MACPAC

Commissioners

Sara Rosenbaum, JD, *Chair*
Marsha Gold, ScD, *Vice Chair*
Brian Burwell
Sharon Carte, MHS
Andrea Cohen, JD
Gustavo Cruz, DMD, MPH
Toby Douglas, MPP, MPH
Leanna George
Christopher Gorton, MD, MHSA
Herman Gray, MD, MBA
Stacey Lampkin, FSA, MAAA, MPA
Norma Martínez Rogers, PhD, RN, FAAN
Charles Milligan, JD, MPH
Sheldon Retchin, MD, MSPH
Peter Szilagyi, MD, MPH
Penny Thompson, MPA
Alan Weil, JD, MPP

Anne L. Schwartz, PhD,
Executive Director

July 11, 2016

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

The Honorable Orrin G. Hatch
Chairman, Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20150

The Honorable Ron Wyden
Ranking Member, Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20150

The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone Jr.
Ranking Member, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

RE: Medicare-Medicaid Coordination Office Fiscal Year 2015 Report to Congress

The Medicaid and CHIP Payment and Access Commission (MACPAC) is pleased to comment on the U.S. Department of Health and Human Services (HHS) report to Congress released in March 2016: Medicare-Medicaid Coordination Office Fiscal Year 2015 Report to Congress. MACPAC is required by statute to review HHS reports to Congress and provide written comments to the Secretary and appropriate committees of Congress.

The Commission supports the goal of improving the alignment and coordination between the Medicare and Medicaid programs to reduce duplication and inefficiency, and ultimately improve health outcomes and reduce the costs of care for dually eligible beneficiaries. The Commission offers comments regarding Medicare-Medicaid Coordination Office's (MMCO) Financial Alignment Initiative.

Medicaid and CHIP Payment and Access Commission

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000
202-273-2452

Report Summary

The MMCO was established under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and is charged with improving care and reducing costs for dually enrolled beneficiaries, and rationalizing the administration of services for dually eligible Medicaid and Medicare beneficiaries. In this fifth annual report, MMCO highlights past and ongoing work and also makes legislative recommendations. The report includes an overview of the status of the Financial Alignment Initiative. As of June 2016, 13 states participate in the demonstration (10 under the capitated model and 3 under a managed fee for service (FFS) or an alternative model) with approximately 450,000 individuals enrolled. Each state model is unique with different target populations, benefits, care coordination services, and payment frameworks. The Centers for Medicare & Medicaid Services (CMS) is evaluating the overall effect of the demonstration on beneficiary experience, quality outcomes, and expenditures and service utilization for both Medicare and Medicaid.

MACPAC Comments

The Financial Alignment Initiative is an important and significant undertaking. Dually eligible beneficiaries are among the poorest and sickest individuals covered by either Medicaid or Medicare, and account for a disproportionate share of spending in both programs. In 2011, dually eligible beneficiaries comprised 14 percent of all Medicaid beneficiaries but accounted for 33 percent of Medicaid spending.

While the Commission supports the broad goals of the Financial Alignment Initiative, it is concerned about how little has been learned to date. Three years have passed since the start of the first demonstration program and there is little publicly available information on the demonstration's effects on use of services, spending, the beneficiary experience, and other outcomes. CMS has offered states the opportunity to extend the demonstration for another two years to allow for additional time for evaluation. Even so, more timely findings are needed in order to inform decisions on implementation of the demonstration in the coming years and future initiatives.

While CMS has announced its intention to produce annual state-specific reports and a final aggregate report, so far only two preliminary evaluation reports have been made available, and neither has included data on the demonstration's effects on Medicaid service utilization or spending. The first released report provides a general overview of the structure of the demonstration programs, early experiences, and implementation processes for 7 of the 14 programs, but no information on the effects on utilization, spending, or health outcomes. The second report focuses on Washington's managed fee-for-service (FFS) model, finding that that the model reduced Medicare spending by 6 percent relative to a comparison group during its first 18 months of operation, saving the Medicare program about $22 million.

