

## Calendar No. 182

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SENATE

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### COMMUNITY BASED INDEPENDENCE FOR SENIORS ACT

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JULY 30, 2015.—Ordered to be printed  
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Mr. HATCH, from the Committee on Finance,  
submitted the following

### R E P O R T

[To accompany S. 704]

The Committee on Finance, to which was referred the bill (S. 704) to establish a Community-Based Institutional Special Needs Plan demonstration program to target home and community-based care to eligible Medicare beneficiaries, having considered the same, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

#### I. LEGISLATIVE BACKGROUND

The Committee on Finance, to which was referred the bill (S. 704) to establish a Community-Based Institutional Special Needs Plan demonstration program to target home and community-based care to eligible Medicare beneficiaries, reports favorably thereon with an amendment and recommends that the bill, as amended, do pass.

##### *Background and need for legislative action*

Medicare covers a broad range of medical treatments, services, and equipment needed by beneficiaries, but there are limitations to Medicare's coverage. To be covered by Medicare, items or services must be considered reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a body part.<sup>1</sup> Medicare law defines categories of services and items that Medicare routinely covers, but Medicare, unlike Medicaid, does not cover long-term services and supports (LTSS) such as

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<sup>1</sup> Social Security Act (SSA) Sec. 1862(a)(1).

services provided by personal care attendants, homemaker services, home delivered meals, and safety equipment.<sup>2</sup>

Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per-person amount to provide all Medicare covered benefits (except hospice) to beneficiaries who enroll in their plan. Medicare beneficiaries who are eligible for Part A, enrolled in Part B, and do not have end-stage renal disease are eligible to enroll in an MA plan if one is available in their area. In general, MA plans offer additional benefits or require smaller co-payments or deductibles than original Medicare. Sometimes beneficiaries pay for these additional benefits through a higher monthly premium, but sometimes they are financed through plan savings. The extent of extra benefits and reduced cost-sharing varies by plan type and geography.

The Committee recognizes the success of the Medicare Advantage program and the potential for plans to provide additional services that could prevent or delay low-income Medicare beneficiaries from needing institutional services. The bill creates a demonstration project to authorize up to five Medicare Advantage plans to use their rebate dollars to provide eligible enrollees with supplemental benefits that allow for care to be delivered in the community, and to test whether these plans can prevent or delay beneficiaries from receiving services in an institution.

## II. EXPLANATION OF THE BILL

### PRESENT LAW

The Medicare Modernization Act of 2003 (MMA, P.L. 108–273) established a new type of Medicare Advantage (MA) plan to coordinate care and to focus on individuals with special needs.<sup>3</sup> Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized (I–SNPs), (2) dually eligible (D–SNPs), and/or (3) individuals with severe or disabling chronic conditions (C–SNPs) who would benefit from enrollment in a coordinated care plan.

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including: state licensure as a risk-bearing entity; MA reporting requirements that are applicable depending on plan size; and Part D prescription drug benefit requirements. SNP payment procedures mirror CMS’s procedures for MA plans. SNPs prepare and submit a bid like other MA plans, and are paid in the same manner as other MA plans based on the plan’s enrollment and risk adjustment payment methodology. In addition to the MA requirements, SNPs must have evidenced-based models of care (MOC) tailored to the special health needs of the SNP’s target population.<sup>4</sup> A National Committee for Quality Assurance approval process that includes eleven clinical and non-clinical elements is used to evaluate SNP MOCs.

<sup>2</sup> For more information on Medicaid coverage, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell and CRS Report R43495 and *Long-Term Services and Supports: In Brief*, by Kirsten J. Colello.

<sup>3</sup> SSA Sec. 1859(f) Requirements Regarding Enrollment in Specialized MA Plans for Special Needs Individuals.

<sup>4</sup> SSA Sec. 1859(f)(5), Care Management Requirements.

In May 2015, there were approximately 541 SNPs—336 D–SNP plans, 148 C–SNP plans, and 57 I–SNP plans—that had about 2.1 million enrollees—1.7 million enrollees in D–SNPs, 317,476 enrollees in C–SNPs and 50,000 enrollees in I–SNPs.

*Availability of long term services and supports to Medicare beneficiaries*

The Patient Protection and Affordable Care Act (ACA, P.L. 111–148) authorized MA senior housing facility plans to continue operating indefinitely if they participated in a demonstration prior to January 1, 2010 and they were offered for at least one year.<sup>5</sup> MA plans generally are required to serve areas no smaller than a county, which prevents plans from targeting smaller areas that might have a disproportionate number of healthier enrollees with lower health costs. MA senior housing facility plans may limit their service area to a senior housing facility located in a geographic area.<sup>6</sup> MA senior housing facility plans also must restrict enrollment to residents of a continuing care retirement community.<sup>7</sup> In addition to complying with all MA requirements, MA senior housing facility plans must provide primary care services onsite and have a ratio of accessible physicians to beneficiaries determined appropriate by the Secretary and supply transportation services to beneficiaries to specialty health care providers located outside the facility.

State Health Insurance Counseling and Assistance Programs (SHIPs) and other entities provide outreach activities such as counseling, education, enrollment assistance, health promotion, and other activities to help low-income Medicare beneficiaries understand their health insurance choices so they can make informed decisions. Outreach services, including counseling, are not health services, but are services to help beneficiaries find and make best use of the health programs to which they are entitled. SHIP authority was established with the creation of Medicare Part C, Medicare’s competitive health plan option, Medicare Advantage (previously referred to as Medicare Choice, Medicare + Choice).<sup>8</sup>

REASONS FOR CHANGE

The Committee recognizes the success of the Medicare Advantage program and the potential for plans to provide additional services that could prevent or delay low-income Medicare beneficiaries from needing institutional services. The bill creates a demonstration project to authorize up to five Medicare Advantage plans to use their rebate dollars to provide eligible enrollees with supplemental benefits that allow for care to be delivered in the community.

<sup>5</sup>The MA senior housing facility plan demonstration was established by the Secretary, see the Patient Protection and Affordable Care Act, Section 3208. Making Senior Housing Facility Demonstration Permanent.

<sup>6</sup>SSA Sec. 1859(g)(1), Special Rules for a Senior Housing Facility Plan.

<sup>7</sup>SSA Sec. 1852(l)(4)(B), Continuing Care Retirement Communities are an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

<sup>8</sup>SHIPs were authorized under a grant program in the Omnibus Budget Reconciliation Act of 1990 (P.L. 105–508), Sec. 4360, Health Insurance Information, Counseling, and Assistance Grants.

## EXPLANATION OF PROVISION

This bill would require the Secretary to establish a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program intended to prevent or delay low-income Medicare beneficiaries from receiving services in an institution.

The Secretary would be required to enter into agreements with up to five eligible MA plans to participate in the CBI-SNP demonstration. The Secretary also would be authorized to permit each participating MA plan to enroll up to 1,000 frail, low-income Medicare beneficiaries in the program. The MA plans participating in the CBI-SNP demonstration would be authorized to use their rebate dollars to provide eligible enrollees with supplemental benefits that could include LTSS the Secretary determines to be appropriate such as the following:

- homemaker services;
- home-delivered meals;
- transportation services;
- respite care;
- adult day care services; and
- non-Medicare-covered safety and other equipment.

MA SNPs that meet the following conditions would be eligible to participate in the CBI-SNP demonstration

- has offered SNPs to nursing home-eligible, non-institutionalized Medicare beneficiaries living in the community;
- has worked with low income beneficiaries, including low income beneficiaries eligible for both Medicare and Medicaid (dual-eligibles);
- is located in a state that agrees to make Medicaid data available to conduct an independent evaluation; and
- meets other conditions determined by the Secretary.

Low-income Medicare beneficiaries must meet the following conditions to participate in the CBI-SNP demonstration:

- be eligible for Medicare Advantage;
- meet the income (less than 150% of the federal poverty limit) and asset requirements for a Medicare Part D low-income subsidy (LIS),
- is not eligible for Medicaid;
- has at least two limitations in activities of daily living (ADLs) as defined under the Internal Revenue Code of 1986; and
- is at least age 65.

