ACAP
Association for Community Affiliated Plans

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

September 12, 2011

The Honorable Patty Murray
Chair, Joint Select Committee on
Deficit Reduction
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling
Chair, Joint Select Committee on
Deficit Reduction
129 Cannon House Office Building
Washington, DC 20515

via electronic mail

Dear Senator Murray and Representative Hensarling:

The Association for Community Affiliated Plans (ACAP) recognizes the significant responsibility given to the Joint Select Committee on Deficit Reduction, and we applaud you and your colleagues for your leadership to address the fiscal concerns confronting the country. As a national association representing 58 not-for-profit Safety Net Health Plans that serve approximately 8 million individuals on Medicare, Medicaid, Children's Health Insurance Program (CHIP) and other public health programs in 28 states, ACAP strongly believes that the Joint Select Committee will be able to find the right balance between protecting America's health care safety net and responsibly reducing our deficit.

Like all Americans, Safety Net Health Plans are ready to do their part to solve the problems that confront us all: a weakened economy, strained state budgets and mounting national debt. That is why we have worked and will continue to work in a bipartisan manner to promote changes in policy that improve Medicare and Medicaid, protect beneficiaries, reduce spending, and preserve the essential nature of these important programs.

The next several years will be a period of tremendous change in both the Medicaid and Medicare programs as states and the federal government respond to the challenges and opportunities confronting them. States are preparing to expand their Medicaid programs to provide critical health care services to all individuals in families with incomes up to 133 percent of the federal poverty level (FPL) and to meet other new federal requirements. Many also are developing proposals to improve enrollees' experiences with the Medicaid program. These opportunities come at a time when both levels of government are challenged to manage the growth with more limited resources and ongoing budget constraints. Medicare also faces substantial financial pressures as costs of care increase and baby boomers begin to enroll in the program.

ACAP recognizes that Medicaid and the Children's Health Insurance Program (CHIP) are exempted from the automatic reductions, or "triggers," in the *Budget Control Act of 2011*, and reductions to the Medicare programs are limited to two percent cuts for health

care providers and plans. However, ACAP has always sought to bring positive solutions to light when the country is in a time of need and that is why we are submitting the following recommendations for your consideration as you look for ways to improve and protect these programs while reducing the federal deficit.

Accordingly, ACAP's Safety Net Health Plans propose and support the following policy changes to improve Medicare and Medicaid while saving taxpayers money and preserving the full scope of Medicare, Medicaid, and CHIP benefits.

We urge your consideration of these proposals.

Medicaid and CHIP

Medicaid serves 53 million Americans and is a vital safety net for seniors, people with disabilities, pregnant women, and children. Far from being "welfare," Medicaid directly or indirectly impacts the lives of 150 million Americans. According to the Kaiser Family Foundation, more than half of all Americans received health coverage, long-term care, or assistance with paying Medicare premiums from Medicaid (20 percent), or had a friend or family member who has received such assistance (31 percent).

Medicaid is also a smart investment. It protects public and private resources, and helps local and state economies. Without Medicaid, the uninsured poor would place an even greater burden on an already-strained health care system, particularly emergency rooms. Likewise, Medicaid supports valuable prevention, immunization and screening efforts that preserve public health and prevent costlier ailments down the road. Medicaid supports hospitals, nursing homes and health care professionals, all of whom are vital components of the economic stability of local communities.

Continued support of the Medicaid program in its current form is, therefore, extraordinarily important. ACAP strongly supports retention of the "maintenance of effort" provision until 2014, when additional health coverage opportunities will be available to individuals and families. ACAP understands the significant fiscal pressures that states now face, but cutting beneficiaries and services is not an appropriate pathway to fiscal stability. Similarly, ACAP continues to support the federal government in its full partnership with states to support the Medicaid program. The impetus for block grants currently under discussion in Congress is clearly to limit federal expenditures by allowing states to reduce beneficiaries and services, which will jeopardize the program.

