

Medicare Payment Coalition for Frail Beneficiaries

FEINGOLD AMENDMENT

MEDICARE+CHOICE PAYMENT REFORM FOR SPECIALIZED PROGRAMS FOR FRAIL AND AT RISK BENEFICIARIES

(a) REVISIONS TO RISK ADJUSTMENT METHODOLOGY.—

(1) IN GENERAL.—The Secretary shall revise the risk adjustment methodology under section 1853(a)(3) of the Social Security Act (42 U.S.C. 1395w–23(a)(3)) applicable to payments to Medicare+Choice organizations offering specialized programs for frail elderly and at-risk beneficiaries to take into account variations in costs incurred by such organizations.

(2) METHODS CONSIDERED.—In revising the risk adjustment methodology under paragraph (1), the Secretary shall consider—

- A. hybrid risk adjustment payment systems, such as partial capitation,
- B. new diagnostic and service markers that more accurately predict high risk,
- C. improving the structural components of risk adjustment, such as reducing payment lag, to account for specific risk factors such as high end of life costs and high death rates;
- D. providing for adjustments to payment amounts for beneficiaries with comorbidities,
- E. testing concurrent risk adjustment methodologies,
- F. testing payment methods using data from specialized programs for frail elderly and at-risk beneficiaries, and
- G. the recommendations identified in the MedPAC report required under subsection (f).

(3) IMPLEMENTATION.—The Secretary shall implement such revisions to the risk adjustment methodology for items and services furnished on or after January 1, 2006.

(b) INTERIM CONTINUATION OF BLENDED RATE FOR SPECIALIZED PROGRAMS FOR FRAIL ELDERLY AND AT-RISK MEDICARE BENEFICIARIES RESIDING IN INSTITUTIONS.—

(1) IN GENERAL.—In the case of a Medicare+Choice organization that complies with the requirements under paragraph (2) and that offers a Medicare+Choice plan that provides for a specialized program for frail elderly and at-risk beneficiaries that exclusively serves beneficiaries in institutions or beneficiaries that are entitled to medical assistance under a state plan under Title XIX, notwithstanding section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(3)(C)(ii)), such organization shall be paid according to the method described in Section 1853(a)(3)(C)(ii)(I) until such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.— A Medicare+Choice organization may not qualify for the payment methodology under paragraph (1) unless the organization collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(c) INTERIM CONTINUATION OF PAYMENT METHODOLOGIES FOR DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, payment methodologies for Medicare demonstration programs for specialized programs for frail elderly and at-risk beneficiaries that comply with the requirements under paragraph (2) shall continue under the terms and conditions of the demonstration authority, including the risk adjustment factors and formula used for paying such demonstration programs, until such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.— A Medicare demonstration program may not qualify for the payment methodology under paragraph (1) unless the program collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(d) DEMONSTRATION PROGRAM FOR M+C PAYMENT REFORM FOR SPECIALIZED PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish a five year demonstration to develop and evaluate:

- A. payment models that pay appropriately for specialty M+C plans that exclusively serve or serve a disproportionate number of frail or at risk beneficiaries; and
- B. clinical models that improve outcomes beyond “usual care.”

(2) REQUIREMENTS.— Medicare+Choice organizations and their provider networks qualified to participate in this demonstration will meet the following requirements:

A. **Plan Composition:** Eligible plans and providers include those that:

- i. exclusively serve frail or at risk Medicare beneficiaries;
- ii. serve a disproportionate number of frail or at risk beneficiaries; or
- iii. serve a disproportionate number of dual eligibles.

B. **Clinical Capacity:** Plans or their provider networks must employ a clinical delivery system that meets the needs of frail or at risk enrollees, including—

- i. initiatives to prevent, delay, or minimize the progression of chronic disease and disabilities;
- ii. high-risk screening to identify risk of hospitalization, nursing home placement, functional decline, death, and other factors that increase the costs of care provided;
- iii. staff with special training in chronic care and geriatric care such as geriatricians, geriatric nurse practitioners, geriatric care managers, etc;

- iv. initiatives for promoting integration of care, financing, and administrative functions across health care settings; and
 - v. clinical protocols for specific high cost conditions identified by the Secretary for which outcomes will be evaluated as part of this demonstration.
- C. **Data Collection:** The organization must collect such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey or another appropriate mechanism.
- D. **Quality Assurance:** The organization must employ quality standards and track quality indicators specified by the Secretary that are relevant to the special needs of enrollees. Criteria for evaluating outcomes will be clearly defined in advance.

