ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

January 21, 2016

The Honorable Orrin G. Hatch
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Submitted via email to chronic_care@finance.senate.gov

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch and Senator Wyden,

The Association for Community Affiliated Plans (ACAP) greatly appreciates the opportunity to provide comments to the Senate Finance Committee (SFC) in response to the *Bipartisan Chronic Care Working Group Policy Options Document* and, in particular, its proposed policies under consideration to provide continued access to Medicare Advantage Special Needs Plans (SNPs) for vulnerable populations.

ACAP is an association of 60 not-for-profit, community-based Safety Net Health Plans located in 24 states. Our member plans provide coverage to over fifteen million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Advantage Dual-Eligible SNPs. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Eighteen of our plans are D-SNPs, and 14 of our plans participate in the Financial Alignment Demonstration, accounting for close to 30 percent of all enrollment in the Demonstration.

ACAP's positions summarized below are explained in greater detail later in the letter.

- **Reauthorization of D-SNPs.** ACAP strongly supports permanent reauthorization of D-SNPs.
- **Medicare Advantage Risk Adjustment.** ACAP supports adding additional behavioral health conditions and distinguishing between full and partial dual-eligible beneficiaries to improve the risk-adjustment methodology used for Medicare Advantage plans.
- **Behavioral Health.** The requirements 42 CFR Part 2 related to substance abuse treatment are inconsistent with efforts to better integrate physical and behavioral health and coordinate care. Given the applicability of HIPAA to the sharing of protected health information, the requirements of 42 CFR Part 2 should be lifted as it applies to health plan care coordination activities.
- **Telehealth.** CMS should permit MA plans to conduct telehealth services and to include telehealth in their annual bids.
- **Supplemental Benefit Flexibility.** ACAP supports permitting Medicare Advantage plans with additional flexibility to offer supplemental benefits. This flexibility will help D-SNPs

better tailor medical and social services for their dual-eligible enrollees.

- **Developing Quality Measures for Chronic Conditions.** ACAP urges the Senate Finance Committee to ensure that quality measures are thoroughly tested and proven reliable before they are publicly reported or tied to plan payment.

Reauthorization of D-SNPs: D-SNPs have been reauthorized numerous times, but only in a series of short-term extensions. D-SNPs are currently authorized through the end of 2018. The lack of a long-term authorization destabilizes the program for beneficiaries, states, health plans, and providers. ACAP supports the permanent authorization of D-SNPs, because doing so enables these plans to tailor their care management, provider interventions, and partnerships with community-based organizations to the unique needs of their dual-eligible enrollees.

We also note that expectations around D-SNPs integration with Medicaid services should be reflective of state's policies and readiness for moving Medicaid services for dual eligibles into managed care.

Medicare Advantage Risk Adjustment: ACAP views D-SNP and MMP sustainability as a consumer issue. If D-SNPs or MMPs withdraw from the Medicare program due to payment inadequacy, dual-eligible beneficiaries can experience a disruption in their continuity of care; they can lose access to the services and care coordination that are only available to them through DSNPs and MMPs; and they may have to navigate Medicare and Medicaid (including long-term care and behavioral health) on their own. That's why an accurate Medicare Advantage risk adjustment methodology is so important.

ACAP supports multiple improvements to the risk adjustment model to ensure that it accurately predicts the costs of dual-eligible beneficiaries and better accounts for behavioral health-physical health interactions. Specifically, we support: (1) adopting the CMS proposal from November 2015 (i.e., the six segment risk-adjustment approach) that improves the accuracy of risk-adjustment for full-benefit and partial-benefit dual eligibles, (2) adding more behavioral health-physical health interactions in the model, (3) including additional HCCs for substance abuse conditions and mental health conditions, such as depression and anxiety, and using these conditions in behavioral health-physical health interactions, (4) accounting for multiple chronic conditions, (4) using two years of beneficiary diagnosis data to determine HCC categories, and (5) requiring a study on the effects of including Activities of Daily Living (ADLs) in the model. All of these changes should apply to both Medicare Advantage plans and MMPs.

Behavioral Health**:** Among the Federal regulations relevant to health plans seeking to deliver coordinated care to their members are those found in Title 42, Part 2 of the Code of Federal Regulations—42 CFR Part 2, or "Part 2". These regulations are intended to safeguard the confidentiality of patient records concerning alcohol and substance abuse treatment records. It requires certain providers to obtain patient consent before sharing substance use treatment information with health plans and other providers. As a recent ACAP report demonstrates, owing in part to these regulations, substance use disorder (SUD) treatment programs operate in

silos. The integration of SUD services with mental and physical health care is impeded owing to the restrictions on the disclosure of SUD information. The federal requirement for patient consent for disclosure of Part 2 information has prevented Safety Net Health Plans from accessing the information they need about members who have SUD, from sharing that information when they receive it with the members' health care providers, and from coordinating care for their members who need it most.

The privacy of members who live with an SUD is of paramount importance. The requirements 42 CFR Part 2 related to substance abuse treatment are inconsistent with efforts to better integrate physical and behavioral health and coordinate care. Given the applicability of HIPAA to the sharing of protected health information, the requirements of 42 CFR Part 2 should be lifted as it applies to health plan care coordination activities.

Telehealth: ACAP supports measures to encourage plan innovation with telemedicine. ACAP's Medicaid plans are using telehealth in innovative ways that improves care coordination and access to care. We support permitting MA plans to include telehealth services in their annual bids, and we support permitting MA plans to include telehealth services in their bids that are not currently allowed under traditional Medicare, such as remote monitoring. Telehealth is an area where plans and states are currently innovating. For example, some states have formed workgroups to identify which telehealth services should be permitted under Medicaid. Flexibility for MA plans on telehealth would help align telehealth initiatives between Medicare and Medicaid.

ACAP also believes that MA plans should be able to use telehealth services to comply with network adequacy requirements in certain instances, such as in rural areas, or in instances of shortages of a certain provider type, such as a particular specialist.

Supplemental Benefit Flexibility: ACAP is supportive of the SFC policy proposal to expand the type of supplemental benefits MA plans can offer to meet the needs of chronically ill enrollees. Doing so will allow D-SNPs to better tailor medical and social services for their high-need enrollees.

Developing Quality Measures for Chronic Conditions: ACAP believes that quality metrics should be applied to both MA plans and Medicare fee-for-service, to ensure that all individuals with multiple chronic conditions are receiving the care they need. In crafting its policy recommendation, SFC should consider the unique challenges in capturing accurate, patient-reported data, particularly among patients with cognitive, health, or language barriers. SFC should also be sensitive to the existing disparities in quality measurement for dual-eligible beneficiaries and individuals with disabilities. ACAP supports thorough reliability testing of any proposed quality measure before it is publicly reported or tied to payment.

ACAP is prepared to assist with additional information, if needed. If you have any additional questions, please do not hesitate to contact Christine Aguiar at (202) 204-7519 or caguiar@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer