ACAP | Association for Community Affiliated Plans

2001 K Street, N.W., Suite 804 | Washington, DC 20006
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

May 22, 2009

The Honorable Max Baucus
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Sent Via Email

Chairman Baucus and Senator Grassley:

The Association for Community Affiliated Plans (ACAP) is pleased to submit the following comments in response to the Senate Finance Committee's May 11th policy options paper entitled *"Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans."*

ACAP is a national trade organization representing 42 not-for-profit safety net health plans that serve more than six million Americans in Medicare, Medicaid, SCHIP, and other public health programs in 23 states. At this time, twenty-one ACAP members operate Special Needs Plans (SNPs) as an integral part of their mission to care for low-income and medically needy populations. In addition, many of our members have participated in state and local efforts to expand health coverage to their residents.

Because of ACAP's expertise in serving publicly-insured populations, our comments will address proposals throughout the paper, but will focus specifically on those related to public health programs and the needs of low-income and racially and ethnically diverse populations.

Section 1: Insurance Market Reforms

Non-Group and Micro-Group Market Reforms, Small Group Market Reforms

Risk Adjustment: One of the options proposed for reforming the non-group, micro-group, and small group markets would develop a system for risk adjustment comparable to that used for adjusting Medicare payments to private plans. ACAP urges the Senate Finance Committee to recognize that the risk of certain populations can vary widely, particularly with regard to low-income populations. Underlying disparities in education, literacy, primary language, health status and other challenges such as homelessness or co-occurring mental health and substance abuse must be considered and incorporated into any system that seeks to risk-adjust link health plan payments. Likewise, it is critical that reforms to the health system provide incentives to serve a high risk population. The current Medicare risk adjustment system fails to recognize psycho-social issues and is not sufficiently refined to address enrollees with multiple, chronic conditions, limitations in activities of daily living, and the persistency of chronic health conditions.

> ***Recommendations:*** *ACAP urges caution in applying the Medicare risk adjustment system to payments for health plans until the Centers for Medicare and Medicaid Services addresses the shortcomings in the methodology that fails to address disparities in health status, mental health conditions, psycho-social needs, and other elements for health plans serving a higher need population.*

Health Insurance Exchange: Plan Participation

Ensuring Participation of Health Plans Serving Public Programs: The options paper states that all private insurers with a state license to operate in the individual and small-group market would be required to participate in the exchange. From this language, it is unclear whether the subgroup of health plans that serve publicly-insured populations (and not the individual or small-group insurance market) would be allowed to participate in the health insurance exchange. It is also unclear whether uniquely-licensed managed care organizations known as health insuring organizations, or HIOs, would be allowed to participate. This becomes particularly important if the Senate chooses the option to allow Medicaid and CHIP beneficiaries to enroll in coverage through the health insurance exchange.

Based on ACAP's conversations with Finance and Help Committee staff, we believe that this is simply a function of the way this document was drafted since we have received numerous assurances that any health plan that is allowed to operate in a state would be allowed to participate in the health insurance exchange.

> ***Recommendation:*** *ACAP urges the Senate Finance Committee to use standard federal legislative language to clarify that all "health insurance issuers" (*as defined in section 2791(b)(2) of the Public Health Service Act*) and "health maintenance organizations" (*as defined in section 2791(b)(3) of the Public Health Service Act*) can participate in the health insurance exchange. In addition, the definition of "health plan" used in the Social Security Act would also provide a more inclusive definition of health plan. ACAP is also willing to work with the Committee to explicitly provide for the participation of health plans that serve public programs such as Medicaid.*

Health Insurance Exchange: Functions Performed by the Secretary

Addressing the Needs of Low-Income Populations in a Health Insurance Exchange: The Committee's options paper clearly provides an opportunity for any uninsured individual to participate in the health insurance exchange. Given ACAP member plans' experience in serving low-income and medically needy populations, we are concerned that there seems to be little discussion about the unique needs of these populations beyond their inability to cover the cost of premiums.

It is widely acknowledged that low-income populations suffer from different medical, mental, and social issues than middle or higher income populations. Likewise, they are confronted by much higher barriers to access to services (and therefore may need providers that offer transportation, translation, and other services), health disparities (based on race, ethnicity, age, gender, primary language, and socio-economic status), and the need for supplemental, non-Medical assistance (since as food stamps or TANF).

State-based health expansion efforts in Massachusetts and California recognized these needs and structured their expansion programs to address them.[1] This is why ACAP strongly urges Congress to give the Secretary the responsibility to ensure that ALL health plans serving a subsidized population have the systems in place to address the needs of their low-income enrollees.

