

The SNP Alliance



A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

Key SNP Provisions in Health Care Reform and Reconciliation Bills

The SNP Alliance made significant progress in obtaining health care reform provisions that will continue to advance the role of SNPs in providing specialty care to vulnerable Medicare and Medicaid beneficiaries. In addition to the first multi-year extension of statutory authority for SNPs, the bill included a CMS office with a direct report to the CMS Administrator to coordinate Medicare and Medicaid policy for dual eligibles; enhanced payment for beneficiaries new to Medicare who enroll in chronic condition SNPs; Secretarial authority to make frailty adjusted payments to fully integrated SNPs; and an evaluation of payment adequacy for selected high-risk groups under the current Medicare Advantage risk adjustment methodology.

Following is a list of SNP and SNP-related provisions contained in the Senate Health Care Reform bill and highlights of selected provisions in the reconciliation bill, both of which were signed into law on March 23, 2010 and March 30, 2010, respectively.

SNP Provisions

1. **SNP Extension:** Extends SNP authority through 2013.
2. **Transition.** Any beneficiary that no longer meets eligibility criteria must transition out of the SNP plan where they no longer are eligible by no later than January 1, 2013.
3. **Application of frailty adjuster:** Secretary may apply frailty adjustment under PACE payment rules, effective 2011, to Dual SNPs that are fully integrated, with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.
4. **Extension of Dual SNP contracting waiver:** Existing Dual SNPs that do not have a State contract may continue to operate without a State contract through December 31, 2012 as long as they do not expand into new service area.
5. **Payment adjustment for new Medicare enrollees:** For Chronic SNPs, beginning in 2011, the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. The provision must be budget-neutral and applied in lieu of the default risk score for new enrollees of non-SNP MA plans.
6. **Evaluation and justification of payment method for SNPs serving high-risk beneficiaries:** For 2011 and periodically thereafter, the Secretary shall evaluate and revise the MA risk adjustment methodology in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions. The Secretary shall publish a description of any evaluation conducted during the preceding year and any revisions made as a result of such evaluation.
7. **SNP Certification:** For 2012 and subsequent years, SNPs will be to be approved by NCQA, based on standards established by the Secretary.

CMS Office on Dual Integration

1. **Federal Coordinated Health Care Office:** CMS shall establish an office to bring together officers and employees of the Medicare and Medicaid programs to:
 - a. More effectively integrate Medicare and Medicaid benefits.
 - b. Improve the coordination between the federal government and states for dually eligible individuals.
2. **The goals of the office:**
 - a. Providing dual eligible individuals full access to the benefits to which such individuals are entitled.
 - b. Simplifying the process for duals to access the items and services to which they are entitled.
 - c. Improving the quality of health care and long-term care for duals.
 - d. Increasing duals' understanding of and satisfaction with their coverage.
 - e. Eliminating regulatory conflicts between rules under Medicare and Medicaid.
 - f. Improving care continuity and ensuring safe and effective care transitions for duals.
 - g. Eliminating cost-shifting between Medicare and Medicaid and among health care providers.
 - h. Improving the quality of performance of providers of services and suppliers under Medicare and Medicaid.
1. **Specific responsibilities:**
 - a. Providing States, SNPs, physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under Medicare and Medicaid programs for duals.
 - b. Supporting State efforts to coordinate and align acute care and long-term care services for duals with other items and services furnished under the Medicare program.
 - c. Providing support for coordination of contracting and oversight by States and CMS for Medicare and Medicaid with respect to the integration of Medicare and Medicaid programs in a manner that is supportive of the goals described above.
 - d. To consult and coordinate with MedPAC and the Medicaid and CHIP Payment and Access Commission with respect to policies relating to the enrollment in, and provision of, benefits to duals.
 - e. To study the provision of drug coverage for new full-benefit duals, as well as to monitor and report annual total expenditures, health outcomes, and access to benefits for duals.
2. **Reports to CMS Administrator:** The Office Director shall be appointed by and report to the CMS Administrator.
3. **Annual Report to Congress:** The Secretary shall submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for duals.

Selected Reconciliation Payment Provisions Applying to all Medicare Advantage Plans

1. **MA payments.** MA payments in 2011 are frozen. Beginning in 2012, the provision reduces the MA benchmarks relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. The changes will be phased-in over 3, 5 or 7 years, depending on the level of payment reductions. The provision creates an incentive system to increase payments to high-quality plans by at least 5%. It also extends CMS authority to adjust MA risk scores for observed differences in coding patterns relative to fee-for-service.
2. **Medical cost ratio:** Ensures that MA plans spend at least 85% of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.
3. **Health insurance provider Fee.** Delays the industry fee by 3 years to 2014 and modifies the annual industry fee for revenue neutrality. In the case of tax-exempt insurance providers, provides that only 50 percent of their net premiums that relate to their tax-exempt status are taken into account in calculating the fee. Provides exemptions for voluntary employee benefit associations (VEBAs) and nonprofit providers more than 80 percent of whose revenues are received from Social Security Act programs that target low income, elderly, or disabled populations.