The Secretary would be authorized to permit beneficiaries certain exceptions to the normal annual coordinated election period. Beneficiaries eligible for the CBI-SNP demonstration could dis-enroll at any time from an MA plan that was not participating in the CBI-SNP and then enroll in an MA plan that was participating in the CBI-SNP demonstration as long as the eligible beneficiary resided in the CBI-SNP demonstration plan's service area. In addition, beneficiaries eligible to participate in the CBI-SNP demonstration who were enrolled in original Medicare (fee-for-service) and a Medicare Part D plan could dis-enroll at any time from original Medicare and Part D plans and enroll in a CBI-SNP as long as the eligible beneficiaries resided in the CBI-SNP demonstration plan's service area.

The Secretary would be required to help educate eligible Medicare beneficiaries about the availability of the CBI-SNP demonstration through beneficiary outreach assistance programs such as SHIPs and other organizations that assist Medicare beneficiaries with enrollment and eligibility information.

#### EVALUATION AND EXPANSION

The Secretary will ensure the CBI-SNP demonstration is budget neutral. Taking into account the evaluation described below, the Secretary may expand the duration and scope of the CBI-SNP demonstration if:

- the expansion is expected to improve the quality of care (as defined by the CMS Administrator) without increasing net Medicare and Medicaid expenditures, or reduce spending without reducing the quality of care;
- the Chief Actuary of CMS certifies that the expansion would not increase net program spending; and
- the expansion would not deny or limit the coverage or provision of benefits to applicable individuals.

If the Secretary determined that the CBI-SNP demonstration was expected to reduce Medicare and Medicaid spending without reducing quality of care or improved quality without increasing spending, then the Secretary would be authorized to expand the duration and scope of the CBI-SNP demonstration, including implementing it nationally and/or permanently expanding it as long as the CMS Chief Actuary certified that the expansion would not increase Medicare and Medicaid spending.

The Secretary would be required to arrange for an independent, third-party evaluation of the CBI-SNP demonstration. Prior to implementation of the CBI-SNP demonstration, the Secretary would be required to clearly articulate the evaluation criteria which would include the following criteria: specific demonstration goals, hypotheses to be tested, and clear data collection and reporting requirements. The Secretary would be required to ensure that the evaluation determined whether or not the CBI-SNP demonstration program met the following conditions:

- improved patient care,
- reduced hospitalizations or rehospitalizations,
- reduced or delayed Medicaid nursing facility admissions and lengths of stay,
- reduced spend down of income and assets for purposes of becoming eligible for Medicaid; and
- improved quality of life for the demonstration population and beneficiary and caregiver satisfaction.

By January 1, 2022, based on at least three years of data, the Secretary would be required to submit a report to Congress documenting the results of the CBI-SNP evaluation and recommendations for legislative or administrative action.

#### EFFECTIVE DATE

The Secretary would be required to implement the CBI-SNP demonstration by January 1, 2018. The CBI-SNP demonstration would be conducted for five years.

### III. BUDGET EFFECTS OF THE BILL

#### B. COMMITTEE ESTIMATES

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the following statement is made concerning the estimated budget effects of the revenue provisions of the “Community Based Independence for Seniors Act” as reported.

The bill is estimated to have the following effects on Federal budget receipts for fiscal years 2016–2025:

	By fiscal year, in millions of dollars—											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–2020	2016–2025
CHANGES IN DIRECT SPENDING												
Budget Authority .....	4	0	0	0	0	0	0	0	0	0	4	4
Estimated Outlays .....	*	*	1	1	1	*	*	*	0	0	3	4

\* = Less than \$500,000.

Source: Estimate provided by the staff of the Congressional Budget Office.

#### C. BUDGET AUTHORITY AND TAX EXPENDITURES

##### *Budget authority*

In compliance with section 308(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 (“Budget Act”), the Committee states that the bill as reported involves increased budget authority (see table in Part A, above).

##### *Tax expenditures*

In compliance with section 308(a)(1) of the Budget Act, the Committee states that the bill does not involve increased tax expenditures.

#### D. CONSULTATION WITH CONGRESSIONAL BUDGET OFFICE

In accordance with section 403 of the Budget Act, the Committee advises that the Congressional Budget Office has submitted a statement on the bill.