(3) PAYMENT

- A. Plans will be paid no less than 100% of FFS costs for a comparable case mix.
- B. The payment model will build upon the CMS-HCC 61 significant condition model.
- C. Plans will be paid under the standard 61-condition model for non-frail members and under a special frailty-adjusted payment for the frail or at risk members based on Part A and B benefit requirements.
- D. Plans that agree to an additional mandate for benefits exceeding Part A and B services will be compensated separately for these services.
- E. The frailty adjuster will be structured as an add-on in relation to the amount of underpayment resulting from the standard formula;(i.e., if a plan’s payment leads to a 10% underpayment, a plan’s total payments will be increased by 10%. Plan payments will be adjusted retroactively to keep pace with changes in the composition of the beneficiary pool).
- F. CMS will provide reinsurance above a specified threshold (e.g., the reinsurance could be based on one or more risk corridors where CMS reinsures a certain percentage of costs exceeding a predefined threshold. e.g., CMS pays 50% of excess costs for the first \$500,000 in excess costs, 75% of the next \$250,000 in excess costs, etc. The risk corridors could also be linked to total enrollment and risk, with the assumption that smaller plans with higher risk levels are less able to absorb large losses).
- G. Financial incentives will be included for plans and providers. “Bonus payments” will be made in relation to meeting predefined outcome targets.

(4) BUDGET NEUTRALITY will be determined as follows:

- A. For Medicare only beneficiaries, budget neutrality will be measured in relation to Medicare FFS payments for a comparable case mix.

- B. For dually eligible, the program will be considered budget neutral if total spending for Medicare and Medicaid does not exceed what the two programs combined would have spent for a comparable case mix absent the demonstration.
- C. Budget neutrality will be applied in relation to Medicare or dually eligible beneficiaries participating in the demonstration, not to all individuals eligible to participate in the service area.

(5) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary to carry out this demonstration program.

(6) **FUNDING.**—There are authorized to be appropriated to the Secretary \$25,000,000 for carrying out the demonstration program under this subsection.

(e) MEDPAC STUDY TO IDENTIFY FRAILTY INDICATORS AND DEVELOP FRAILTY ADJUSTMENT TO M+C PAYMENTS

(1) **In General**-- Congress shall direct the Medicare Payment Advisory Commission, in consultation with private organizations representing Specialty M+C plans and providers, to evaluate and report to Congress and the Secretary on a frailty adjustment to the M+C risk adjustment methodology that ensures appropriate payment for M+C plans that serve a disproportionate number of frail or at risk Medicare beneficiaries.

(2) **Study Parameters:** The study will identify indicators of frailty, medical complexity or risk that result in higher costs for certain risk groups within the Medicare population such as institutionalized residents, nursing home certifiable residents living in the community, beneficiaries with multiple complex chronic conditions, those with functional or cognitive impairments that limit their ability to live independently and other indicators of higher health care utilization.

(3) **Frailty Indicators:** Indicators may include specific diagnoses or clusters of diagnoses; the presence of multiple serious chronic conditions; certain groupings of chronic conditions; the presence of functional impairments or, alone or in combination with diagnostic factors, a specific hierarchy of functional loss; or other factors that result in the need for complex medical care and/or higher medical costs.

(4) MedPAC shall submit to Congress and the Secretary recommendations on a frailty adjustor to the M+C risk adjustment methodology within 24 months of enactment

(f) DEFINITIONS.—

(1) **Specialized Programs for Frail and At Risk Beneficiaries:** In this section, the term “specialized programs for frail elderly and at-risk beneficiaries” means—

- A. demonstrations approved by the Secretary for purposes of testing the integration of acute and expanded care services, under prepaid financing, which include, but are not limited to prescription drugs and other non-covered ancillary services, care coordination, and home and community-based services, such as the social health maintenance organization demonstration project authorized under section 2355 of the Deficit Reduction Act of 1984 and expanded under section 4207(b)(4)(B)(i) of the Omnibus Reconciliation Act of 1990;

- B. demonstrations approved by the Secretary for purposes of improving quality of care and preventing hospitalizations for nursing home residents, such as the EverCare demonstration project;
- C. demonstrations approved by the Secretary for purposes of testing methods for integrating medicare and medicaid benefits for the dually eligible, such as the Minnesota Senior Health Options program, the Wisconsin Partnership program, the Massachusetts Senior Care Organization program, and the Rochester Community Care Network program;
- D. demonstrations approved by the Secretary under subsection (d); and
- E. such other demonstrations or programs approved by the Secretary for similar purposes, as determined by the Secretary.

(2) “Frail or at risk beneficiary” means an individual who:

- A. has a level of disability such that the individual is unable to perform for a period of at least 90 days due to a loss of functional capacity—
 - (i) at least 2 activities of daily living; or
 - (ii) such number of instrumental activities of daily living that is equivalent (as determined by the Secretary) to the level of disability described in clause (i);
- B. requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment;
- C. has multiple medically complex chronic conditions;
- D. is at risk of hospitalization, nursing home placement, functional decline, or death within twelve months or other factors that increase the costs of medical care;
- E. has a severity of condition that makes the individual frail or disabled (as determined under guidelines approved by the Secretary).

(3) “Activities of Daily Living” means each of the following:

- A. Eating.
- B. Toileting.
- C. Transferring.
- D. Bathing.
- E. Dressing.
- F. Continence.

(4) “Disproportionate” in relation to plan composition means a higher percentage of frail or at risk beneficiaries than the national average for all Medicare+Choice plans.

(g) EFFECTIVE DATE: Upon Enactment