

# HR 3162: Children's Health and Medicare Protection Act of 2007 (Key SNP Related Provisions)

## SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR SPECIAL NEEDS PLANS (SNPS).

- . (a) Extending Restriction on Enrollment Authority for SNPs for 3 Years- Subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w-28) is amended by striking `2009' and inserting `2012'.
- 0. (b) Structure of Authority for SNPs-
  - 0. (1) IN GENERAL- Such section is further amended--
    - 0. (A) in subsection (b)(6)(A), by striking all that follows  
`means' and inserting the following: `an MA plan--
      - 0. (i) that serves special needs individuals (as defined in subparagraph (B));
      - 0. (ii) as of January 1, 2009--
        - 0. (I) at least 90 percent of the enrollees which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007;
        - 0. (II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); or
        - 0. (III) at least 90 percent of the enrollees in which have a severe or disabling chronic condition of the type that the plan is committed to serve as indicated by the data submitted for the risk-adjustment of plan payments; and
      - 0. (iii) as of January 1, 2009, meets the applicable requirements of paragraph (2) or (3) of subsection (f), as the case may be.'; and
    - 0. (B) in subsection (f)--
      - 0. (i) by amending the heading to read as follows:  
`Requirements for Enrollment in Part C Plans for Special Needs Beneficiaries';
      - 0. (ii) by designating the sentence beginning `In the case of' as paragraph (1) with the heading  
`REQUIREMENTS FOR ENROLLMENT- ' and with appropriate indentation; and
      - 0. (iii) by adding at the end the following new paragraphs:
        - 0. (2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS- In

the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(I), the applicable requirements of this subsection are as follows:

- 0. ` (A) The plan has an agreement with the State that includes provisions regarding cooperation on the coordination of care for such individuals. Such agreement shall include a description of the manner that the State Medicaid program under title XIX will pay for the costs of services for individuals eligible under such title for medical assistance for acute care and long-term care services.
- 0. ` (B) The plan has a contract with long-term care facilities and other providers in the area sufficient to provide care for enrollees described in subsection (b)(6)(B)(i).
- 0. ` (C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(I) for such plans.

0. ` (3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS- In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(II), the applicable requirements of this subsection are as follows:

- 0. ` (A) The plan has an agreement with the State Medicaid agency that--
  - 0. ` (i) includes provisions regarding cooperation on the coordination of the financing of care for such individuals;
  - 0. ` (ii) includes a description of the manner that the State Medicaid program under title XIX will pay for the costs of cost-sharing and supplemental services for individuals enrolled in the plan eligible under such title for medical assistance for acute and long-term care services; and
  - 0. ` (iii) effective January 1, 2011, provides for capitation payments to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).

0. ` (B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-pocket costs for same services permitted for such individuals under title XIX.

0. ` (C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(II) for such plans.

0. ` (4) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS- In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(III), the applicable requirements of this subsection are as follows:

- 0. ` (A) The plan is designated to serve, and serves, Medicare

beneficiaries with one or more of the following specific severe or disabling chronic conditions:

- 0. ` (i) Cardiovascular.
- 0. ` (ii) Cerebrovascular.
- 0. ` (iii) Congestive health failure.
- 0. ` (iv) Diabetes.
- 0. ` (v) Chronic obstructive pulmonary disease.
- 0. ` (vi) HIV/AIDS.
- 0. ` (B) The plan has an average risk score under section 1853(a)(1)(C) of 1.35 or greater.
- 0. ` (C) The plan has established and actively manages a chronic care improvement program under section 1852(e)(2) for each of the conditions that it serves under subparagraph (A) that significantly exceeds the features and results of such programs established and managed by Medicare Part C plans that are not specialized Medicare Part C plans for special needs individuals of the type described in this paragraph.
- 0. ` (D) The plan has a network of a sufficient number of primary care and specialty physicians, hospitals, and other health care providers under contract to the plan so that the plan can clearly meet the routine and specialty needs of the severely ill and disabled enrollees of the plan throughout the service area of the plan.
- 0. ` (E) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(III) for such plans.'
- 0. (2) QUALITY STANDARDS AND QUALITY REPORTING- Section 1852(e)(3) of such Act (42 U.S.C. 1395w-22(e)(3) is amended--
- 0. (A) in subparagraph (A)(i), by adding at the end the following: ` In the case of a specialized Medicare Part C plan for special needs individuals described in paragraph (2), (3), or (4) of section 1859(f), the organization shall provide for the reporting on quality measures developed for the plan under subparagraph (D)(iii).'; and
- 0. (B) in subparagraph (D), as added by section 422(a)(1), by adding at the end the following new clause:
- 0. ` (iii) SPECIFICATION OF ADDITIONAL QUALITY MEASUREMENTS FOR SPECIALIZED PART C PLANS- For implementation for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of--
- 0. ` (I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical

- assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries;
0. (II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution; and
0. (III) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(III)) that serve predominantly individuals with severe or disabling chronic conditions by measuring the special needs for care of such individuals.'
0. (3) EFFECTIVE DATE; GRANDFATHER- The amendments made by paragraph (1) shall take effect for enrollments occurring on or after January 1, 2009, and shall not apply--
0. (A) to a Medicare Advantage plan with a contract with a State Medicaid integrated Medicare-Medicaid plan program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004; and
0. (B) to plans that are operational as of the date of the enactment of this Act as approved Medicare demonstration projects and that provide services predominantly to individuals with end-stage renal disease.
0. (4) TRANSITION FOR NON-QUALIFYING SNPS-
0. (A) RESTRICTIONS IN 2008 FOR CHRONIC CARE SNPS- In the case of a specialized MA plan for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w-28(b)(6)(A)) that, as of December 31, 2007, is not described in either subclause (I) or subclause (II) of clause (ii) of such section, as amended by paragraph (1), then as of January 1, 2008--
0. (i) the plan may not be offered unless it was offered before such date;
0. (ii) no new members may be enrolled with the plan; and
0. (iii) there may be no expansion of the service area of such plan.
0. (B) TRANSITION OF ENROLLEES- The Secretary of Health and Human Services shall provide for an orderly transition of

those specialized MA plans for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w-28(b)(6)(A)), as of the date of the enactment of this Act), and their enrollees, that no longer qualify as such plans under such section, as amended by this subsection.

- 0. (c) Sunset of Additional Designation Authority-
- 0. (1) IN GENERAL- Subsection (d) of section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) is repealed.
- (2) EFFECTIVE DATE- The repeal made by paragraph (1) shall take effect on January 1, 2009, and shall apply to plans offered on or after such date.

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**SEC. 413. MA PLAN ENROLLMENT MODIFICATION**

- 0. (c) Improved Enrollment Policies-
- (1) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES-
  - (A) IN GENERAL- Section 1851(e) of such Act (42 U.S.C. 1395w-21(e)) is amended by adding at the end the following new paragraph:
  - 0. (7) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES- In no case may the Secretary provide for the enrollment in a MA plan of a Medicare Advantage eligible individual who is eligible to receive medical assistance under title XIX as a full-benefit dual eligible individual or a qualified medicare beneficiary, without the affirmative application of such individual (or authorized representative of the individual) to be enrolled in such plan.'
  - 0. (B) NO APPLICATION TO PRESCRIPTION DRUG PLANS- Section 1860D-1(b)(1)(B)(iii) of such Act (42 U.S.C. 1395w-101(b)(1)(B)(iii)) is amended--
    - 0. (i) by striking 'paragraph (2) and' and by inserting 'paragraph (2),'; and
    - 0. (ii) by inserting ', and paragraph (7),' after 'paragraph (4)'.
  - (C) EFFECTIVE DATE- The amendments made by this paragraph shall apply to enrollments that are effective on or after the date of the enactment of this Act.

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**SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAYMENTS.**

- 0. (a) In General- Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395-23(a)(1)(C)).
- 0. (b) Particulars- The report under subsection (a) shall include an evaluation of at least the following:
  - 0. (1) The need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with co-morbid conditions and associated cognitive impairments.
  - 0. (2) The need and feasibility of including further gradations of diseases and conditions (such as the degree of severity of congestive heart failure).
  - 0. (3) The feasibility of measuring difference in coding over time between Medicare part C plans and the medicare traditional fee-for-service program and, to the extent this difference exists, the options for addressing it.
  - (4) The feasibility and value of including part D and other drug utilization data in the risk adjustment model.

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**SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE ADVANTAGE PLANS AND FEE-FOR-SERVICE MEDICARE.**

- . (l) Determination of Blended Benchmark Amount-
  - ` (1) IN GENERAL- For purposes of subsection (j), subject to paragraphs (2) and (3), the term `blended benchmark amount' means for an area--
    - ` (A) for 2009 the sum of--
      - ` (i) 2/3 of the applicable amount (as defined in subsection (k)(1)) for the area and year; and
      - 0. ` (ii) 1/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year;
    - 0. ` (B) for 2010 the sum of--
      - 0. ` (i) 1/3 of the applicable amount for the area and year; and
      - 0. ` (ii) 2/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year; and
    - 0. ` (C) for a subsequent year the amount specified in subsection (c)(1)(D)(i) for the area and year.
  - (2) FEE-FOR-SERVICE PAYMENT FLOOR- In no case shall the blended benchmark amount for an area and year be less than the amount specified in subsection (c)(1)(D)(i) for the area and year.
  - ` (3) EXCEPTION FOR PACE PLANS- This subsection shall not apply to payments to a PACE program under section 1894.'

**SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.**

0. (c) Minimum Medical Loss Ratio- Section 1857(e) of the Social Security Act (42 U.S.C. 1395w-27(e)) is amended by adding at the end the following new paragraph:

` (4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO- If the Secretary determines for a contract year (beginning with 2010) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(j)(4)) of at least .85--

` (A) for that contract year, the Secretary shall reduce the blended benchmark amount under subsection (l) for the second succeeding contract year by the number of percentage points by which such loss ratio was less than 85 percent;

0. ` (B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

` (C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.'.

0. (e) MedPAC Report on Varying Minimum Medical Loss Ratios-

(1) STUDY- The Medicare Payment Advisory Commission shall conduct a study of the need and feasibility of providing for different minimum medical loss ratios for different types of Medicare Part C plans, including coordinated care plans, group model plans, coordinated care independent practice association plans, preferred provider organization plans, and private fee-for-services plans.

(2) REPORT- Not later than 1 year after the date of the enactment of this Act, submit to Congress a report on the study conducted under paragraph (1).