##### *S. 704—Community Based Independence for Seniors Act*

Summary: S. 704 would establish a demonstration program in the Medicare Advantage (MA) program to test the effectiveness of granting MA plans flexibility to use part of their existing payments to provide for certain long-term care services and supports. The legislation would appropriate \$3.5 million for the demonstration program and its evaluation.

CBO estimates that enacting S. 704 would increase direct spending by about \$4 million over the 2016–2025 period. Pay-as-you-go procedures apply because the bill would affect direct spending. Enacting the bill would not affect revenues.

S. 704 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary effect of S. 704 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	by fiscal year, in millions of dollars—											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016– 2020	2016– 2025
CHANGES IN DIRECT SPENDING												
Budget Authority .....	4	0	0	0	0	0	0	0	0	0	4	4
Estimated Outlays .....	*	*	1	1	1	*	*	*	0	0	3	4

\* = Less than \$500,000.

Basis of estimate: S. 704 would require the Secretary of Health and Human Services to conduct a demonstration program to test the effectiveness of granting MA plans flexibility to use part of their existing payments to provide certain long-term care services and supports to beneficiaries participating in the demonstration.

#### *Community-Based Institutional Special Needs Plan Demonstration*

Under current law, MA plans submit a bid indicating the per capita payment they are willing to accept for providing Part A and Part B benefits to a beneficiary of average health. That bid is compared with a benchmark that is set according to a statutory formula, and represents the maximum amount that Medicare will pay an MA plan for providing Part A and Part B benefits in a given region. In most cases, MA plans submit bids that are below the benchmarks in the areas that they serve. When this happens, the federal government returns a percentage of the difference to the MA plan as a rebate. Plans must return the rebate to their beneficiaries in the form of reduced cost sharing or additional approved benefits.

S. 704 would require the Secretary of Health and Human Services to establish a demonstration program called the Community-Based Institutional Special Needs Plan (CBI-SNP) beginning January 1, 2018, for a period of five years. Under the demonstration, the Secretary would be required to contract with up to five MA plans that each could enroll up to 1,000 beneficiaries to participate in the demonstration. In order to participate in the demonstration, both plans and beneficiaries would have to meet certain eligibility criteria. The demonstration project would not change the amount of payments made to MA plans. However, participating plans would have flexibility to use their existing rebate dollars to provide certain long-term care services and supports, including homemaker services, home-delivered meals, and other services as the Secretary determines appropriate. The demonstration program and its evaluation would be financed through a transfer of \$3.5 million from the Hospital Insurance and Supplemental Medical Insurance Trust Funds; CBO estimates that those funds would be spent over the 2016–2025 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR S. 704, AS ORDERED REPORTED BY THE SENATE  
COMMITTEE ON FINANCE ON JUNE 24, 2015

	By fiscal year, in millions of dollars—												
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016– 2020	2016– 2025
	NET DECREASE (–) IN THE DEFICIT												
Statutory Pay-As- You-Go Impact ...	0	0	0	1	1	1	1	0	0	0	0	3	4

Intergovernmental and private-sector impact: S. 704 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

Estimate prepared by: Federal Costs: Paul Masi and Andrea Noda; Impact on State, Local, and Tribal Governments: J'nell Blanco Suchy; Impact on the Private Sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

#### IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the Committee states that, with a majority present, the Community Based Independence for Seniors Act, as modified, was ordered favorably reported on June 24, 2015 as follows:

Final Passage of The Community Based Independence for Seniors Act—approved, as modified, by voice vote.

#### V. REGULATORY IMPACT AND OTHER MATTERS

##### A. REGULATORY IMPACT

Pursuant to paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill as amended.

##### *Impact on individuals and businesses, personal privacy and paperwork*

The bill is not expected to impose additional administrative requirements or regulatory burdens on individuals. The bill is expected to reduce administrative requirements and regulatory burdens on some businesses.

The provisions of the bill do not impact personal privacy.

##### B. UNFUNDED MANDATES STATEMENT

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the bill does not contain any private sector mandates. The Committee has determined that the bill contains no intergovernmental mandate.



**VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED**

In the opinion of the Committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill as reported by the Committee).