> ***Recommendation:*** *To ensure that the unique needs of "subsidized" enrollees are appropriately met, ACAP urges the Senate Finance Committee to give the Secretary of Health and Human Services the responsibility to ensure that any health plan (including a public plan, if this option is enacted) that serves a subsidized population through the health insurance exchange must:*
>
> - *Demonstrate sufficient experience and expertise in serving a low-income population;*
> - *Maintain a sufficient network of providers, including federally qualified health centers and other safety net providers, that have a history of serving low-income, publicly-insured, or previously uninsured populations to ensure appropriate access to care for the newly covered population;*
> - *Have systems and processes in place to address and reduce health disparities based on race, ethnicity, gender, age, socio-economic status, and primary language and that those systems and processes are approved by the Secretary;*
> - *Demonstrate proficiency in screening and care coordination for the purpose of providing, or arranging for the provision of, services to assist enrollees in obtaining access to other government and private benefits, including services to address non-medical and psycho-social needs; and*
> - *Submit to external evaluations to identify areas of improvement, monitor performance, or quality differences among participating plans.*
>
> *These requirements will ensure that the unique needs of low-income enrollees will be met in any coverage offered through a health insurance exchange.*

Income and Language Barriers to Information about the Exchange: ACAP applauds the Committee for empowering the Secretary to reduce income- and language-related barriers for individuals seeking coverage through the health insurance exchange. Efforts cited in the options paper include maintaining a customer service call center that includes multilingual assistance, allowing individuals to enroll at sites in their communities, and establishing a web portal that informs people about eligibility for other public programs. These are important tools to ensure that people with the highest hurdles to comprehending and accessing coverage will not be left behind.

---

[1] "Medicaid Health Plans: A Turnkey Solution for Expanding Health Insurance Coverage – Case Studies in California and Massachusetts," The Lewin Group, 2007.

Recommendation: *Recognizing that this is not the final legislative language, ACAP strongly urges the Senate Finance Committee to maintain and expand the instruments available to the Secretary that reduce income- and language-related barriers to obtaining information about and enrolling in coverage through the health insurance exchange. Such items would include requiring the exchange web portal to be available in a wide range of languages (not just English and Spanish); ensuring that information from plans, the exchange, and the Federal government are created at no more than a 6th grade learning level; and allowing consumers to enroll in local, community-based settings that minimize any stigma and maximize access to information.*

Single v. Multiple Exchanges: ACAP appreciates the Senate Finance Committee's recognition that a single national exchange may not be the most appropriate method of setting up an exchange. Given the diversity within the country's states and regions, allowing state-based exchanges to operate under Federal rules and guidelines would allow those states to tailor an exchange that best meets the needs of their residents. ACAP also believes that a national exchange should operate alongside state-based exchanges to ensure that the residents of a state are not deprived the opportunity to obtain coverage if a state proves unable or unwilling to establish or maintain an exchange. However, ACAP is concerned about the option to allow multiple state-based exchanges to operate in a single state for fear that the complexity of the system may generate confusion and unnecessary administrative and bureaucratic burden for state agencies, individuals seeking coverage, and health plans providing coverage.

Recommendation: *ACAP urges the Senate Finance Committee to provide for the establishment of state-based health insurance exchanges that operate within a single national health insurance exchange. ACAP urges the Committee to give the Secretary the authority to approve a single entity (most likely a state agency, state-established exchange authority, or a private entity approved by a state's governor) that will have the sole power and responsibility to operate an exchange in the state. No state should be required to establish an exchange if it does not wish to, but then it should be understood that the national exchange would only be the only exchange allowed to operate in that state.*

Section 2: Making Coverage Affordable

Benefits Options

ACAP reiterates the concerns expressed in Section 1 regarding importance of any health reform/health coverage legislation to address the unique needs of low-income beneficiaries. Certainly, the Senate Finance Committee provides for the option of Medicaid-eligible individuals to receive coverage in a variety of ways, discussed in greater detail herein. However, this document fails to sufficiently address the needs of low-income populations that would not be Medicaid-eligible under this plan but who would still be receiving subsidized coverage – issues such as the need for health plans to provide access to safety net providers such as federally qualified health centers or safety net hospitals, the need for health plans to screen for eligibility for other benefits (including eligibility for additional Medicaid benefits), and the danger posed by health plans whose business model does not address or acknowledge the needs of a low-income population.

The Massachusetts model demonstrates that only offering subsidized individuals a choice of plan and premium assistance is not sufficient if those choices fail to offer a more robust and appropriate set of services and an infrastructure necessary to address the complex medical, mental, and psycho-social needs of this a population. Congress should not disregard the reality that low-income individuals struggling with higher incidence of job loss, substance abuse, mental and behavioral health issues, family instability, complex chronic illness and poor nutrition and housing conditions have much greater health care needs than those with higher incomes.

> ***Recommendation:*** *ACAP strongly urges the Committee to recognize the unique needs of low-income populations and provide them with a benefits package sufficient to address these issues. Individuals receiving a subsidy to purchase coverage should be able to choose among health plans that consistently offer an appropriate benefits package and other non-health related services that best meet the needs of people with low incomes. Subsidies should be provided to ensure that low-income individuals can select higher levels of coverage in the health insurance exchange since the more robust service package offered by the high level plans may be more appropriate to meet the complex health and social needs of this population. In addition, should Medicaid be offered through an exchange, individuals receiving a subsidy should be given the option to select Medicaid as well as other offerings via an exchange.*

Low-Income Tax Credits

Health Coverage Tax Credits: ACAP strongly supports providing lower-income families with subsidies to help them pay for health care coverage through the exchange. However, ACAP is concerned that this mechanism may prove too cumbersome for low-income populations and may create an unintended hurdle for those seeking coverage. ACAP suggests that the Committee avoid cumbersome tax policy and consider instead paying subsidies for low-income populations directly to the health plans serving those individuals.

> ***Recommendation:*** *ACAP strongly supports providing lower-income families subsidies for health care coverage, but recommends that these subsidies be paid directly to the health plans serving subsidized individuals, rather than to the individuals by means of tax credits.*

Section 3: Public Health Insurance Option

Although ACAP believes that safety net health plans are equipped to provide the best stability, access and care coordination for individuals entering the insurance market, ACAP does not oppose allowing individuals to choose from a range of health care coverage products, including a publicly-sponsored alternative plan, provided that any such plan be required to meet the same high standards to which private health plans are held. By this standard, Approach 1 as proposed by the Committee does not meet this requirement and thus, ACAP rejects this option. ACAP also rejects Approach 2, which organizes the public plan at a regional level and would thus not easily allow for participation smaller, community-based or single-state health plans. There is no reason to believe that a regulated public plan administered by a third party couldn't operate on a state or local level or that there couldn't be competing public plans. In addition, while we applaud the Committee for applying standards such as the establishment of provider networks, compliance

with reserve fund requirements, and external governance to a public plan under Approach 2, ACAP recommends a broader set of requirements on the public plan to ensure that it is truly on a 'level-playing field' with private health plans.

Approach 3 comes closest to meeting the standards set out by ACAP's member plans for participation by a "public plan," provided that the State-run public option complies with the guidelines set out by ACAP for rules governing a public plan.

> ***Recommendations:*** *ACAP believes that safety net health plans are best equipped to provide access to high quality and well-coordinated health care for individuals newly acquiring health insurance. However, should the Committee opt to develop a public plan, ACAP urges the Finance Committee to reject Approaches 1 and 2 and instead implement a modified Approach 3 whereby any state-based public plan:*
>
> 1. *Is governed by an independent authority at either a regional or state level, which has the ability to delegate operations of the public plan to nonprofit or other publicly-chartered health plans serving that region or state;*
> 2. *Meet the same federal and state regulatory standards as other participating health plans, including audit, solvency, and reserve requirements;*
> 3. *Receive payments that are equitable in comparison to payments received by other participating health plans for coverage of comparable populations;*
> 4. *Will not be presumed to be the sole beneficiary of any possible default assignments and that any default assignments necessitated by an individual coverage mandate will be based on measurable standards of quality and outcomes for all public and other health plan options available to an enrollees;*
> 5. *Is tested and evaluated on the same outcome and quality measurements as other participating health plans, and that those results are made publicly accessible;*
> 6. *Along with other participating health plans, is paid in a manner consistent with requirements for actuarial soundness in Medicaid to ensure the efficient delivery of benefits to their enrollees;*
> 7. *Is required to pay primary care provider rates that accurately reflect the cost of care and are sufficient to ensure voluntary provider participation in the public plan, as well as ensure appropriate utilization and coordination of all health care services;*
> 8. *Is under the same marketing limitations as other participating health plans; and*
> 9. *Provides care management of the enrolled population sufficient to meet the purpose of improving quality and controlling costs across the health care system.*

<u>Without these standards being applied to public plans under Approach 3, ACAP may be forced to oppose the public plan option as inconsistent with ACAP's stated requirements for a public plan.</u>

Section 4: Role of Public Programs

Eligibility Standards and Methodologies: ACAP supports the approach proposed by the Committee that applies a nationwide minimum level of Medicaid eligibility based on income. However, the Committee's options paper defines income for Medicaid and the subsidized population using modified adjusted gross income (MAGI). While we support establishing a nationwide definition of income, ACAP is concerned that this proposed definition effectively reduces upper income eligibility limits which would cause people to lose existing coverage through Medicaid. ACAP similarly questions the prohibition of income disregards for this reason.

In addition, the Committee proposes allowing the maintenance of effort requirement to expire after the exchange is fully operational, whereby the Secretary of Health and Human Services will identify obsolete eligibility categories. ACAP urges the Committee to recognize that current categorical eligibility pathways support vulnerable populations and although all individuals below a certain income threshold will be covered, the loss of these pathways above that income threshold may cause significant hardships to individuals and families with substantial health care needs.

> ***Recommendation:*** *ACAP strongly supports the Committee's efforts to establish a nationwide minimum income eligibility level for Medicaid. However, ACAP opposes the application of MAGI if the term, as currently defined, could be used to reduce upper income eligibility limits which would cause people to lose existing Medicaid coverage. In addition, ACAP urges the Committee to modify its proposal to ensure that any effort to modify existing non-income Medicaid eligibility categories will be done to eliminate duplicative and unnecessary categories while maintaining vital categories that protect vulnerable populations.*

Medicaid Program Payments: ACAP agrees that a Medicaid expansion will increase costs on the states and that is why we support federal assistance to states that will newly cover expansion populations under Medicaid. However, we are concerned that those states that have implemented state-only coverage expansions to low-income populations will not be eligible for additional federal funding assistance.

In addition, the options paper suggests that provider rates could be set at a certain percentage of Medicare (such as 80%). We agree that enhancing provider rates can expand access to care for low-income individuals. However, we are concerned that the Committee will not recognize that any increase in provider rates without a concurrent increase in the payments made to health plans will have a detrimental impact on plans' willingness to participate in the program or their ability to maintain services or beneficiary protections. In addition, ACAP strongly supports strengthening federal oversight of state rate development practices to require states to adhere to Medicaid's actuarial soundness requirements, which require states to adjust rates to plans as plans pay higher rates to providers.

> ***Recommendations:*** *ACAP urges the Committee to:*
>
> 1. *Ensure that states that have independently expanded coverage to low-income populations prior to health reform be eligible for federal financial assistance for a period of no less than five years;*

2. *Establish a mechanism to adjust health plan rates as statutorily mandated provider payment adjustments are implemented; and*

3. *Require CMS to ensure state compliance with federal requirements mandating actuarially sound payments for health plans.*

Options for Medicaid Coverage: ACAP believes that, despite its flaws and inadequacies, the Medicaid program provides a vital and important structure of benefits and assistance for low-income populations. While ACAP is willing to work with the Committee to address the shortcomings of the Medicaid program, we fundamentally believe that, among the three approaches for expanding Medicaid, Approach 1 offers the best option to ensure that low-income and Medically-needy Americans obtain the services they need.

ACAP believes that Approaches 2 and 3, while innovative, would prove too complex for individuals and the health plans that seek to serve them. ACAP fails to understand the logic of providing a minimal benefits package coupled with a wrap-around benefit of Medicaid services given that this approach would require any health plan serving a Medicaid-eligible person to manage and negotiate between multiple payers and regulators. In addition, ACAP is concerned that the impact on enrollees would be equally confusing as beneficiaries would struggle to manage benefits through the exchange and Medicaid. Likewise, ACAP has concerns that Approaches 2 and 3 would segregate the highest-need beneficiaries into the Medicaid program while less costly beneficiaries would be moved into the exchange, meaning that state fiscal pressures forcing benefits reductions or increases in cost sharing would impact those most unable to sustain those losses.

