The Medicare Modernization Act May Help ALFs

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While seniors increasingly see assisted living facilities as a viable living option, ALF financing and regulations continue to limit the ability of many providers to serve residents with more extensive care needs. However, help may be on the way.

The Medicare Modernization Act (MMA) contains provisions to establish Special Needs Plans (SNPs) that specialize in care of high-risk beneficiaries. ALFs can explore options for developing or affiliating with SNPs as a means of enhancing their long term care service capabilities.

What is a SNP?

A SNP is a specialized Medicare Advantage (MA) plan that exclusively or disproportionately serves "special needs individuals." MMA defines "special needs" people as persons dually eligible for Medicare and Medicaid, people living in an institution or in the community with similar needs, and individuals with severe or disabling chronic conditions. Persons residing in a long term care facility for 90 days or more, including those living in a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility for the mentally retarded (ICF/MR), or an inpatient psychiatric facility are eligible. While this "institutional" definition does not include ALFs specifically, it does include persons living in the community with

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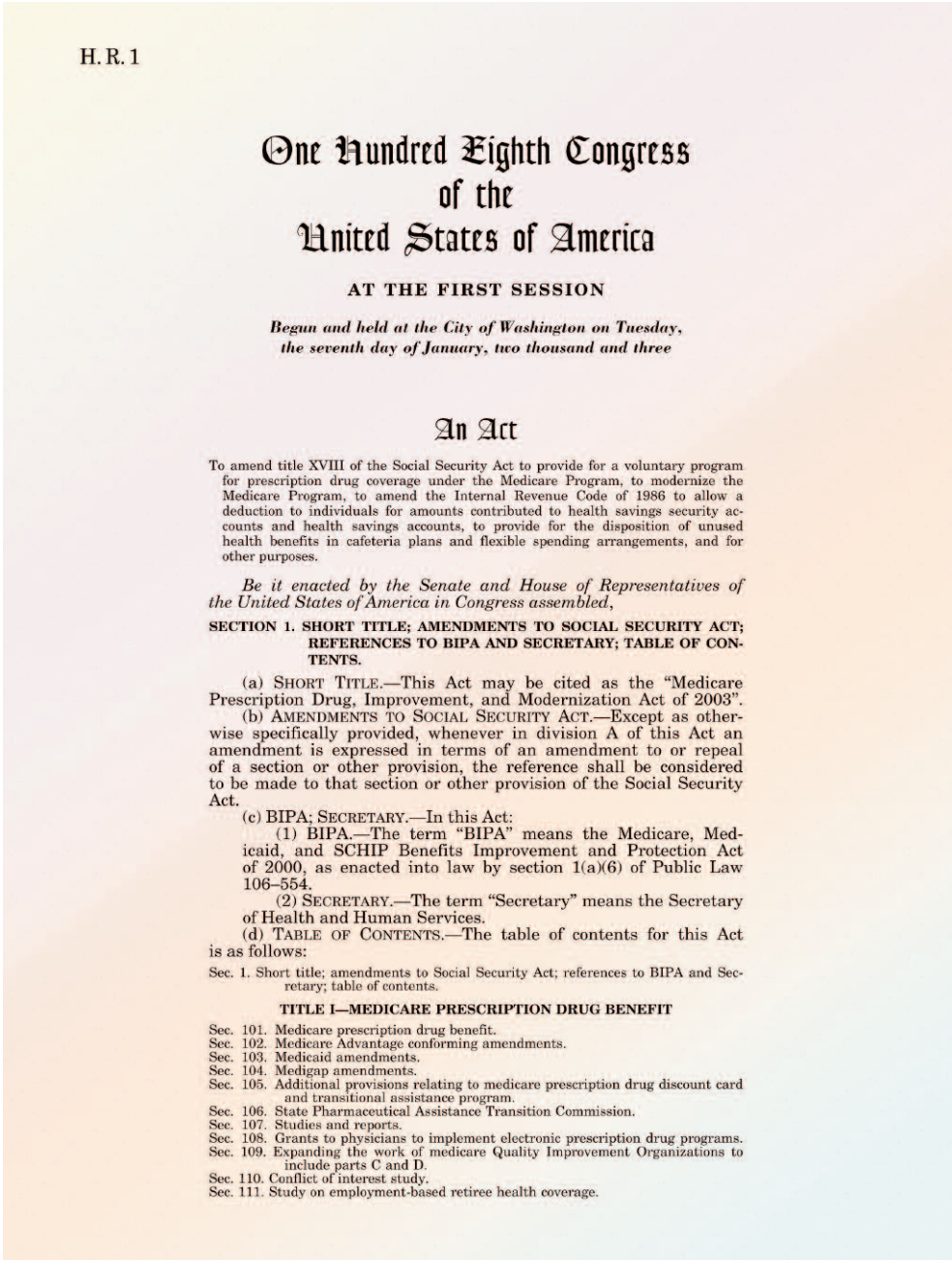