At the same time, ACAP recognizes that there are ways to improve the Medicaid program to move it into the most current and sophisticated systems of care coordination and care management. While many states have embraced care management for their Medicaid populations, many other states have not adopted these systems at the expense of

improved quality for beneficiaries. Therefore, ACAP makes the following recommendations to the Joint Select Committee with regard to Medicaid:

1. **Congress should encourage states to expand capitated care management systems for all non-dual eligible Medicaid populations** (please see our recommendations on expanding integrated care for dual eligibles in a subsequent section of this letter). Fully capitated Medicaid managed care programs are providing cost-effective care and are helping states meet quality improvement goals.[1] For example, Medicaid managed care has demonstrated it provides greater care coordination for enrollees than traditional fee-for-service programs, while focusing on preventive and in-home care, and minimizing and delaying the need for institutional care.[2]

   RECOMMENDATION: **Congress should incentivize states to expand capitated managed care through a temporary increase in the FMAP for expenditures on newly-capitated populations or through technical assistance grants to help states work through expansion of capitation.** With the strong patient protections that exist in Medicaid law and regulation, expanding capitated managed care will not only protect patient access to health care services, it will also help to reduce unnecessary spending associated with fee-for-service Medicaid.

   RECOMMENDATION: Congress should reduce bureaucratic barriers to a state's use of managed care while ensuring that federal beneficiary protections are preserved. Currently, states may not move children with special health care needs or those that are dually eligible for Medicaid and Medicare from fee-for-service to managed care without going through a cumbersome federal waiver process. Rather than mandate a waiver for each expansion of managed care, Congress should require the Department of Health and Human Services to use the standard State Plan Amendment process to expand care management for these populations, in addition to the other populations that are already allowed to use this process. However, ACAP supports federal rules governing the protection of beneficiaries in managed care. States should not be allowed to opt out of those requirements.

2. **Automatically Adjust the Medicaid FMAP During Economic Downturns.** Medicaid is a counter-cyclical program. As the economy slows, more people lose their jobs and health care coverage, meaning they turn to Medicaid. But

[1] Lewin Group and AHIP, "Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies," March 2009
[2] ACAP. "How Safety Net Health Plans are Transforming Primary Care: Case Studies from the Field." August 3, 2010.

state revenues fall during a recession, making it harder to fund the program at the time when its citizens need it most. Automatic increases of the FMAP during times of economic distress would ensure access to Medicaid and would not leave states to make drastic cuts to benefits and eligibility to meet budget requirements. A counter-cyclical FMAP would also promote economic stability by maintaining the states' ability to pay doctors, hospitals, clinics, and health plans.

RECOMMENDATION: Congress should enact legislation to automatically increase the FMAP in proportion to the decline in the economy. A formula similar to that enacted in the American Recovery and Reinvestment Act of 2009 would hold states harmless for otherwise-mandated FMAP reductions and provide greater increases for states with higher unemployment rates. The FMAP increase could be triggered on (and phased-out) when the national unemployment rate reached (or fell below) a specified level, and be graduated to reflect the overall impact that a greater economic downturn has on a state's ability to support its Medicaid programs.

3. **Enhance State Flexibility in Co-payment Levels Subject to Community Norms**. ACAP does not support enrollee cost-sharing as a way for states to create barriers to services. But states should be given flexibility, in certain circumstances, to impose co-payments and premiums on the highest-income Medicaid enrollees. Higher co-payments or utilization limits should be allowed for services with inappropriately high utilization rates, such as the use of emergency rooms for non-emergency services.

   RECOMMENDATION: Congress should provide states with needed flexibility related to beneficiary co-payments, either through a specific statutory provision or by allowing existing restrictions to be waived with CMS approval. Such flexibility will allow states to tailor co-payments to address the specific issues that are unique to their individual health care systems.

4. **Congress should implement 12-month continuous eligibility for all individuals enrolled in Medicaid.** Medicaid suffers from a significant problem known as "churn," where enrollees are continuously disenrolled and re-enrolled in the program, often owing to complex "re-determination" requirements that bear little relation to actual eligibility status.[3] Many of these

[3] Ku, MacTaggart, Pervez, and Rosenbaum, George Washington University Department of Health Policy. *Improving Medicaid's Continuity and Quality of Care.* July 2009. Report sponsored by ACAP.

individuals lack health coverage while disenrolled. Recent research shows that churn will continue to be widespread, even when Medicaid is expanded and state-based health insurance Exchanges are established.[4] This study estimates that half of all adults with incomes under 200 percent of the poverty line – 28 million people – will experience income changes that will require them to change coverage between Medicaid and the Exchanges within any one-year period. This shift in eligibility between Medicaid and the Exchanges may trigger a sudden change in plans and provider networks, which can have serious repercussions for one's financial and health status.