> ***Recommendations:*** *ACAP strongly supports the Committee's Approach 1 to expand coverage to newly eligible Medicaid beneficiaries. ACAP is willing to work with the committee to reform and improve the Medicaid program, but believes that Medicaid offers the best combination of benefits and beneficiary protections for low-income or medically-needy populations.*
>
> *However, should the Committee proceed with Approach 2 or 3, ACAP would strongly suggest that any health plan serving the Medicaid population be required to provide a sufficiently robust and fully integrated set of benefits to enrollees, meet the minimum standards outlined by ACAP previously, and be reimbursed in an actuarially sound manner. Although the concept of a Medicaid-only plan to serve this population seems appealing, ACAP would urge the Committee to recognize that there already exist a certain subset of health plans that fall into this description and there would be little need to "create" Medicaid-only plans where such plans already exist.*

Placing Authority for the Children's Health Insurance Program with the Exchange: ACAP does not necessarily oppose the Committee's proposal to move non-Medicaid, CHIP-only expansions into the health insurance exchange. However, to preserve continuity of care for families that transition between Medicaid and CHIP (as well as those families for whom family members are divided among multiple programs), ACAP would accept the movement of CHIP into exchange *as long as* those health plans serving Medicaid are also given the option to serve the exchange and CHIP in order to allow for seamless flow of people whose eligibility changes.

This continuity will also be critical for individuals transitioning from CHIP to other subsidized coverage through the exchange.

> ***Recommendation:*** *ACAP recommends that health plans serving state Medicaid programs also be given the option to serve the exchange so that coverage for families and individuals transitioning between Medicaid, CHIP and other subsidized coverage will be seamless, and , and for ease of coverage for families whose members are covered by different programs. In addition, ACAP urges the Committee to give the Secretary of Health and Human Services the responsibility to ensure that any health plan (including a public plan, if this option is enacted) that serves a subsidized population through the health insurance exchange meets standards as outlined on page 3 of these comments.*

Quality of Care in Medicaid and CHIP: ACAP applauds the Committee's efforts to apply similar quality measures as enacted in the *Children's Health Insurance Program Reauthorization Act (CHIPRA)* to all Medicaid-eligible populations. Currently, most states require extensive quality reporting for Medicaid managed care organizations. Unfortunately, comparable reporting requirements are not required across all delivery systems under the Medicaid program, including the fee-for-service and primary care case management systems. Without this analysis, it is impossible for federal and state policymakers, as well as beneficiaries, to truly assess the relative strengths and weaknesses of each system as it relates to the quality of services delivered.

> ***Recommendation:*** *ACAP strongly supports the Senate Finance Committee's efforts to apply similar quality measures established in CHIPRA to all Medicaid eligible populations, including those enrolled in Medicaid managed care, fee-for-service, and primary care case management. ACAP urges the Committee to clarify the language to clearly state that quality measurements would apply across all Medicaid delivery systems. In addition, ACAP suggests that any measures developed should be endorsed by the National Quality Forum or any successor organization.*

Enrollment and Retention Simplification: ACAP applauds the Finance Committee for its inclusion of provisions to enact 12-month continuous eligibility for adult populations in Medicaid. The effect of this policy is to substantially eliminate the "churning" of eligible individuals on and off Medicaid, a significant problem that impacts the continuity of care delivered to beneficiaries by the providers and plans that serve them. Improving enrollee retention in Medicaid is a cost-effective way to reduce the number of uninsured people and to improve the security of their health insurance coverage. That is why ACAP has been a long-time supporter of efforts to eliminate churning and is in the process of developing legislative language[2] to accomplish this goal.

However, while twelve-month eligibility would accomplish ACAP's goal of reducing churn and maintaining coverage for Medicaid enrollees, ACAP remains concerned that eligible individuals may fall off the Medicaid rolls at redetermination after the twelve-month period is completed. Therefore, ACAP also supports incentives for states to simplify reenrollment processes by providing incentive bonus payments to encourage the increased use of anti-churning policies.

---

[2] ACAP is happy to make the language of the *Medicaid Continuous Quality Act* available to the Committee for your consideration.

Recommendations: *ACAP strongly supports the policy described in the Committee's options paper that would mandate 12-month continuous eligibility for all Medicaid enrollees. In addition, in an effort to completely eliminate Medicaid "churning" after the twelve-month period, ACAP proposes the Committee implement a bonus payment structure to encourage states to adopt additional redetermination simplifications such as:*

1. *Elimination of in-person interview requirement.*
2. *Automatic renewal (use of administrative renewal).*
3. *Enhanced data-sharing between agencies.*
4. *Eligibility based on pending status.*
5. *Default reenrollment in managed care plans.*

Automatic Countercyclical Stabilizer: ACAP strongly supports the Committee's proposal to update the matching formula to account for Medicaid's counter-cyclical nature. Simultaneously, ACAP believes that increased federal match should be paired with state maintenance-of-effort requirements for Medicaid eligibility, benefits and provider reimbursement.

