



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
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

October 5, 2012

The Honorable Wally Herger
Chairman
House Ways and Means Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

submitted electronically

Dear Representative Herger and Members of the Subcommittee:

The Association for Community Affiliated Plans (ACAP) submits the attached paper on Special Needs Plans as part of the record for the Committee's hearing on Medicare Health Plans held on September 21. We strongly urge re-authorization of Duals Special Needs Plans (D-SNPs) to allow stability for beneficiaries, health plans and states while more permanent options for duals are developed based on learning from the Duals Financial Alignment Demonstrations which will begin during 2013. It is imperative that D-SNPs remain an option to provide integrated care to a highly vulnerable population.

ACAP is a national association representing 58 not-for-profit Safety Net Health Plans that serve nearly 10 million individuals on Medicare, Medicaid, Children's Health Insurance Program (CHIP) and other public health programs in 28 states. Approximately half of ACAP plans operate D-SNPs; even more will serve dually eligible beneficiaries in the upcoming demonstrations.

We appreciate the opportunity to submit this statement. Questions may be addressed to Mary Kennedy, Vice President for Medicare and Managed Long Term Care at: mkennedy@communityplans.net or 202-701-4749.

Sincerely,

Margaret A. Murray
Chief Executive Officer



Congress Should Reauthorize the Medicare Advantage Special Needs Plan Program Before the End of the Year

Request

ACAP urges the House and Senate to reauthorize the Medicare Advantage (MA) Special Needs Plan (SNP) Program by the end of 2012 to provide certainty for health plans and continuity of care for dual eligibles and other vulnerable Medicare beneficiaries, and to improve the SNP program by enacting policies that assure actuarially sound payment, fair comparison to other MA plans, and support the critical role that Safety Net Health Plans play in the SNP program.

Background

People enrolled in both Medicare and Medicaid, or “dual eligibles,” tend to be among the poorest, most frail, most medically needy Americans. But because Medicare and Medicaid are separately administered, these beneficiaries are often poorly served. Strong incentives for cost-shifting between the two programs lead to unnecessarily high spending across *both* programs. **The Medicare Modernization Act established SNPs, which provide an integrated care setting for dual eligibles.** Fully-integrated care management for dual eligibles is the best way to improve care coordination and reduce unnecessary barriers to care, supports and services.

The *Affordable Care Act* renewed focus on dual eligibles with the establishment of the Federal Office of Medicare-Medicaid Integration. Several states are implementing shared savings demonstrations in 2013. Others are planning for 2014. But successful movement to a fully-integrated risk-based model requires stability, long-term planning and thoughtful implementation. **Given uncertainty around the timing, location and populations included in these demonstrations, SNPs remain essential to coordinating care for many dual eligibles. We expect discussions on a more permanent setting for integrated care to begin in 2014.**

Policy Requests

As it looks forward to legislative action before the end of the year, ACAP calls on Congress to pass legislative language to:

- 1. Reauthorize the MA Special Needs Plan Program for a period of no less than five years.** Current authorization ends in January 2014, and **CMS requires that SNPs submit notices of intent to operate in 2014 before the end of this year.** Until a new permanent integrated program emerges for dual eligibles, Congress must provide greater certainty to health plans and Medicare beneficiaries by reauthorizing the SNP program for no less than five years. The uncertainty caused by short-term reauthorization periods is a continuous threat to the quality and continuity of care provided to SNP enrollees.
- 2. Provide accurate payment to SNP Plans by improving the risk adjustment process to reflect the actual health care needs of the enrolled population.** With respect to risk adjustment for MA, Congress should (1) expand the types of health conditions considered when calculating risk adjustment, such as mental health and substance abuse; (2) require CMS to use the prior two years of patient health data, as supported by MedPAC; (3)



include a greater number of conditions for each person to assure more accurate payment for people who have more complex care needs, also recommended by MedPAC; and (4) require the use of an enrollee's health status in calculation of the risk score during the first year of Medicare eligibility using either a risk assessment or through claims obtained through Medicaid or private health coverage.

3. **Adjust all SNP payments to recognize the frailty of individual dual eligibles enrolled in the plan.** The current risk adjustment model provides a frailty adjuster only to those SNPs that provide Medicaid managed long-term care services for high concentrations of individuals at a nursing home level of care. ACAP recommends the frailty factor be paid to a SNP serving a person who has been certified as needing a nursing home level of care and resides in the community. Both PACE programs and the early integrated demonstrations recognized this institutional bias and paid a "frailty factor" to support community-based care. Current statutory language on the frailty adjuster is limited to those plans with a high concentration of these members. The adjuster should be paid for each person who is frail.
4. **Stars Quality Ratings and the related Bonus Payments should more accurately reward plans serving Duals. The quality of care among plans serving higher-need populations should be compared with similar SNP plans and not with regular MA plans serving a healthier population.** In the absence of a unique quality measurement system for SNP plans, Congress should require CMS to attribute three stars as a baseline for a SNP plan *if* the SNP plan meets all the SNP Structure and Process measures. Comparisons should also be made with Medicare Fee-for-Service for a similar population.
5. **Maintain the integrity of the CMS demonstration process by prohibiting the marketing of plans that are not participating in the demonstrations to dual eligibles within the demonstration.** The purpose of the demonstration process at CMS is to test and analyze best practices for the service of dual eligibles in a coordinated care environment. The only way that the analysis can be successful is if there is integrity in the demonstration. Actively marketing non- demonstration Medicare Advantage products to beneficiaries within the demonstration should be prohibited and broker fees should be limited for any plan switches that do occur.
6. **Ensure that safety net health plans remain a viable option for beneficiaries in public programs including D-SNPs, dual demonstrations, the Exchange and the 2014 Medicaid market by improving access to capital for safety net health plans.** As Medicare and Medicaid increasingly turn to health plans to serve dual eligibles, Congress should seek ways to increase access to local coordinated care plans. Safety Net Health Plans have specific expertise in serving Medicare and Medicaid beneficiaries, currently serving one-third of all Medicaid managed care enrollees in capitated plans and over 10% of all D-SNP enrollees. Non-profit plans have limited access to capital needed to expand their plans and meet insurance reserve requirements. In 1996, Congress created a loan guarantee program to help in the creation of plans operated by Community Health Centers to bring a local-focus to the delivery and coordination of care. Congress should now create a similar loan guarantee program building off the definition of safety net health plan created under the *Affordable Care Act*.