MEDPAC Medicare Payment Advisory Commission

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March 2, 2011

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

RE: RFP-CMS-2011-0009

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) request for proposals for state contracts to support the development of service delivery and payment model demonstration programs that integrate care for the population of beneficiaries who are dually eligible for Medicare and Medicaid. The demonstration consists of two phases: the first phase is the design period, during which CMS may award up to 15 contracts to assist states develop proposals. Under the second phase, the proposals approved by CMS will be implemented for testing through the Center for Medicare and Medicaid Innovation (CMMI). MedPAC appreciates your staff's ongoing efforts to administer and improve Medicare's and Medicaid's payment systems, particularly considering the competing demands on the agency. MedPAC would like to comment on a number of issues for CMS to consider when selecting proposals for the design period and when selecting demonstrations to test through the CMMI.

The Commission is encouraged that CMS is engaging states to improve the coordination of Medicare and Medicaid benefits for dual-eligible beneficiaries. Improving the medical and long-term care delivery systems for the dual-eligible beneficiaries is very important. Compared with other Medicare beneficiaries, dual-eligible beneficiaries on average are more likely to report poor health status and are almost three times more likely than other Medicare beneficiaries to have three or more limitations in their activities of daily living. Beneficiaries who qualify for Medicare and Medicaid often have high needs for medical and long-term care, social services, and non-clinical services. Many dual-eligible beneficiaries are in need of integrated care systems, yet our research indicates that the medical and long-term care of the dual-eligible population is often fragmented and uncoordinated. Existing programs that do integrate Medicare and Medicaid funding and benefits for the dual-eligible beneficiaries are few in number and tend to be small.

Engaging the states to develop demonstration programs that coordinate care for dual-eligible beneficiaries is a necessary and constructive direction. Demonstration programs can be very informative, and as we continue our research on dual-eligible beneficiaries, the Commission looks forward to learning from the state demonstrations. The proposals by themselves could be informative and could describe new or alternative integrated care models for the Commission to consider. However, the Commission has expressed concerns that the traditional demonstration process can be long, cumbersome, and inconclusive. Because the cost, quality, and delivery system issues for dual-eligible beneficiaries are so urgent, the Commission will continue its work in this area and may have recommendations in the future.

MedPAC's work on dual-eligible beneficiaries has centered on understanding the characteristics of this population and their Medicare and Medicaid spending patterns and analyzing the strengths and weaknesses of integrated care programs as well as these programs' expansion barriers. We have conducted an in-depth data analysis on this population, reviewed the literature on integrated care programs and care coordination models, visited multiple integrated care programs in the states, and interviewed numerous stakeholders. The Commission has been studying and is interested in models that integrate the Medicare and Medicaid financing and care coordination for dual-eligible beneficiaries. Our comments here reflect considerations about the characteristics of the state integrated care programs we think are important to test and the data that need to be collected to ensure a careful evaluation. In this letter, we would like to comment on the following five areas:

- Testing models that integrate Medicare and Medicaid funding and coordinate all medical, long-term care, and behavioral health services for dual-eligible beneficiaries;
- Outcomes data;
- Increasing enrollment;
- Beneficiary protections; and
- Appropriate use of Medicare funds.

Testing models that integrate Medicare and Medicaid funding and services

Our work indicates that models where either a managed care plan or a provider receives both Medicare and Medicaid funding streams and assumes responsibility for both sets of benefits offers the greatest opportunity for improved care coordination and care management. In these models, the financial incentives of both programs and the entity (managed care organization or provider) are aligned and the entity has a financial interest to ensure that all necessary services are furnished and coordinated. The entities also have the flexibility to offer non-medical services that are not covered by either program but that meet beneficiaries' care needs and lower total spending. In addition, Medicare and Medicaid risk on spending can be limited if both programs pay the entities a capitated amount.

We also recognize the challenges in implementing integrated care programs and particularly in developing a "one size fits all" approach. The needs of dual-eligible beneficiaries differ by sub-group and states vary in their approach to integrated care programs.

MedPAC encourages CMS to select programs where either a managed care plan or a provider directly receives two sets of capitated payments - one from Medicare and the other from Medicaid – and covers all Medicare and Medicaid benefits. Other models may also make sense to test, but the Commission urges CMS to examine capitated models because they allow for the flexibility to develop a patient specific mix of social and clinical services. MedPAC agrees with CMS that the design contracts are an opportunity for states and CMS to work together to test programs that align the full range of acute, behavioral health, and long-term care supports and services. CMS can work with states to implement new programs, to expand existing programs to include long-term care or behavioral health services that the programs currently do not cover, or to increase enrollment in high performing programs.

Outcomes data

MedPAC agrees with CMS that an important purpose of the state contracts is to evaluate a variety of integrated models. CMS and states could collect quality and cost data using consistent measures across demonstration programs. CMS could also collect information on beneficiary demographics and health status so that performance measures can be risk-adjusted. This information may be helpful for evaluating integrated care programs in the future.

Increasing enrollment

Our research indicates that there are small fully integrated programs in the states that improved care coordination for dual-eligible beneficiaries, but that low enrollment is often a limitation of these programs. Enrollment in individual PACE programs ranges from 11 to close to 2,500 participants. And only 5 percent of the dual-eligible beneficiaries are enrolled in the same managed care plan for both their Medicare and Medicaid benefits in New Mexico's integrated care program. Expanding enrollment in integrated care programs is an issue that CMS may have to address during the state demonstrations. The Commission will continue to assess this issue as well. CMS could test alternative enrollment strategies during the demonstrations.

Beneficiary protections

When testing a demonstration through the CMMI, PPACA permits the Secretary to waive any necessary requirements to Title XI (general provisions, peer review, and administrative simplification) and Title XVIII (Medicare). CMS needs to have a clear definition of which components of Titles XI and XVIII can be waived before any of the state demonstrations are implemented. The Commission believes that Medicare beneficiary rights needs to be preserved, including ensuring access to the appropriate range of benefits, to an adequate provider network including specialty care, to opt out of an integrated program, and to appeal any coverage determination. Finally, each demonstration programs' spending should be transparent and auditable.

Appropriate use of Medicare funds

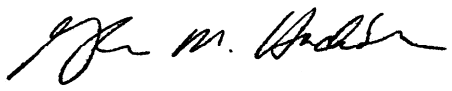
One program approach— those where states would manage the Medicare funds for dual-eligible beneficiaries— raises concerns about the appropriate use of Medicare funds. This model was included in PPACA as one of the models that can be tested by the CMMI and at least five states are interested in directly receiving Medicare funding for the dual-eligible beneficiaries. Savings achieved by lowering the use of all services (including those financed by Medicare) would accrue to the state. The Commission is concerned that under this approach, states would have a financial incentive to use Medicare funds to reduce their own spending and Medicare would not receive any savings. There is a long history of states using financial strategies such as intergovernmental transfers to maximize federal support while minimizing the state's own contributions and increasing federal spending. If these types of programs are approved, they should have carefully designed transparent accountability mechanisms to assure Medicare's program integrity.

Conclusion

MedPAC appreciates your consideration of these policy issues. The state design contracts and implementation of state integrated care programs are an opportunity for CMS to engage states on the dual-eligible beneficiaries. The Commission values the ongoing collaboration between CMS and MedPAC staff on the dual-eligible beneficiaries, and we look forward to continuing this relationship.

If you have any questions on our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/ca/wc