Recommendations: *ACAP strongly supports the Finance Committee's proposal for a countercyclical FMAP increase.*

<u>Dual Eligibles</u>

Waiver Authority for Dual Eligible Demonstrations: The options paper proposes a new five-year Medicaid demonstration waiver for exploring alternative approaches to coordinating care for dual eligibles. We applaud the Committee for recognizing dual eligibles as an underserved group whose care is bifurcated across two federal programs. Too often, dual eligibles experience poor transitions of care, premature nursing home stays, or multiple hospitalizations due the lack of care coordination.

In partnership with the Medicaid Health Plans of American, ACAP sponsored a paper in which The Lewin Group explored the potential for savings if more duals were enrolled in integrated care options. The savings opportunity in changing the trajectory of spending is compelling -- a relatively achievable reduction of 4.2% of combined savings across the two programs yields over $300 billion in savings in the 15-year period from 2010 to 2024.

States determine whether dual eligible integration will occur. Yet, as the Lewin paper clearly shows, the savings from better care for dual eligibles accrue initially to the Medicare program because unnecessary emergency room visits and hospitalizations and re-hospitalizations are reduced. Savings to the states, in the form of reduced or delayed nursing home costs, occur several years later. Because states will incur an upfront cost without receiving any of the savings of better integration, it is crucial that states which participate in efforts to promote integrated care receive upfront payments to cover the costs of planning and actuarial advice. Additional incentive payments could take the form of gain sharing from the Medicare savings resulting from such an effort.

ACAP welcomes a clear pathway that allows states to test new ideas with regard to the treatment of dual eligibles. However, it is not clear what happens to states like Arizona, Massachusetts, Wisconsin, and Massachusetts which long ago used 5-year demonstration waiver authority to

develop their models and are now operating under various waivers. The word "alternative" could later be defined by CMS to preclude adoption of proven models of dual eligible coordination by new states. Even worse, it could be used to prevent continuation of current waiver approaches.

The paper also notes that waiver authority has traditionally been used for the expansion of eligibility and/or benefits. The 1.7 million partial-benefit duals are a group whose income and assets make them almost immediately eligible for full Medicaid benefits when they enter a nursing home. States should be encouraged and incented to include this group in their dual care coordination approaches as a way of avoiding or delaying institutional use by this vulnerable group.

This section of the paper indicates that OMB has imposed budget neutrality in 1115 waivers since 1982 despite lack of a statutory requirement. The proposed option is silent on the budget neutrality requirement. The Lewin paper cited above shows that initial savings in coordinated care accrue to the Medicare program for the first four or five years of an integrated initiative.

> ***Recommendation:*** *ACAP recommends that Congress establish a new Medicaid demonstration authority for exploration and continuation of coordinated care strategies for the full range of dual eligible beneficiaries. The Congress should direct OMB not to impose a budget neutrality test or to include Medicare savings in any test imposed. In addition, Congress should allow states to share in any savings from reductions in Medicare acute care dollars as a result of this improved integration. ACAP urges Congress to clarify how the Medicare program will be involved in this new waiver authority. We believe that states with current waivers be able to retain their current authority or transition to the new model.*

Cost Effectiveness Test: The Committee's options paper proposes to allow states to use Medicare program savings to meet the cost effectiveness test in 1915(b) waivers. These waivers would remain as 2-year options. ACAP enthusiastically supports the proposal that removes the long-standing wall between Medicare and Medicaid spending and savings in dual eligible initiatives. Removing this barrier will be very helpful, but actively promoting adoption by allowing states some gain sharing from these efforts would be even better. As we mentioned in the demonstration waiver section, States determine whether dual eligible integration will occur. Yet, as the Lewin paper clearly delineates, the initial savings from better care for dual eligibles accrues initially to the Medicare program as unnecessary emergency room visits and hospitalizations and re-hospitalizations are reduced. Savings to the states, in the form of reduced or delayed nursing home costs occurs several year s later. Because of that pattern, it is crucial that state efforts to promote integrated care be recognized through clear payment incentive sin the form of reduced administrative outlays for planning and actuarial advice and in the form of some gain sharing with the Medicare program.

