BIPARTISAN POLICY CENTER

**Testimony of**
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**before the**
**Committee on Finance**

**United States Senate**

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Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner, and Members of the Committee, thank you for the opportunity to discuss important policy changes that can help health care providers and health plans improve health outcomes for chronically ill patients. The Committee's work in drafting the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 demonstrates that bipartisanship in health care is not a thing of the past. These policies address the unique needs of chronically ill patients and promotes patient and family-centered care. The Chronic Care Working Group's bipartisan, transparent, and deliberative process of seeking feedback and an ongoing dialogue with the stakeholder and patient community should serve as the model for smart policy development in Congress. The Bipartisan Policy Center greatly appreciated the opportunity to share our input with the Working Group as part of that thorough process.

Since 2007, BPC's Health Project has worked with stakeholders including patients, health care providers, plans, states, and federal policymakers to develop solutions that to promote better quality of care, while limiting the growth of health care costs in federal health programs. Under the leadership of the Health Project's Co-Chairs, former Senate Majority Leaders Bill Frist and Tom Daschle, BPC has released a series of reports and policy recommendations to address acute care and long-term care needs of frail and chronically ill individuals. On our efforts in long-term care delivery and financing, former White House and Congressional Budget Office Director Alice Rivlin and former Health and Human Services Secretary and Governor Tommy Thompson co-chaired the efforts.

In February 2016, BPC issued incremental recommendations on policies to improve long-term care financing. Last fall, we released a report focused on better integration of Medicare and Medicaid services and supports for individuals who are dually eligible for Medicare and Medicaid coverage.[1,2] Last month, BPC issued a report that provides recommendations to remove barriers that health plans and providers face as they seek to treat chronically ill Medicare beneficiaries.[3]

## Care Needs of Chronically Ill Individuals

Research conducted by BPC and others makes clear that the presence of chronic conditions, particularly when paired with functional or cognitive impairment, is a key driver of utilization of medical services for Medicare beneficiaries. Medicare data from 2015 demonstrate that the number of chronic conditions that a patient has is directly correlative to higher Medicare spending and rates of hospitalization – as the number of chronic conditions rise, so do average Medicare costs per beneficiary.[4]

For instance, compared to beneficiaries with fewer than four chronic conditions, the Medicare beneficiaries who have four or more chronic conditions:

- Incur average annual Medicare costs that are more than five times as high;
- Have hospital readmission rates that are twice as high; and
- Have four times as many emergency department visits.

The presence of functional and cognitive limitations among chronically ill beneficiaries is also highly predictive of Medicare costs. Functional impairments are defined by difficulty in performing activities of daily living, such as bathing or transferring to and from bed without assistance.[5] Cognitive impairments can include diminished intellectual capacity associated with dementia or Alzheimer's disease, which can present safety concerns for patients.[6] Medicare patients with functional or cognitive impairment have expenses that are more than three times as high as those without functional or cognitive impairment.[7]

BPC's research indicates that there are roughly 3.6 million community-residing "Medicare-only" beneficiaries (*i.e.* beneficiaries are not eligible for full Medicaid benefits) who have three or more chronic conditions and functional or cognitive impairment. In addition, there are roughly 7.5 million Medicare beneficiaries who are dually eligible for full Medicaid benefits. The two populations have complex needs for services and social supports to address their multiple chronic conditions, frailty, and cognitive deficits. For dual-eligible beneficiaries, Medicaid covers many of the long-term services and supports (LTSS) that the beneficiary needs, but the LTSS is often not well integrated with medical care covered under Medicare. For frail and chronically ill Medicare-only individuals, the supports and services are not covered under Medicare, although they could be made available if there were more flexibility and financial incentives for Medicare Advantage (MA) plans and health care providers.

## Policies to Improve Integration of Medicare and Medicaid Benefits for Dual-Eligible Individuals

In its September 2016 report, BPC made several recommendations to reform Dual-Eligible Special Needs Plans (D-SNPs) within the MA program, and to consolidate regulatory authority within the Centers for Medicare and Medicaid Services (CMS) for policies applicable to dual-eligible beneficiaries.[2] Most of these recommendations are very similar or consistent with the CHRONIC Care Act.

Specifically, among other recommended policies in the report, we recommended:

- Permanently reauthorizing D-SNPs, but requiring that D-SNPs integrate clinical health services, behavioral health, and LTSS by January 1, 2020;
- Authorizing CMS to align the Medicare and Medicaid grievance and appeals processes for D-SNPs in a manner that benefits the dual-eligible individual; and
- Consolidating regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office.

