U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

July 24, 2017

TO: Members, Subcommittee on Health Subcommittee

FROM: Committee Majority Staff

RE: Hearing entitled "Examining the Extension of Special Needs Plans."

The Subcommittee on Health will hold a hearing on Wednesday, July 26, 2017, at 10:15 a.m. in 2322 Rayburn House Office Building. The hearing is entitled "Examining the Extension of Special Needs Plans."

I. WITNESSES

- Chris Wing, Chief Executive Officer, SCAN Health Plan;
- Larry Atkins, President, National MLTSS Health Plan Association; and
- Melanie Bella, Consultant and Former Director, Federal Coordinated Health Care Office, Centers for Medicare and Medicaid Services.

II. BACKGROUND

Medicare Advantage

In Medicare Advantage (MA), health insurance companies ("plans") bid to offer Medicare Parts A and B coverage to Medicare beneficiaries; this bid includes plan administrative costs and profit. Under statute and regulation, CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark. The benchmark is an administratively-determined bidding target. If a plan's bid is above the benchmark, then the plan receives the benchmark payment from Medicare, and enrollees have to pay the additional premium. If the plans bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plans bid and its benchmark.[1] Plans enrollment-weighted bids averaged 94 percent of fee-for-service (FFS) spending in 2016.[2] Medicare Advantage (MA) enrollment in 2016 totaled more than 17 million Medicare beneficiaries, encompassing nearly one in three Medicare beneficiaries.[3] In 2016, beneficiaries could choose from an average of nine plans in their counties.[4]

[1] For further reading, http://www.medpac.gov/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report-.pdf and http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0
[2] Page 136, http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0 Note: While sources are cited, MedPAC and MACPAC content may be quoted directly in this memo without citation.
[3] Page 131, http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0
[4] Page 132, http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0

Special Needs Plans

In the Medicare Advantage (MA) program, special needs plans (SNPs) are a subcategory of coordinated care plans. SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which authorized them through 2008. Subsequent legislation extended the expiration date of SNP authority on four separate occasions, and the Congress imposed a number of additional requirements on SNPs, including requiring dual eligible SNPs to have contracts with states, narrowing the types of chronic conditions for chronic care SNPs, requiring all SNPs to meet model-of-care requirements, and having their models of care reviewed by the National Committee for Quality Assurance (NCQA).

What primarily distinguishes SNPs from other MA plans is that they limit their enrollment to one of the three categories of Medicare beneficiaries with special needs. There are three types of SNPs: (1) Dual-eligible SNPs (D–SNPs) enroll beneficiaries eligible for both Medicare and Medicaid (dual-eligible beneficiaries); (2) Institutional SNPs (I–SNPs) enroll beneficiaries residing in a nursing home or in the community who are nursing home certifiable; and Chronic condition SNPs (C–SNPs) enroll beneficiaries with certain severe or disabling chronic conditions. Most regular MA plans must allow all Medicare beneficiaries residing in their service area who meet MA eligibility criteria to enroll in the plan, but SNPs can limit their enrollment to one of the three categories of special needs individuals recognized in statute and tailor their benefit packages to their special needs enrollees. In 2016, about 1.8 million beneficiaries were enrolled in D-SNPs, more than 330,000 beneficiaries were enrolled in C-SNPs, and 58,000 beneficiaries were enrolled in I-SNPs. [5] In 2016, there were 568 SNPs – the majority of which (62 percent) were D-SNPs.[6]

While the general rule in MA is that beneficiaries may enroll in, or disenroll from, an MA plan only during the open enrollment period (October through December of a year for plan coverage the following calendar year), SNPs also have special enrollment rules. For D-SNPs, dual eligible beneficiaries and other low-income individuals can enroll and disenroll from MA plans monthly (this beneficiary flexibility applies to all MA plans, not just SNPs). Regarding I-SNPs, beneficiaries who reside in an institution have the month-to-month enrollment option—and this enrollment flexibility is extended to beneficiaries at risk of institutionalization as well. With respect to C-SNPs, these plans can enroll an individual with CMS-specified chronic or disabling conditions when the presence of the condition is certified by a physician.

