National
MLTSS
Health Plan Association

House Committee on Ways and Means, Subcommittee on Health
Testimony of G. Lawrence Atkins, PhD
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Chairman Tiberi, Ranking Member Levin, and Members of the Subcommittee:

Thank you for the opportunity to provide testimony on promoting integrated and coordinated care and services for Medicare beneficiaries. We want to commend the Committee on its attention to this most important area of focus.

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 spending and Medicaid's LTSS spending together to provide fully integrated and coordinated care for the individual.

Today I would like to discuss the importance of integrating and coordinating care and services, the key role that LTSS plays in integration, and our thoughts on how to improve our current programs for integration.

Fully-integrated approaches that streamline and coordinate care and services for persons with disabilities and older adults covered under Medicaid, or under Medicare and Medicaid, improve the accountability to consumers and states for quality and outcomes and access to care and services, while better managing cost for states, and achieving greater efficiency and sustainability. Our experience with integrated models reflect that consumer satisfaction with integrated care is high and integrating LTSS with medical care helps reduce medical spending for beneficiaries with complex care needs. For example, member satisfaction surveys in CMS's Financial Alignment Demonstration show that more than half of consumers receiving care through an MMP rated the quality of their health plan a 9 or 10 out of 10 and 80% of health plans received at 7 out of 10 or higher[1]. In addition, a recent study of Minnesota's integrated plans (MN Senior Health Options (MSHO)) found that enrollees were half as likely to have a hospital admission and less likely to have an ER visit than enrollees in non-integrated Medicaid plans (MN Senior Care Plus (MSC+)).[2]

LTSS is a critical component of care for Dual Eligibles. More than 40 percent of dual-eligible beneficiaries rely on LTSS [3] and Duals 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)[4].

Fully-integrated models are still only available to a small portion of the Dual Eligible population. The Program for All-inclusive Care of the Elderly (PACE) is the longest-standing fully-integrated program. It is a model that has worked well for older adults with complex-care needs, although it has only been able to enroll a small number of them. It is not well-suited for persons with disabilities under age 65.

The Duals Special Needs Plans (D-SNPs) and Fully-Integrated Dual Eligible SNPs (FIDE-SNPs) have provided a greater opportunity to expand coverage under an integrated approach, but these

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[1] "Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results from the 2015 CAHPS Survey." Centers for Medicare and Medicaid Services. Apr. 2016. Web. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsApr2016.pdf>

[2] WL Anderson, Z Feng and S Long. Minnesota Managed Care Longitudinal Analysis. ODAL/ASPE/DHHS, March 2016. Enrollees in Minnesota's integrated plans (MN Senior Health Option (MSHO)) were:
- 48 percent less likely to have a hospital stay, and if so, had 26 percent fewer stays than enrollees in a non-integrated plan
- 6 percent less likely to have an outpatient ED visit, and if so, had 38 percent fewer visits than enrollees in a non-integrated plan

[3] "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>.

[4] *Ibid*

approaches require alignment with a Medicaid MLTSS plan – which is difficult to achieve with just a D-SNP.

The Financial Alignment Initiative's Medicare and Medicaid Plans (MMPs) are the most fully integrated, but are only operating under demonstration authority that expires in a few years.

For integrated care to become available in a meaningful way for the population of Dual Eligibles that would benefit tremendously from it, Congress will need to act to reauthorize and expand existing programs and to enable the creation, on a permanent basis, of more universal approach to integrated care.

In the immediate future, Special Needs Plans (SNPs) in all forms, which are currently authorized only through December 31, 2018, should be permanently authorized. In addition, the FIDE-SNP, which aligns Medicare and Medicaid, should be encouraged as an important model for Dual Eligibles, while maintaining the option for states to choose to contract with D-SNPs that may not have reached FIDE-SNP status. Upon completion of the FAI demonstration, MMPs should be permanently extended, with opportunities for states to launch new MMPs.

PACE should have the ability to expand the model's capacity to serve older adults with disabilities. As changes are made to PACE that make it more generally attractive, it will come to resemble other integrated managed care plans. As it does, it should come under the consumer protections that apply for these other integrated models, including marketing and network adequacy requirements.

There are challenges in trying to expand coverage for Dual Eligibles under integrated approaches. The most significant have been the challenges in aligning their Medicare and Medicaid coverage, and getting high rates of participating in fully-aligned models.

Where states have MLTSS plans and D-SNPs and may require organizations providing MLTSS to also offer a D-SNP plan, it has been difficult to get beneficiaries enrolled in the MLTSS and Medicare plan (MA or D-SNP) of the same organization. The choice that Duals have of Medicare coverage (fee-for-service, MA, or SNP) often results in Duals having different Medicare and Medicaid coverage, which makes it difficult for plans to coordinate care and achieve the outcomes and health care savings of an integrated model.

For fully-aligned models, states have experimented with both voluntary enrollment and passive enrollment with an opt out. Some states have been quite successful with enrollment, but in

general enrollment in fully integrated plans remains below optimal levels, and more work is needed to encourage or enable higher levels of enrollment.

Eventually, all eligible Medicaid beneficiaries should be afforded the benefits that come with full integration of LTSS and Medicare. States should have the option of creating a requirement for eligible individuals to be in a Medicare product that is fully integrated - whether it is a health plan product (e.g., MMP, DSNP, MA), PACE, ACO, or some other new modality. Consumers should have the choice of modality and, of course, choice within the modality.

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[5] 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, 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;

[5] 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.

- 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.

In conclusion, we urge the Committee to approve legislation to permanently reauthorize all SNP types. We further encourage the Committee to continue to work on ways to advance the most fully-integrated approaches to serve all consumers who need LTSS, and would like to work with Members of the Committee on legislative proposals that could enhance integration opportunities in the future.