These changes will break down the financial siloes between Medicare and Medicaid-covered services to allow for an integrated approach to meeting a D-SNP enrollee's medical needs and LTSS needs, while also making the navigation of benefits more manageable for D-SNP enrollees. The CHRONIC Care Act's policy provision to make the Medicare-Medicaid Coordination Office the central contact point for aligning Medicare's federal grievance and appeals processes with the corresponding processes of state Medicaid programs would minimize conflicting overlap between the two programs.

These three policy changes – when combined with other BPC recommendations for improving three-way contracting models for the delivery of Medicare and Medicaid benefits – can enhance the ability of health plans and providers to meet the medical and non-medical needs for dual-eligible beneficiaries. By financially and clinically integrating Medicare-covered services with Medicaid social support and LTSS benefits, we can improve health outcomes of dual-eligible beneficiaries through a reduction in avoidable hospitalizations, emergency department visits, and hospital readmissions, particularly for patients with complex chronic conditions, as shown in a recent report examining the Senior Health Options program in Minnesota.[8]

## Policies to Break Down Barriers to Integrating Social Supports in Care Models Serving Medicare-only Beneficiaries with Chronic Illnesses

As a part of an April 2017 report, BPC recommended policies designed to improve the ability of MA plans, Accountable Care Organizations (ACOs), and other alternative payment model (APM) participants to furnish and finance valuable non-Medicare-covered supports and services for frail and chronically ill Medicare-only patients.[3]

Among other recommendations, BPC recommended the following policy changes that are very similar to changes proposed under the CHRONIC Care Act:

- Modifying the MA "uniform benefit requirement" to allow MA plans to target non-Medicare-covered social supports, as MA supplemental benefits, to certain high-need, high-cost Medicare-only enrollees with chronic conditions;
- Allowing MA plans that target non-Medicare-covered supports to chronically ill enrollees to have an exemption from the MA program rules that limit the coverage of supplemental benefits to only those services and items that are "primarily health-related"; and
- Establishing a prospective voluntary enrollment process in the Medicare Shared Savings Program (MSSP) for ACOs, through which beneficiaries can actively choose to have their care and spending attributed to a specific ACO.

These policy changes and others included in BPC's April 2017 policy recommendations can help to modernize the Medicare program in response to evidence showing that non-Medicare-covered supports can play a critical role in improving health outcomes.[3] A growing body of research demonstrates that the provision of non-medical social supports and services, which are not covered under the traditional Medicare benefit, can reduce hospitalizations, emergency department visits, and other expensive acute care episodes when the supports are targeted to frail and chronically ill patients. Examples include non-emergency transportation to medical appointments for frail individuals or home delivery of nutritious, low-sodium and low-sugar meals for patients with congestive heart failure, diabetes, and other chronic conditions. In pilot programs tested in the community, the provision of these targeted non-medical supports resulted in as high as a 27 percent reduction in medical costs and significant reductions in avoidable hospitalizations.[9] Other interventions, such as minor home modifications to reduce the risk of falls,[10] or targeted case management to help coordinate a patient's medical and social support needs, have also been shown to improve health outcomes.[11]

Despite the clear value of many non-Medicare-covered social supports in reducing the risk of avoidable Medicare expenses, the Medicare program has established regulatory and payment policy barriers that limit the ability of MA plans, ACOs, and other APM participants to integrate non-Medicare-covered supports into their care models for high-need, high-cost Medicare-only patients. If a health plan or provider organization is accountable for the quality of care provided to a beneficiary population and is accepting financial risk by working within a spending benchmark, the Medicare program should provide flexibility to allow the MA plans and providers that meet quality thresholds to furnish non-Medicare-

covered supports in a targeted way to frail and chronically ill Medicare-only beneficiaries, as a part of a person- and family-centered care plan for frail chronically ill Medicare-only patients. Our recent work and policy recommendations from the April 2017 report make clear that with these flexibilities, the MA plans, ACOs, and other providers could make these non-Medicare-covered supports available to targeted beneficiaries in a manner that does not add new costs to the Medicare program.

*Medicare Advantage Policies*

In the MA program, there are two principal regulatory barriers that prevent MA plans from financing high-value non-Medicare-covered social supports for targeted groups of chronically ill enrollees. First, the Social Security Act requires that if an MA plan offers a supplemental benefit that is financed through MA rebate dollars, the MA plan must offer that supplemental benefit to all enrollees – and may not, in most cases, target the supplemental benefit to subsets of enrollees who meet eligibility criteria. Second, MA program regulations and guidance require that supplemental benefits must be "primarily health-related" – a distinction that often leads to uncertainty for plans seeking to offer non-Medicare-covered social supports as supplemental benefits. These regulations and guidance policies also place specific restrictions on the ability of MA plans to offer certain types of supplemental benefits, such as a durational limitation on the offer of in-home meal delivery and a limitation on the availability of minor home modification benefits to only include shower and bathroom-related modifications. In combination, these two policy barriers can often prevent MA plans from tailoring supplemental benefit offerings to meet the needs of the specific chronically ill enrollee.