H. R. 1

One Hundred Eighth Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the seventh day of January, two thousand and three

An Act

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in division A of this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Medicare prescription drug benefit.
Sec. 102. Medicare Advantage conforming amendments.
Sec. 103. Medicaid amendments.
Sec. 104. Medigap amendments.
Sec. 105. Additional provisions relating to medicare prescription drug discount card and transitional assistance program.
Sec. 106. State Pharmaceutical Assistance Transition Commission.
Sec. 107. Studies and reports.
Sec. 108. Grants to physicians to implement electronic prescription drug programs.
Sec. 109. Expanding the work of medicare Quality Improvement Organizations to include parts C and D.
Sec. 110. Conflict of interest study.
Sec. 111. Study on employment-based retiree health coverage.

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similar needs, including those living in AL settings.

Obtaining SNP Status

Reportedly, over 150 applications have been made to the Centers for Medicare and Medicaid Services (CMS) for SNP designation. Sixty-eight SNPs already have been approved. Most of the approved plans specialize in care for persons dually eligible for Medicare and Medicaid or for persons living in institutions or in the community with similar needs. Evercare plans, plans functioning under dually eligible demonstrations in Minnesota, Wisconsin, and Massachusetts, and several Social HMO demonstration sites are transitioning to SNP status.

There are five factors that make this legislation particularly important to ALFs:

- *Exclusive enrollment.* The statute allows SNPs to restrict their enrollment to a defined special needs population, including the possibility of limited enrollment to a specific set of care facilities.
- *Open enrollment.* Dually eligible and institutional beneficiaries have special election periods that allow them to enroll or disenroll from SNPs in any given month. This exemption from "lock-in" will allow "special need individuals" to enroll in a SNP as soon as their health need dictates, rather than wait for the annual enrollment period established for standard MA plans.
- *Foundation for serving the dually eligible.* Many long term care recipients, because of low income or after spending down their resources on long term care services, become dually eligible for Medicare and Medicaid. While most states do not offer opportunities for integration of Medicare and Medicaid, this legislation offers the potential for more extensive integration of Medicare and Medicaid outside of demonstration status. CMS currently is transitioning three dual eligible demonstrations to SNP status. This will establish a precedent for how and to what extent dual SNPs will be able to continue integrating financing and service delivery. To the degree that ALFs can work with CMS and states to integrate Medicare and Medicaid funding, the SNP legislation may provide a more flexible vehicle for offering a more comprehensive array of long term care services.
- *Risk-adjusted financing.* While SNPs are paid under the same financing structure as other MA plans, CMS is moving toward risk-adjusted payment, which will result in higher payments to SNPs for high-risk beneficiaries than the original demographic-based model of Medicare managed care financing. This will provide the incentive and means for developing specialized interventions for high-risk beneficiaries.
- *New quality measures.* CMS is beginning to explore new ways to monitor quality for SNPs that are more appropriate for providers who serve persons with multiple, complex, and ongoing care needs. Such measures will allow SNPs, related care providers, and CMS to more appropriately assess *total* quality and cost performance in serving high-risk beneficiaries.
- *Specialized pharmacy benefit.* While SNPs plans also operate under the same regulations as other MA plans, the former are more likely to establish formularies and pharmacy management methods more appropriate for persons requiring multiple medications since high-risk beneficiaries are the focus of the SNP legislation.
- *Umbrella for LTC innovation.* While the current SNP legislation is limited in scope, the SNP legislation offers organizations interested in specializing in care for high-risk beneficiaries a vehicle for developing chronic care service innovations under mainstream financing. Virtually all of the national elderly managed care demonstrations are developing initiatives under the new SNP legislation, including Evercare, the dually eligible demonstration sites, Social HMOs, and On Lok.