ACAP urges the Committee to go beyond simply removing barriers to actively incentivizing states for more coordinated care initiatives for duals. Rapid adoption of these efforts would occur if states could recover their administrative costs and have some sort of gain-sharing with the federal government

> ***Recommendation:*** *ACAP urges Congress to permit states to use savings from Medicare and Medicaid coordinated care programs for dual eligibles in determining the cost effectiveness test for 1915(b) waivers. Part of the test should allow states to allocate the*

full cost of initial actuarial and administrative costs to the federal government. CMS is directed to develop a gain sharing option with the states. 1915(b) waiver periods should be aligned with 1915(c) waiver periods because home and community based services are usually part of the state's strategies. In addition, at state option, states could choose a 5-year waiver period beginning with the first renewal of the waiver. The Committee should be more explicit about the distinction it envisions for the new waiver authority in the new waiver option proposed for duals and the role of the 1915(b) waivers.

Medicare Coverage

Office of Coordination for Dual Eligible Beneficiaries: ACAP strongly supports the creation of an entity that is responsible for the coordination of public policy for the duals. But more importantly, we are pleased to see the accountability that is envisioned for that office by it placement within HHS in the Secretary's office and the public reporting on duals that is required. Information on the cost, quality and access for duals is effectively hidden in the various state and federal program components. Absurd as it sounds, researchers who wrote the paper on dual integration for ACAP and MHPA and researchers helping Kaiser Family Foundation on its recent duals papers on spending and utilization were required to cobble together the data from multiple sources, and trend that 2005 data forward to 2009.

Recommendation: *ACAP supports the creation of an Office of Coordination for Dual Eligible Beneficiaries which is placed in the Office of the Secretary and which has clear accountability for reporting on the cost, quality and access of dual eligibles.*

Section 6: Prevention and Wellness

Promotion of Prevention and Wellness in Medicaid: One of the basic tenets of managed care is the promotion of high quality primary and preventive care services. Therefore, ACAP support efforts to promote the availability and use of preventive services, including the enhanced FMAP for states that provide adult preventive services, funding to support healthy life-style programs at the state level, and grants to encourage innovative prevention and wellness programs. While ACAP supports the promotion of team-based care, we would urge language that makes it clear that states can utilize grants to strengthen and support these activities within a managed care environment.

Recommendation: *ACAP urges that language be added to the option concerning promotion of team-based care to clarify that grants will be available for multi-disciplinary team-based care within any delivery system as long as the specified requirements are met.*

Section 7: Options to Address Health Disparities

Required Collection of Data

To facilitate ongoing reporting and quality improvement activities to reduce disparities, ACAP recognizes the need to collect complete and accurate information on race, ethnicity and language for all Medicare beneficiaries and supports the necessary funding to upgrade the SSA databases to facilitate collection of data. However, we urge Congress to ensure that adequate funding is also

provided to support any upgrades that are required across the delivery system to be able to receive and utilize the data.

> ***Recommendation:*** *ACAP urges Congress to provide grant funding to support any necessary upgrades across the delivery system to allow the collection and transfer of vital information on race, ethnicity and language for all Medicare beneficiaries.*

Data Collection Methods

ACAP supports requiring the Secretary to evaluate and report on approaches for collecting disparities data on Medicaid and CHIP. We would caution that until the evaluation is completed, it would be inappropriate to assume that all current quality reporting can be adapted to report by race, ethnicity and primary language. For example, HEDIS reporting that is done at the health plan level may not include a large enough sample size at the plan level to produce reliable results. However, a survey or other measurement using data at the state or national level would not have the same sample size issues. In addition, as discussed above, we believe it is vital that any quality reporting should look at data across all delivery systems serving the Medicaid and CHIP populations, including fee for service and PCCM models.

> ***Recommendation:*** *The Secretary should be clearly charged with evaluating health disparities across all Medicaid and CHIP delivery systems (managed care, fee-for-service, and primary care case management).*

Standardized Categories for Data

ACAP supports the use of standardized reporting and formatting of race and ethnicity data based on the OMB Directive 15 and the additional funding to states to support the technology upgrades. States should also be required to transfer the race and ethnicity data to participating Medicaid Managed Care Organizations to foster the health plan's ability to develop targeted quality improvement efforts. The additional funding provided to the states should also support adjustments in the actuarially sound rates paid to the health plans to allow necessary technology upgrades at the plan level.

