for over-the-counter drugs to encourage enrollees’ participation in care management activities or to reward desired behaviors (e.g., getting screening tests).

We note that for too many Medicare-Medicaid enrollees the concept of “choice” is a false choice. They have no opportunity to participate in a fully integrated care delivery system that includes care coordination. We reject the notion that the status quo is adequately meeting the health care needs of this population.

Medicaid Managed Care Plan Experience

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

Health plans are accredited by The National Committee for Quality Assurance (NCQA) and URAC, which evaluate them on rigorous standards relating to network management, access, quality, and beneficiary rights. Medicaid health plans report on care quality using standard Healthcare Effectiveness Data and Information Set (HEDIS) metrics that enable states to evaluate quality improvement over time. For example, in 2011, Colorado health plans improved in 17 of 24 performance measures required by the state, addressing topics ranging from chronic disease medication monitoring to increasing use of prenatal care monitoring. Some states also use Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate health plan performance and beneficiaries’ satisfaction. In its June 2011 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that data from the 2010 CAHPS survey showed

that Medicaid enrollees gave their plans higher marks than patients in privately insured or Medicare plans. No such comprehensive measures or surveys exist in FFS Medicaid.

Health plans serving the Medicaid population already serve large numbers of elderly and disabled persons. MHPA member companies operate 315 Medicare Advantage plans serving close to 4.7 million Medicare recipients. Another 567,000 Medicare beneficiaries are served in 179 Medicare Special Needs Plans operated by our members, with three quarters of these individuals participating in Dual Eligible Special Needs Plans, or D-SNPs. MACPAC's March 2012 report to Congress included an analysis of Medicaid Statistical Information System (MSIS) data that showed that approximately 2.6 million disabled persons were already enrolled in comprehensive, risk-based Medicaid managed care plans as of 2008.

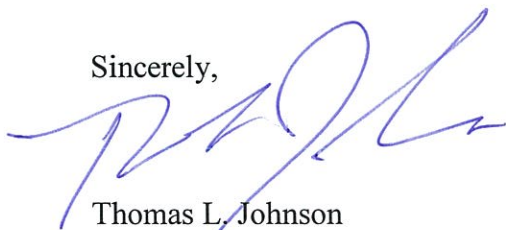
Conclusion

MHPA recognizes that many Medicare-Medicaid enrollees have complex medical and behavioral conditions. We also know that this population is more likely to be institutionalized and is subject to higher rates of hospitalization and re-admissions, as well as emergency room visits. Many lack family support to help them navigate between programs and providers. Without a major change in policy, this population will continue to get sicker and will continue to drive a disproportionately high share of Medicaid and Medicare spending.

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

Thank you for considering our thoughts and suggestions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'T. Johnson', is written over the printed name.

Thomas L. Johnson
President & CEO