House Committee on Energy and Commerce, Subcommittee on Health

Testimony of G. Lawrence Atkins, PhD, Executive Director

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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]

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[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

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[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/MCRAdvPartDEnrolData/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 modalities[6] 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 meet 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.

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[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.