BPC conducted an analysis of the projected costs of offering an illustrative set of non-Medicare-covered social supports to Medicare-only MA enrollees who resided in the community and had three or more chronic conditions and functional or cognitive impairment. BPC's recommendations aim to provide the flexibility for patients to receive non-Medicare-covered supports and services as part of a care plan developed by providers and care teams in consultation with patients and their families. For this population, BPC recommended allowing coverage of "any item or service reasonably related to improving or maintaining health or functional status, if the services are part of that care plan. To facilitate estimating costs of providing these types of services and supports, we projected the costs of in-home meal delivery, non-emergent medical transportation, minor home modifications, and targeted case management services.

The analysis suggests that if the uniform benefit requirement were waived, in conjunction with flexibility on the "primarily health-related" benefit requirement, MA plans could offer the four illustrative non-Medicare-covered supports – to chronically ill enrollees who meet the criteria – as supplemental benefits within current budgets that do not require additional Medicare spending. BPC's analysis indicates that if the four non-covered supports were targeted to chronically ill enrollees and the costs of providing those services were spread across the entire enrollee population, MA plans could provide those four supports for merely $5 per member per month. If the provision of these non-Medicare-covered social supports reduced hospitalizations, emergency department visits, and other Medicare spending for the targeted group of enrollees, there is also a potential for savings.

*Accountable Care Organization Policies*

Many ACOs report that the lack of a voluntary enrollment pathway for beneficiaries contributes to significant year-to-year fluctuations in the makeup on an ACO's attributed beneficiary population (for whom the ACO is assuming financial risk), while simultaneously impeding improved patient engagement in the care process by beneficiaries who ultimately are attributed to the ACO. While the Next Generation ACO demonstration includes a voluntary enrollment option, voluntary enrollment is not currently available for most ACOs operating in the MSSP. This problem not only inhibits the ability of ACOs to better coordinate the delivery of Medicare-covered services that a beneficiary receives, but also provides a strong disincentive for ACOs to invest in non-Medicare-covered supports for attributed beneficiaries

with chronic conditions and frailty. While providing these non-covered supports and services can improve health outcomes over the long-term, beneficiaries may not be attributed to the ACO year after year. When a beneficiary is aware that he or she is being cared for under an ACO arrangement and actively selects that ACO, there is greater potential for coordination between the patient and the care team. For these reasons, BPC recommended that CMS establish a voluntary enrollment option for all ACOs, in a manner similar to the proposal included in the CHRONIC Care Act.

*Other Policy Options for Both MA Plans and ACOs*

In addition to the policies included in the CHRONIC Care Act, BPC also recommended policies that could improve financial incentives for both MA plans and ACOs to provide non-Medicare-covered supports to their enrolled or attributed beneficiaries. These recommendations could be addressed by CMS, without additional statutory changes from Congress, and could augment the great work of the Committee on the CHRONIC Care Act. The recommendations are also similar to options that the Committee included in its Chronic Care Working Group Options Paper. Among other options, BPC recommended that CMS test the potential for incorporating a frailty adjustment factor into the Medicare risk adjustment model that is used for the MA and ACO programs. Such a frailty factor could address significant under-prediction of the actual medical expenses of the highest cost beneficiaries, while also better accounting for the costs of beneficiaries with functional impairment. With more accurate risk adjustments for frail patients, MA plans and ACOs would have greater incentive to integrate non-Medicare-covered supports into care models for chronically ill beneficiaries. BPC also recommended that CMS examine options for adding a new quality measure to the MA and ACO quality measurement programs that would assess the extent to which the MA plan or ACO actively integrates non-Medicare-covered supports into the care model for chronically ill beneficiaries. Given that MA quality bonuses and higher ACO sharing rates are tied to quality measure performance, MA plans and ACOs could have a strong incentive to incorporate non-Medicare-covered supports into their care models, in response to the new quality measure. If done well, this could also remove incentives for plans to avoid the sickest beneficiaries.

## Conclusion

BPC applauds the hard work that the Committee and its Chronic Care Working Group have taken to develop thoughtful bipartisan legislation to better address the needs of Medicare beneficiaries with complex chronic conditions. Through the policy changes included in the CHRONIC Care Act, many frail and chronically ill Medicare patients could benefit from improved care coordination, access to care in the home and community setting, and availability of non-Medicare-covered social supports. We appreciate the opportunity to continue to work with the Committee in confronting the health care delivery system challenges facing this vulnerable population.

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