RECOMMENDATION: Congress should enact mandatory 12-month continuous eligibility, requiring individuals to change health coverage no more than once a year. Currently, states have the option to provide 12-month continuous eligibility for children, but not for adults.

Dual Eligibles

People who are eligible for both Medicaid and Medicare, or "dual eligibles," tend to be among the poorest, most frail, most medically needy among us. But because Medicare and Medicaid are administered separately, these beneficiaries are often poorly served by the two programs. Strong incentives for cost-shifting between the two programs exist: as a result, spending for dual eligibles is unacceptably high in each program.

The Affordable Care Act (ACA) renewed focus on dual eligibles with the establishment of the new Federal Office of Medicare-Medicaid Integration (the "Duals Office"). In conjunction with the Center for Medicare and Medicaid Innovation, the Duals Office recently issued planning contracts to 15 states to develop integrated programs and announced a shared savings demonstration. ACAP supports the creation of this singular and accountable entity within CMS to coordinate activities for duals.

Fully integrated care management for dual eligibles presents the best opportunity to improve care while realizing substantial savings in entitlement spending. This requires the management of and payment for services within a clinically- and programmatically-integrated, risk-based model. Currently, fully integrated care is difficult because beneficiaries are managed through separate Medicaid and Medicare Advantage contracts with little coordination between states and the federal government with regard to the unique needs of the population. While Dual Special Needs Plans (SNPs) have been the primary means of aligning Medicare and Medicaid since 2003, this Medicare Advantage structure for dual eligibles must be reworked to fully integrate benefits, care coordination,

[4] Sommers B. and Rosenbaum S. Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges. *Health Affairs*, February 2011. Vol. 30, No. 2. 228-236.

and payment under a single program to better meet the needs of the dual eligible population.

To achieve meaningful program improvements while saving significant costs, ACAP believes that expanding the flexibility of states for those populations dually eligible for Medicare and Medicaid will help to produce innovative models of care integration. While this expanded flexibility should not come at the expense of reducing coverage for vulnerable populations, we believe that giving the states options to expand coordinated care will help improve the quality of care for dual eligibles.

A 2008 report from The Lewin Group entitled "*Increasing Use of the Capitated Model for Dual Eligibles: Cost Saving Estimates and Public Policy Opportunities*"[5] finds that Medicaid health plans are well positioned to effectively serve the dual eligible population. The report finds that:

> *Many MCOs – as well as many state Medicaid agencies – now have extensive experience serving high-need populations through an integrated care model, and the "industry's" sophistication in designing, implementing and overseeing such programs has improved substantially throughout the past decade. Historically, few coordinated care programs for high-need subgroups existed, and the "coordinated care" aspects of these programs focused on assigning individuals to a "medical home" primary care provider, encouraging proper use of the MCO's provider delivery system, and deploying utilization review practices such as prior authorization for expensive services. While these techniques remain in use and of value, current Medicaid MCO programs for high-need subgroups (e.g., the Medicaid-only SSI population) typically go far beyond this traditional approach…*
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> *For example, states now often require Medicaid MCOs to demonstrate an effective process for assessing each new high-need enrollee's health care needs, housing situation, family structure and social support system, then developing and continually adjusting individualized treatment and care coordination plans. Care coordination has advanced to provide more individualized care planning and effective approaches to identify emerging health conditions in order to avoid crisis based interventions. Such requirements and coordinated care techniques do not exist in the fee-for-service environment across the acute, chronic and long term care parts of the health system.*

[5] The Lewin Group. *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities.* March 26, 2008. Report sponsored by ACAP and Medicaid Health Plans of America.

States have also become increasingly adept at putting effective MCO contract requirements in place for high-need subgroups, and monitoring MCO performance aggressively.

In addition, estimates from The Lewin Group's 2008 paper have potential federal savings of $150 billion over 10 years, were all states to operate a truly integrated program:

…large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. The clinical and eligibility characteristics of the dual eligibles population are exceptionally well-matched to the strengths of a fully integrated care program operated by at-risk health plans. For any given dual eligibles subgroup moved into a capitated setting, encompassing the fully benefits package of Medicare and Medicaid covered services, we estimate initial… net savings (across the Medicare and Medicaid programs) of approximately 3% per year, growing to nearly 6% per year as of CY2024. Given the large baseline size of the per capita spending on dual eligibles (more than $7 trillion nationwide across the upcoming 15 years), these relatively modest percentage savings translate into rather massive dollar amounts.