Fully Integrated Dual Eligible (FIDE) SNPs were created in section 3205 of the Affordable Care Act. Designed to promote the full integration and coordination of Medicare and Medicare benefits for dual eligible beneficiaries by a single managed care organization. FIDE-SNPs are described in section 1853(a)(1)(B)(iv) of the Social Security Act and at 42 CFR §422.2. FIDE SNPs must meet five elements related to integration of services and benefits.[7]

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[5] Page 138, http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0
[6] Page 139, http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-9-medicare-advantage.pdf?sfvrsn=0
[7] Citing CMS description in full, https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html The five elements are: (1) Enroll special needs individuals entitled to medical assistance under a Medicaid State Plan, as defined in Section 1859(b)(6)(B)(ii) of the Act; (2) Provide dually-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization; (3) Have a CMS approved MIPPA compliant contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;(4) Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and,(5)

Section 206 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018. However, most stakeholders agree that earlier Congressional action is far preferable for beneficiaries, plans, providers, and states to have certainty.

Dual Eligible Beneficiaries

One important consideration for the Committee is how SNP policy – especially regarding D-SNPs that serve dually-eligible beneficiaries—intersects with the Medicaid program. Dually-eligible beneficiaries ("dual eligibles") are persons who receive both Medicare and Medicaid benefits by virtue of both their (a) age or disability and (b) low incomes. As MedPAC and MACPAC have noted, "this population is diverse and includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness."[8]

For dual eligibles, Medicare is the primary payer for acute and post-acute care services covered by that program. Medicaid provides varying levels of assistance with Medicare premiums and cost sharing and, for many beneficiaries, covers services not included in the Medicare benefit, such as long-term services and supports (LTSS). Full-benefit dual eligibles receive the full range of Medicaid benefits offered in a given state. For partial-benefit dual eligible, Medicaid pays Medicare premiums and may also pay the cost sharing for Medicare services.[9]

According to CMS, "during 2015, 11.4 million Americans were concurrently enrolled in both the Medicare and Medicaid programs" and "individuals enrolled in both programs are more likely to have qualified based on a disability than Medicare-only beneficiaries (52 percent of enrollees versus 17 percent) as shown in the nearby table."[10]

Original Reason For Medicare Entitlement	Medicare-Only Enrollees	Medicare-Medicaid Enrollees
Age	82.9%	46.3%
Disability	16.7%	52.4%
ESRD	0.2%	0.6%
Disability and Current ESRD	0.2%	0.7%

Medicare and Medicaid provide a comprehensive set of benefits for dual eligibles, but how dual eligibles may receive their benefits can vary widely. Dual eligibles in D-SNPs receive their Medicare through a managed care plan, but as MACPAC notes, "states may deliver Medicaid benefits to enrollees on a FFS basis, through managed care, or both." As MACPAC notes:

Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

[8] Page 3, https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf

[9] https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf

[10] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2016_RTC.pdf

> [I]n practice, the experience of dually eligible beneficiaries is more complex than having coverage from both Medicaid and Medicare. Both programs deliver services through [FFS] and managed care, and many beneficiaries receive services under both arrangements. For Medicaid services, many enrollees are enrolled in both a comprehensive plan for most medical services and a limited-benefit plan that provides oral health, behavioral health (including mental health and substance use services), LTSS, or transportation services. Each of these plans has its own set of providers, covered benefits, and processes that beneficiaries must understand and navigate.