Among several issues of concern to the Commission are the apparently high rates of beneficiaries opting out and disenrolling from the demonstration, although opt-out rates are only available for a few states. Approximately 56 percent of all eligible beneficiaries for the New York Fully Integrated Duals Advantage program opted out of the demonstration, as have 29 percent of all eligible beneficiaries in the Massachusetts program, and 50 percent of all eligible beneficiaries in California. We are encouraged that CMS and states are working to address low enrollment by improving communication and outreach activities to beneficiaries and providers, and assessing the implementation of the passive enrollment process. However, the limited information available on reasons for opting-out and disenrolling raises questions as to the particular barriers to enrollment. These may include insufficient beneficiary education and choice counseling, but also other program features such as Medicare policies prohibiting lock-in. Understanding the reasons why individuals who enter the program do not remain enrolled, and remedies that could be taken to reduce opt-out and disenrollment, will be critical to the design of future efforts.

The Commission is also interested in learning about the factors that led to low rates of state participation in the demonstration. Initially, 37 states and the District of Columbia submitted a letter of intent to participate and 26 states followed through with a proposal. Subsequently, 16 states fully withdrew and 2 partially withdrew, citing concerns about the payment methodology, rate setting mechanisms, carve-out allowances, and limited health plan interest. Given that states have long expressed interest in improving coordination between Medicare and Medicaid for this high-cost, high-need population, it will be important to know what specific features of the demonstration design were barriers to state participation and how the demonstration may have conflicted with other state efforts to integrate care for dually eligible beneficiaries.

The Commission also encourages CMS to capture the demonstrations' effects on alignment of the administrative aspects of Medicare and Medicaid; for example, whether an integrated appeals and grievance process is associated with higher beneficiary satisfaction, or if integrating and simplifying outreach and marketing materials results in improved beneficiary knowledge of the program. In addition, the Commission is interested in several other aspects of the initiative, including understanding how overlapping Medicare and Medicaid services are paid for and the effects of care coordination on care delivery.

It is also important to have a better understanding of various aspects of payment policy, including how Medicaid payment rates were developed and modified over time, the adequacy of rates for plans taking on new integration activities, and plan perspectives on financial sustainability of this effort, particularly given lower than anticipated beneficiary enrollment. Moreover, with exodus of six health plans from the demonstration and the Commonwealth of Virginia indicating that it will end its demonstration in 2017, future evaluation reports should identify also how individuals are transitioned out of the demonstration and demonstration plans, and CMS' plans for future transitions if other states or plans leave the demonstration.

Given the amount of thought and effort that CMS and states have devoted to the design and implementation of these models, the Commission remains hopeful that the evaluations provide significant learnings on how to improve delivery of care for dually eligible beneficiaries. Given the length of time left in the demonstration, the fact that Virginia is terminating its participation, and no new states are entering, it is of critical importance that findings are available to policymakers, researchers, advocates, plans, and providers so that lessons learned can be deployed in developing policies for the future. In particular, such information could be used as a learning opportunity and adapted to other models, such as Dual-Eligible Special Needs Plans, that are working to provide a coordinated Medicaid and Medicare benefit package to dually eligible beneficiaries.

MACPAC intends to continue monitoring the effects and status of the Financial Alignment Initiative, and examine findings from the demonstration to assess aligning and coordinating the Medicaid and Medicare programs for dually eligible beneficiaries. We appreciate the opportunity to provide comments on this important initiative and policy issues raised in this report. We hope to see timely findings that will help MACPAC make recommendations to help improve the Medicaid program's interaction with the Medicare program to improve care for dually eligible beneficiaries.

Sincerely,

Sara Rosenbaum, JD

Cc:
Andy Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services

Victoria Wachino, Director for the Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services

Tim Engelhardt, Director of the Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services