Given the findings of this report, ACAP believes that policy changes that expand care coordination for dual eligibles will yield significant savings to both Medicare and Medicaid while also providing high quality care for this population. Specific recommendations include:

5. **Congress should create a permanent, distinct program for fully integrated care for dual eligibles.** While Dual Special Needs Plans have been the primary vehicle for aligning Medicare and Medicaid, they are not ideal and have not achieved the necessary scale.

   RECOMMENDATION: **Congress should replace the existing bifurcated structure of providing care management of Medicare and Medicaid benefits to dual eligibles with a new, fully integrated, permanent and distinct program managed and funded separately from Medicare Advantage.** While dual Special Needs Plans have been the primary vehicle for aligning Medicare and Medicaid, they are not ideal. Oversight and quality measurement should be focused solely on those who are dually eligible for Medicare and Medicaid. The new program would:

   a. **Encourage states' expansion of capitated care management systems** for dual-eligible Medicaid populations by allowing enrollment of dual eligibles in integrated care for both Medicaid and

Medicare benefits through the Medicaid State plan rather than temporary waivers or demonstrations.

b. **Achieve sufficient scale through the enrollment of all eligible beneficiaries into this program,** but allow them to "opt out" into the current bifurcated system. All beneficiaries would have an assessment of needs and a plan of care that evolves with their changes in health care status. Beneficiaries would have the freedom to choose among all participating fully integrated plans and retain their choice of providers within the plan's network.

c. **Allow shared savings of Medicare dollars with the states.** Early savings in integrated care programs occur in Medicare, arising largely through reduced hospitalizations. States should be able to share in these early savings in addition to the later savings Medicaid will achieve as people are diverted from nursing homes, which are primarily paid by Medicaid.

6. **Congress should stabilize the SNP Program for dual eligibles during the transition to systematic reform to assure continuity.** It is important that we not move dual eligible individuals in current coordinated managed care back to fee-for-service because the current payment system does not adequately recognize the unique needs of dual eligible, especially those who are under 65. Moreover, if Congress does not choose to create a new model of coordinated care for dual eligibles, these same changes should be enacted to improve the current program. It is crucial that plans serving high-need individuals remain financially viable and capable of serving their enrollees.

   RECOMMENDATION: Payment to dual SNPs uses the same methods as plans serving healthier Medicare enrollees; dual SNPs estimate program costs and submit a financial "bid" alongside plans that serve the full spectrum of Medicare beneficiaries. Dual SNPs are at an additional disadvantage because the STARS quality measurement and resulting bonuses do not adjust for the health conditions and unique challenges of the Dual SNP population. To address this problem, **ACAP urges Congress to modify the Dual Eligible SNP program to:**

   a. **Pay SNPs appropriately by refining the risk adjustment system** to pay appropriately for plans that specialize in complex populations,

   b. **Provide the frailty factor for all enrollees who qualify as community-based persons** at a nursing home level of care

regardless of the overall composition of the Dual Eligible SNP,

c. **Recognize previous health status at the time of initial enrollment into Dual SNPs** (ACA limited this approach to the Chronic SNPs only), and

d. **Assess quality improvement and bonus incentives for duals in an "apples to apples" way,** using a matched cohort of plans and fee-for-service beneficiaries for comparison.

ACAP recognizes concerns among some advocates about the expanded use of health plans to serve dual eligibles and stands prepared to work alongside patient advocates to expand the use of coordinated care while at the same time protecting beneficiaries' choice of plans, choice of providers within their plan, access to care, and benefits.

The deliberations of the Joint Select Committee on Deficit Reduction present a unique opportunity to reduce spending while improving and protecting our most vulnerable fellow Americans, and the health care programs that serve them. ACAP stands ready to assist the Committee and its members as they conduct their important work. Please do not hesitate to contact me if ACAP can be of any further assistance to you.

Sincerely,

Margaret A. Murray
Chief Executive Officer

cc: Members, Joint Select Committee on Deficit Reduction
Members, Senate Finance Committee
Members, Senate Health, Education, Labor and Pensions Committee
Members, House Energy and Commerce Committee
Members, House Ways and Means Committee