Accordingly, "policymakers have long-standing concerns around the lack of coordination between Medicaid and Medicare, and how this can result in fragmented care, high costs, and poor outcomes."[11] In October 2016, MACPAC reported that many dual eligibles are enrolled in three or more plans and data suggests almost half of dual eligibles are enrolled in at least one limited benefit Medicaid managed care plan.[12]

While dual eligibles tend to be some of the most vulnerable beneficiaries served by Medicare and Medicaid – beneficiaries who could greatly benefit from greater care coordination, clinical integration, and streamlined service – in CY 2012, most individuals dually eligible for Medicare and Medicaid services (76 percent) were enrolled only in Medicare FFS.[13] Given the realities that dual eligibles can change enrollment each month, may be enrolled in multiple plans, and tend to be relatively older, sicker, and higher utilizers of services, there remains great potential to improve care, increase coordination, enhance quality, and reduce unnecessary utilization and excess spending. As MedPAC noted last year, "[i]n 2011, the most recent year of data available, dual eligibles represented about 20 percent of Medicare beneficiaries but accounted for about 35 percent of Medicare spending. For Medicaid, dual eligibles represented about 14 percent of enrollment and about 33 percent of total spending."[14] With the growth of spending in both Medicare and Medicaid outpacing economic growth and with the annual increase in dual eligible enrollment outpacing overall population growth, improvements that encourage high quality care while curbing inefficiencies will likely be needed.[15]

As Congress considers the extension of SNPs, there are many important variables to consider. MedPAC made program recommendations in 2013 and the Commission still largely holds to those recommendations.[16] Recently, many stakeholders have been focused on examining how SNPs—especially D-SNPs—intersect with other programs serving dual eligibles.

Financial Alignment Demonstration Projects. One development in recent years that has received a lot of attention for its potential impact on dual eligibles has been the Financial Alignment Demonstration Projects ("Duals Demos") undertaken in 2011. Financial Alignment

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[11] https://www.macpac.gov/wp-content/uploads/2016/10/Medicaid-and-Medicare-Plan-Enrollment-for-Dually-Eligible-Beneficiaries.pdf
[12] https://www.macpac.gov/wp-content/uploads/2016/10/Medicaid-and-Medicare-Plan-Enrollment-for-Dually-Eligible-Beneficiaries.pdf
[13] Page 43, https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf
[14] Page 263, http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0
[15] Page 61 for dual eligible enrollment growth on an annual basis, https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf
[16] http://www.medpac.gov/docs/default-source/reports/chapter-14-medicare-advantage-special-needs-plans-march-2013-report-.pdf?sfvrsn=0

Initiative includes a capitated model and a managed fee-for-service model. In the FY 2016 annual report of the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"), CMS explained that "under the capitated model, a state, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated Medicare and Medicaid services. Under the managed fee-for-service model, a state and CMS enter into an agreement by which the state would be eligible to benefit from a portion of the savings from initiatives that improve quality and reduce costs of Medicare and Medicaid services."[17]

As of last summer, CMS had approved 14 demonstrations in 13 states and did not expect additional state demonstration efforts. Most demonstrations will operate for five years, and there were about 450,000 dual eligibles enrolled as of spring 2016. The majority of demonstrations (11 of the 14) are testing a "capitated" model, which uses health plans know as Medicare-Medicaid Plans (MMPs) to provide all Medicare and most or all Medicaid benefits to dual eligibles who are enrolled. As MedPAC notes, "enrollment in the MMPs has been much lower than some expected because many beneficiaries have declined to participate, 'opted out.'"[18] MedPAC noted that "the implementation of the demonstration has consistently proven to be more difficult than expected," so "the results from the demonstration at the end of its original three-year lifespan could be less definitive than policymakers would like." [19] CMS has worked with states to extend a number of the demonstrations for additional years – a move that MedPAC supported.

***PACE Programs*.** Many dual eligible are served by the Programs of All-Inclusive Care for the Elderly (PACE). PACE provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants. Financing for the program is capped, which allows providers to deliver all services participants need rather than limit them to those reimbursable under Medicare and Medicaid fee-for-service plans. The PACE model of care is established as a provider in the Medicare program and enables states to provide PACE services

[17] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2016_RTC.pdf Section 2602 of the Affordable Care Act created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"). The Medicare-Medicaid Coordination Office is charged with "making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, States, and the Federal government." https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

[18] Page 264, http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0

[19] Page 297, http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0

to Medicaid beneficiaries as state option.[20] In 2016, CMS proposed a major regulatory update to the PACE program, which has not yet been finalized.