Despite the fact that the legislation does not designate ALFs as "institutional" providers, ALFs do represent a specialty care approach to serving high-risk beneficiaries.

Given these business opportunities, ALFs should explore options for tapping into this new arena. ALFs should:

- Identify organizations that may be developing a SNP in their area.
- Assess the SNP's benefit package in relation to other financing options.
- Assess the advantages and disadvantages of the SNP plan in providing drugs, supplemental Medicare benefits, and long term care benefits for their residents.
- Assess opportunities for contracting with or partnering with a SNP or establishing their own ALF-related SNP.

Most ALFs are not likely to have a large enough resident population, managed care expertise, or financing resources to develop a SNP on their own. However, given the high level of interest in SNP development, there

are likely to be a number of partnership opportunities in most areas of the country. While the benefit package and approach will vary significantly from one SNP to another, all SNPs are likely to be offering an array of benefits and services that will be of greater benefit to ALF residents than other MA or fee-for-service financing alternatives. SNPs also will have the business interest, flexibility, and financial incentive to help ALFs increase their capabilities for being a low-cost/high-quality provider of care for high-risk beneficiaries.

ALFs who are interested in exploring a business partnership with an existing SNP or developing one of their own, should keep in mind that all SNPs must work within the context of existing MA law and within existing state rules and regulations governing Medicaid expenditures. ALFs with sites in more than one state should keep in mind that existing legislation does not allow for national SNPs to be created; instead, they must be regional or community based. However, the new SNP legislation provides a legislative umbrella for a broad spectrum of program innovation to emerge that should interest ALFs.

Despite that fact that the legislation does not designate ALFs as an "institutional" provider, ALFs do represent a specialty care approach to serving high-risk beneficiaries. At a minimum, ALF residents who meet nursing home level of care equivalence standards would qualify as "special needs individuals" under the current SNP institutional definition, without statutory amendments.

Theoretically, it is possible for a multi-state AL company to have enough qualified "special needs individuals" within a given region to warrant developing a SNP for a specific group of ALFs. The keys to success are:

- Assuming risk for the total array of services
- Determining how to reduce hospital and medical costs for high-risk patients
- How to efficiently package an array of personal care and long term care services so that ALF residents don't have to move to a nursing home when their health care needs become more complicated

Getting around the Definition Gap

The definition of LTC facilities, which excludes ALFs, is significant because it gives LTC facility residents three unique benefits under the Medicare Modernization Act that ALF residents are not entitled to, including access to a special enrollment period allowing them to change plans at any time, no cost sharing for dually eligible residents, and coverage of special packaging and other special pharmacy services available through the Medicare Part D benefit. However, it is not clear whether assisted living leaders should seek inclusion of ALFs in the definition of "institutional providers" who care for "special needs individuals."

In most cases, ALFs would be better off partnering with an organization that has the managed care financing and clinical capability necessary to effectively control acute care costs and improve outcomes.

MA payment under the "institutional rate cell" is changing; and it is not clear if ALFs would be better served under an institutional rate cell that includes the cost of their residence and the cost of the a resident's care of if ALFs would be better off charging separately for housing and services, with service costs financed through SNP financing. Much is dependent on the effects of state decisions regarding the funding of Medicaid services in general and the adequacy of CMS-HCC payment levels for high-risk beneficiaries.

SNPs and all other MA plans are still financed in part through a formulary that under pays plans for its highest risk beneficiaries, in relation to fee-for-service financing. It is still unclear what effect the transition to full-risk adjustment and any anticipated changes in the formula (including the potential application of a frailty adjuster) will have on SNP payment rates.

However, it is clear that a large number of plans have concluded that the existing payment levels are adequate to enter the market of specialized managed care. Under current or future funding, a key element to improving the long-term viability of ALFs as an alternative to nursing home care under a SNP strategy is capturing some or all of Medicare and Medicaid financing associated with each ALF resident. It also will be important to reduce hospital costs and medical costs to compensate for the cost of interventions that help a person optimize their health and well being in their chosen residence.

