ACAP
Association for Community Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

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The Honorable Greg Walden, Chairman
House Energy and Commerce Committee
2124 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Ranking Member
House Energy and Commerce Committee
2322 Rayburn House Office Building
Washington, DC 20515

Sent via Email

Chairman Walden and Representative Pallone:

As the House Energy and Commerce Committee considers legislation regarding the reauthorization of Medicare Advantage Special Needs Plans (SNPs), I am writing to offer ACAP's policy recommendations for the D-SNP program. For the purposes of this letter we will be basing our comments on H.R. 3168, the *"Special Needs Plans 3 Reauthorization Act of 2017"* as passed by the Ways and Means Committee on July 13 of this year. On behalf of the Association for Community Affiliated Plans, the 60 Safety Net Health Plans, and the 20 million Americans served by them, we are grateful for the opportunity to explain the policy recommendations and to propose the corresponding legislative language.

Permanent Authorization of D-SNPs

Although we are pleased that H.R. 3168 provides for longer than a short-term reauthorization, ACAP strongly supports permanent authorization of D-SNPs. D-SNPs have been reauthorized numerous times, but only in a series of short-term extensions. The benefit of D-SNPs to enrollees is that they can tailor their care management, provider interventions, and partnerships with community-based organizations to the unique needs of their dual-eligible enrollees. We believe that the lack of permanent authorization destabilizes the program for beneficiaries, states, health plans, and providers. ACAP supports permanent authorization of D-SNPs because doing so would provide certainty to plans, beneficiaries, and states and would foster longer term partnerships and investments in care management and integration with Medicaid.

<u>Suggested technical revision</u>:

- In HR 3168, Section 1, strike clause (a)(2).
- Revise Section 1, clause (a) (1) so that it reads: (a) EXTENSION.—Section 1859(f)(1) of the Social 15 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by 16 striking ''and for periods before January 1, 2019''.

Adjust the Star Ratings Program to adjust for Dual Eligible Status

The Star Ratings system is central to CMS's goal of improving the quality of services provided to Medicare beneficiaries and the system helps beneficiaries compare plan quality and determine plan bonus payments. However, the December 2016 ASPE report to Congress shows that dual status is a significant predictor of low Star Ratings, independent of plan or provider performance. Unfortunately, this suggests that the current Star Rating system fails to adequately account for dual eligible and disability status, producing a structural disadvantage for plans that serve dual-eligible beneficiaries. Because of that, ACAP believes that Congress should require CMS to develop a meaningful, long-term solution that

accurately measures and compares quality of care for plans with high enrollment of dual-eligible beneficiaries. This will not only help to create an accurate “apples-to-apples” measure to help facilitate true comparison among the quality of the unique D-SNP plans, but it will also not penalize plans that choose to serve Dual Eligibiles from being penalized for issues more related to the uniqueness of the population than the quality of the plan itself.

Suggested technical revision:

- Insert in Section 2 the new subsection (2) (on page 21, line 7)”

  (f) ENSURING APPROPRIATE QUALITY MEASUREMENT FOR SPECIAL NEEDS PLANS SERVING DUAL ELIGIBLES. – (1) Not later than the 2020 Medicare Advantage plan year, the Secretary shall revise the Medicare Advantage Star Rating system so that the quality measures used in the system, and the methodology for developing the quality ratings, result in accurate quality measurement for plans that enroll individuals dually eligible for Medicare and Medicaid and individuals with disabilities. (2) In developing revisions to the Star Rating system, the Secretary shall (A) take into account stakeholder feedback before implementing the revisions to the Star Rating system, (B) consider peer grouping Dual Eligible Special Needs Plans, adjusting individual measures, revising the measure set used for Dual-Eligible Special Needs Plans so that all measures used are applicable and appropriate for individuals dually eligible for Medicare and Medicaid, and (C) account for the impact of social determinants of health on quality measurement.

Apply the frailty adjuster at the beneficiary level to all LTSS recipients.

The CMS-HCC risk-adjustment model does not adjust for frailty. For that reason, PACE providers and Fully-Integrated Dual Eligible SNPs (FIDE-SNPs) receive a frailty adjuster. The frailty adjuster is calculated based on these plans’ average level of frailty and is applied at the plan level, as opposed to the beneficiary level. PACE providers and FIDE-SNPs are permitted to receive the frailty adjuster because they directly furnish LTSS services. All other plans, including D-SNPs and MMPs, are excluded from receiving the frailty adjuster. In making this distinction about which plans are eligible for the frailty adjuster, CMS is equating frailty with use of LTSS services.

Medicare spending is higher for LTSS users than it is for non-LTSS users. A recent report by MedPAC and MACPAC found that Medicare per user spending was much higher for LTSS users - $31, 921 for institutional LTSS users, $22,438 for HCBS state plan users, and $19, 172 for HCBS waiver users – while per user spending for non-LTSS Medicare beneficiaries was much lower ($14,089 per user).[1] These additional costs are incurred not only by PACE providers and FIDE-SNPs, but also by D-SNPs, MMPs, and other plans that enroll LTSS users. But because D-SNPs, MMPs, and other plans are not eligible for the frailty adjuster, Medicare payments to these plans do not account for the additional costs associated with LTSS utilization. Because D-SNPs and MMPs exclusively enroll dual eligibles, many of whom are LTSS users, the lack of a frailty adjuster results in fewer resources for these plans.

To be equitable and to appropriate pay plans that care for LTSS users, we believe that Congress should require CMS to apply the frailty adjuster at the beneficiary level for all LTSS users (both institutional and

[1] MedPAC and MACPAC. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. January 2017.

HCBS users) and apply that adjustment to LTSS users enrolled in D-SNPs, MMPs, and other MA plans. This would more appropriately pay plans for the additional Medicare costs associated with LTSS users and would provide D-SNPs and MMPs additional resources to manage the LTSS population.

Suggested technical revision:

- Section 1853(a)(1)(B)(iv) of the Act should be amended to allow CMS to apply the frailty adjuster at the individual level for beneficiaries that receive institutional or community-based long-term care services and supports.

- In addition, ACAP supports language that provides that no later than the 2020 plan year, the Secretary must develop the methodology for applying the frailty adjuster at the individual level for all Medicare Advantage enrollees that receive long-term care services and supports. These changes to the risk-adjustment methodology are not required to be done in a budget neutral manner.

Again, thank you for the opportunity to submit our comments on helping to develop D-SNP legislation that will be considered in the House Energy and Commerce Committee. As always, please do not hesitate to contact Christine Lynch, ACAP's Vice President for Medicare, at clynch@communityplans.net if we can be of any assistance.

Sincerely,

MA Murray

Margaret A. Murray
President and Chief Executive Officer