Managed LTSS. Medicaid enrollees who use long-term care are a diverse group of individuals, who may be young or old, or face different types of physical, cognitive, and mental disabilities. They include: adults with significant physical disabilities, children who are medically fragile, individuals age 65 and older, people with intellectual and developmental disabilities, and individuals who are severely mentally ill. There are several pathways in Federal statute by which an individual may become eligible for Medicaid long-term care.[21]

States are increasingly relying on Managed Long Term Services and Supports (MLTSS) for providing benefits to dual eligibles and others on Medicaid. MLTSS refers to the delivery of long term services and supports through capitated Medicaid managed care programs.

Highlighting the benefits of MLTSS, the Center for Health Care Strategies noted that utilizing MLTSS enables states to improve "rebalancing the setting of care from institutions to community settings and reducing fragmentation between Medicaid acute and primary care, behavioral health services, and LTSS."[22] However, as the researchers noted, "states face barriers to achieving these goals for dually eligible beneficiaries enrolled in MLTSS programs because those individuals must often continue to navigate the Medicare system for primary, acute, and post-acute care services. More integrated care should reduce fragmentation, and improve quality and access to care. Programs in which a single entity is responsible for managing acute, post-acute, and long-term care services may also reduce cost shifting and align incentives for Medicare and MLTSS providers to offer alternative home- and community-based services (HCBS) options to institutional care." [23]

In CMS's experience, "increasing numbers of states are using MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency. The number of states with MLTSS programs increased from 8 in 2004 to 16 in 2012, and CMS has experienced increasing interest from States in the form of concept papers, waiver applications and requests for technical assistance" because "MLTSS offers states a broad and flexible set of program design options."[24]

III. LEGISLATIVE ACTIVITIES

On May 18, 2017, the Senate Finance Committee approved the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017* unanimously by a vote of 26-0. This legislation includes revisions to SNPs and would permanently extend the program.[25]

On June 7, 2017, the Ways and Means Committee examined Special Needs Plans as part of a hearing, "Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for

[20] Content cited without attribution from https://www.medicaid.gov/medicaid/ltss/pace/index.html
[21] https://www.macpac.gov/subtopic/long-term-services-and-supports-population/
[22] http://www.chcs.org/media/State-MLTSS-Considerations-for-D-SNP-Contracting-FINAL-updated.pdf
[23] http://www.chcs.org/media/State-MLTSS-Considerations-for-D-SNP-Contracting-FINAL-updated.pdf
[24] https://www.medicaid.gov/medicaid/managed-care/ltss/index.html
[25] https://www.finance.senate.gov/chairmans-news/hatch-wyden-applaud-committee-passage-of-chronic-care-act

Medicare Beneficiaries."[26] On July 13, the Committee approved bipartisan legislation, H.R. 3168, to improve and extend SNPs.[27]

Building on previous bipartisan efforts in sister committees, the Committee is releasing for comment a draft of legislation improving and extending the SNP program. The Committee is interested in hearing from all stakeholders regarding the policy and language in the discussion draft. The purpose of this discussion draft is to solicit feedback from the wide array of Medicare and Medicaid stakeholders about program and policy specifics. The goal is to foster a conversation with stakeholders that better informs the Committee's bipartisan work to improve and extend this important program.

IV. ISSUES

The following are some issues members may wish to discuss at the hearing:

- What are the challenges to integrating benefits and providing high quality care for elderly patients living in poverty or with a chronic illness?

- How do the SNP extension proposals in Congress complement or conflict with other efforts in Medicaid to integrate the delivery of benefits, improve care coordination, enhance quality, and improve efficiency?

- Are there additional benefits or flexibilities SNPs need to better serve vulnerable patients?

V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Josh Trent or Paul Edattel of the Committee staff at (202) 225-2927.

[26] https://waysandmeans.house.gov/event/medicare-advantage-hearing-promoting-integrated-coordinated-care-medicare-beneficiaries/
[27] https://waysandmeans.house.gov/event/markup-bills-strengthen-medicare-programs-protect-taxpayers/