Promising Partnerships

In most cases, an ALF would be better off partnering with an organization that has the managed care financing and clinical capability necessary to effectively control acute care costs and improve outcomes. In some cases, it may be feasible and preferable for an ALF to develop the financing and care capabilities in-house. Under either option, the more fully a state integrates Medicare and Medicaid under a common capitation using an integrated approach to plan oversight, the more viable it will be for ALFs to develop the kind of interventions

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the resident's calcium and vitamin D intake, history of falls and fractures, and his or her overall risk for osteoporosis. He added that it is important to remind people that men aren't immune from osteoporosis and that, even though the disease doesn't necessarily have overt symptoms in the early stages, it can be very detrimental to residents if it goes untreated. He also noted, "People need to realize that osteoporosis is preventable. But even if they are diagnosed with this condition, it is treatable. Bone loss can be stopped and even reversed."

There are several keys to osteoporosis prevention, including:

- Regular, weight-bearing exercise
- Intake of daily recommended amounts of calcium or vitamin D
- Avoidance of smoking and excessive alcohol consumption

"Exercise and stretching are very important. They help increase strength and balance, thereby helping to prevent falls," Dr. Simonson observed. "The incidence of falls in seniors is massive; and falls are a common cause of accidents, even death."

Increasing awareness, diagnosis, and treatment of osteoporosis among residents is a win-win proposition for assisted living facilities. Everyone benefits from these efforts. However, facility leadership and practitioners who care for residents must be the drivers and work together to keep seniors safe and satisfied in their homes. ALC

Joanne Kaldy is Managing Editor of *Assisted Living Consult.*

References

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necessary to serve as a stable, low-cost/high-quality business strategy for people with serious and disabling chronic conditions.

Under a more fully integrated approach, providers have the flexibility to offer whatever combination of care and services are most clinically effective for an individual without running afoul of Medicare or Medicaid eligibility and coverage rules. This includes providing coverage for long term care and other services that Medicare does not cover.

In developing an ALF/SNP approach, it is also important to keep in mind that under the MMA, the financing of pharmacy benefits will shift from Medicaid to Medicare. Currently, some state Medicaid agencies, such as Washington and Wisconsin, pay ALFs and other specialty providers to provide special packaging of pharmacy services for persons who are dually eligible for Medicare and Medicaid. The assumption is that these dispensing services helped reduce the state's financial burden by reducing premature nursing home placement through an optimization of medication management.

It is not clear how these agreements will work under the new Medicare law. Even if ALFs became classified as an institutional facility, it is not clear that CMS would adopt the same pharmacy policies that some State Medicaid agencies have adopted for ALFs.

The jury is still out on how the Special Needs Plan legislation will affect ALFs over the long-term. However, it is clear that the legislation has "the potential" to strengthen the ability of ALFs to serve high-risk Medicare and Medicaid beneficiaries under a variety of new and yet to be defined, business structures. The more adventuresome ALFs that are interested in exploring their options should keep in mind that:

- Pharmacy policies that are now under the jurisdiction of Medicare and CMS rules governing the new pharmacy benefit.
- Options for serving the dually eligible are significantly related to the degree to which states are willing to pursue waivers and/or modification of Medicaid policy supportive of ALFs and the degree to which CMS is willing or able to recognize ALFs as an institution and/or support more of an integrated strategy for serving special needs individuals.
- The adequacy of SNP payment for ALF services is in large part determined by payment rates established by State Medicaid agencies, and the adequacy of the CMS-HCC payment method for high-cost Medicare beneficiaries.
- The ability for any one ALF to effectively serve as a nursing home alternative is significantly dependent on their ability (individually or in partnership with others) to control acute care costs on the Medicare side and control LTC expenditures on the Medicaid side.

ALFs interested in exploring a SNP option need to do what they have always done best—separate themselves from the pack by serving as a high quality/low cost provider and delivering the services that seniors want by being "special." It will become increasingly important to demonstrate those special features not only to ALF residents and potential SNP business partners but also to regulators and policy makers.

There are still a lot of unknowns, and the winners and losers in the marketplace will be determined—in part—by the skills, capabilities, and creative energies of those leading the way in SNP development. ALC

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