> ***Recommendation:*** *ACAP urges the Committee to require states to share race and ethnicity data with any health plan serving Medicaid and CHIP eligibles and to allow states to pass-through funding for technology upgrades to the participating health plans to support necessary upgrades.*

One option discussed is the requirement that CMS collect and access and treatment data for people with disabilities, including determining where people with disabilities access primary care and the number of providers with accessible facilities and equipment to meet the needs of the disabled. The Secretary would also be required to include data on patients with disabilities by type of disability in the quality reporting requirements. However, there has been no evaluation on how to best carry out the intent of this section. For example, this may be an issue best addressed through consumer surveys versus HEDIA-type measurement.

> ***Recommendation:*** *ACAP recommends that the Secretary be charged with evaluating approaches for ensuring that adequate and reliable measures are implemented for determining the quality of care provided to persons with disabilities.*

Public Reporting, Transparency, Education

As indicated above, ACAP supports developing and publishing quality date by race, ethnicity and gender across all aspects of the Medicaid delivery system, including fee for service and PCCM, if it can be done in a way that produces reliable and actionable data.

Language Access

As indicated above, ACAP strongly encourages the application of robust standards to all health plans serving low-income populations, including the CLAS standards. We also believe that applying the enhanced match to states for translation activities across the entire Medicaid program will serve as a worthwhile incentive to states. In a managed care environment, however, the translation activities may be arranged via the MCO and the Secretary should clearly recognize these costs as eligible for the enhanced match. Finally, ACAP supports as a wise investment the funding for grants to develop and enhance publicly-funded, multi-lingual education and outreach efforts.

> ***Recommendation:*** *ACAP urges Congress to adopt adequate CLAS standards for health plans serving low-income populations. In addition, the Secretary should ensure that states are eligible for the enhanced match for translation services provided directly by the State or under contract with Medicaid Managed Care Organizations.*

Reduction in Infant Mortality and Improved Maternal Well-Being

ACAP supports additional Title V funding to develop and implement targeted approaches to reducing infant mortality. Safety net health plans look forward to being an ongoing and vital partner in these publicly funded efforts to address the issue of infant mortality and maternal well-being.

Additional Comments on Coverage Reform Issues Not Included in Senate Finance Committee Paper

Although they were not raised in the Senate Finance Committee's coverage options paper, ACAP would like to raise the following critical Medicaid issues for your consideration.

Changes to Medicaid Payment for Prescription Drugs: ACAP strongly supports inclusion of an expansion of the Medicaid federal drug rebate program to health plans serving the Medicaid program, as described in the Drug Rebate Equalization Act of 2009 (H.R. 904 and S. 547, introduced by Representative Bart Stupak and Senator Jeff Bingaman, respectively). ACAP contends expanding the drug rebate modernizes the Medicaid program and, importantly, removes the largest incentive for states to carve drugs out of Medicaid health plan capitation. Carve outs are already a reality in thirteen states, and additional states are threatening to remove drugs from the authority of managed care organizations for the sole purpose of gaining drug rebate revenue, which is not available for drugs delivered to managed care enrollees. Carve outs remove health plans' ability to coordinate this portion of enrollees' care, and hinder use of real-time pharmacy data to provide health interventions and assessments of patient care. This policy was also included in President Obama's 2010 Budget, and was scored by CBO as saving $11 billion over ten years.

Recommendations: *ACAP urges Congress to include the Drug Rebate Equalization Act of 2009 in health reform, both as good policy that equalizes treatment of drug spending between Medicaid managed care and fee-for-service programs and prevents drug carve outs, and to offset spending.*

Medicaid Managed Care Organization Provider Tax: ACAP also strongly supports a two-year extension of a provision of the Deficit Reduction Act of 2005 that allows for the continuation of provider taxes on Medicaid managed care organizations (MCOs) that states enacted before December 8, 2005. Eight states – including California, Georgia, Kentucky, Michigan Missouri, Ohio, Oregon and Pennsylvania – have relied on taxes on Medicaid MCOs to generate revenues for their state Medicaid programs. Although the grandfather for these eight states expires at the end of September 2009, the current economic crisis magnifies the loss of these funds to the Medicaid programs in those states.

Recommendation: *ACAP urges the Committee to include an extension of this provision through September 2011, so states can continue to sustain vital Medicaid services.*

Thank you for your efforts to reform the health care system and for this opportunity to submit comments on the policy options you are considering. If you have any questions or would like to follow-up on ACAP's comments, please do not hesitate to contact me at 202-204-7509 or at mmurray@communityplans.net.

Thank you again for your consideration of our comments.

Sincerely,

Meg Murray
Chief Executive Officer