SNP Alliance

2013 Legislative Priorities

September 2013

SNP Reauthorization and Policy Enhancements

1. **To ensure stability of specialty care for high-risk groups**—Enact permanent authorization of SNPs, as follows:
    a. Permanently authorize Institutional SNPs and Institutional Equivalent (IE) SNPs.
    b. Provide qualified IE-SNPs authority to receive frailty adjusted payments, to offer expanded supplemental benefits that support their models of care, to use alternative methods for verifying IE status and modify marketing rules to allow I-SNPs to more easily educate enrollees and their responsible parties about the potential value of plans' benefits.
    c. Permanently authorize Integrated D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits under one of two models:
        i. A D-SNP that covers some or all Medicaid long-term care services and supports (LTSS) and/or behavioral health services through its contract with the state.
        ii. A managed care organization that administers a D-SNP and a Medicaid plan that furnishes some or all LTSS and/or behavioral health services and enrolls a common group of dually eligible beneficiaries in the same plan.
    d. Extend authority for D-SNPs that do not qualify as Integrated D-SNPs through December 2019 to provide states the time to develop integration capabilities allowing D-SNPs to convert to Integrated D-SNPs.
    e. Provide permanent authority to C-SNPs that offer innovative care delivery models and meet quality standards, consistent with the requirements outlined below[1]:
        i. Effective 2016, require C-SNPs to offer innovative models of care that are more intensive and specialized in relation to their targeted population than would commonly be available through a non-SNP Medicare Advantage plan. These models must incorporate the following components:
            - A plan-owned or closely affiliated specialized provider network, clinic or care system with demonstrated expertise for serving the target population, that includes advanced primary care practices[2] specific to the needs of the target population.
            - Care Management methods that include face-to-face encounters with members of the plan's interdisciplinary care team, collaboration among related providers, and

[1]The Model of Care and performance requirements outlined below are only viable if accompanied by the proposed changes in payment and performance evaluation methods outlined in paragraphs 2 and 3 of this proposal.
[2] CMS defines advanced primary care (APC) practices as those that "utilize a team approach to care, with the patient at the center. APC practices emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers. The goal is to improve the quality and coordination of health care services."

interventions designed to prevent, delay or minimize disease and disability progression.

- Self-care education and family caregiver support and education, where appropriate, that includes relevant information on the disease or condition targeted and best practices for addressing the condition.
- Benefits and services uniquely tailored to the population served, including specialized supplemental benefits comprised of non-traditional health care items or monitoring methods consistent with the plan's model of care and relevant to the target population served[3].
- Integrated mental and behavioral health services with physical health services, if relevant to the target population served.

ii. Effective 2017, plans must demonstrate superior performance through:

- Better-than-average performance on one or more measures of priority importance to the target population (e.g., viral loads and CD4 counts for AIDs patients), including outcome measures that are case-mix adjusted for a comparable Medicare subset in the closest geographic area with a large enough population subset to produce a statistically valid benchmark (e.g., county, state, region, etc.); and
- Average annual inpatient hospital, emergency room and inpatient readmission rates below the case-mix adjusted for a comparable Medicare subset in the closest geographic area with a population subset sufficient to produce a statistically valid benchmark (e.g., county, state, region, etc.).

2. To maintain the financial viability of SNPs, we strongly urge Congress to protect Medicare Advantage plans from further cuts in funding 2013 Congressional priorities (e.g., debt ceiling increase, SRG fix, etc.)

3. **To reduce financial barriers to specialization** within the context of budget neutrality, direct the Secretary to:
   a. Improve the accuracy of the MA risk adjusted payment methodology for SNPs by:
      i. Adding a dementia factor to HCC risk adjustment methods (GAO).
      ii. Adding risk factors related to the number of chronic conditions (MedPAC).
      iii. Extending to all SNPs a new enrollee factor comparable to that provided for C-SNPs by ACA.
      iv. Using at least two years of data in calculating risk scores (MedPAC).
      v. Extending authority for all SNPs to receive frailty adjusted payments; establishing an *individual level* frailty adjustment methodology to replace the current plan level method; and using the same survey (HOS-M) and survey administration methods as PACE in calculating frailty scores.
      vi. Implementing other appropriate adjustments needed to improve payment accuracy including, but not limited to, mental illness, HIV-AIDS and Chronic Kidney Disease.

[3] For example, home-based hygiene assistance for catheter care for ESRD patients to keep access lines clean, avoid infections from access line blocks and avoid ER visits or hospitalizations or home health aide visits for frail patients, those with advanced diabetes or those who are bed or chair bound to conduct skin integrity checks to avoid Stage 2 or greater pressure sores that require hospitalization and extensive and costly specialized interventions.

vii. Evaluating the impact of socioeconomic determinants of health status on plan costs and developing appropriate adjustments to address related costs not fully accounted for under the HCC model.

b. Modifying measures for determining STAR bonus payments to align with subgroups being targeted.

c. Permitting all SNPs to offer expanded supplemental benefits in support of their models of care and tailored to the unique needs of the eligible population including, but not limited to non-skilled in-home support services; home health aide and home hygiene services; home assessments, modifications and assistive devices for home safety; adult day care; support for caregivers; and in-home food delivery.

4. **To align performance measurement with the mandate for SNPs to target high-risk/high-need persons**—

a. Require CMS to develop a population-based performance evaluation methodology for SNPs that aligns performance measures with Model of Care requirements and with the unique needs of the populations enrolled in SNPs. This methodology will be developed through a consensus development process in collaboration with NQF, NCQA, SAMHSA and other relevant entities with expertise in quality measurement and with stakeholders from special needs plans. The consensus development process shall include:

i. Identification of a core set of *existing* measures unique to targeted SNP subgroups and aligned with SNP MOC requirements, for interim use in evaluating SNP effectiveness and determining bonus payments. (See Attachment I for SNP Alliance recommendations.)

ii. Recommendations on the following measurement gaps for high-risk/high-need beneficiaries:

- Misalignment of existing measures and Star ratings with subgroups being targeted.
- Absence of measures unique to specialty care and specific special needs groups.
- Need for parsimonious data collection and elimination of duplicative reporting.
- Issues of data validity and reliability for self-report surveys completed by beneficiaries with cognitive impairments, mental illness or behavioral health issues.
- The need for consolidation of Medicare and Medicaid reporting requirements.
- An evaluation of the validity of discounting CAHPS satisfaction ratings for duals.
- The impact of socioeconomic determinants of health status on plan ratings.

ii. The development of benchmarks and risk-adjusted or case-mix adjusted methods for comparing SNPs with standard MA plans and fee-for-service performance, to include factors related to health risk, geography, demographic factors and other factors affecting quality that are independent of plan interventions or ability to control.

b. Require CMS to weight specified, relevant Star rating measures for SNPs more heavily than standard MA measures.

c. Require CMS to develop benchmarks for evaluating C-SNP performance consistent with the standards outlined in paragraph 1(e)(ii) above by January 1, 2017.

d. Require CMS to collect a core set of quality data from Medicare fee-for-service providers that is comparable to data reported by Medicare Advantage Plans and SNPs for Star ratings that would allow CMS to benchmark FFS, MA and SNPs on key quality indicators.
e. Require CMS to use a rulemaking process to provide for industry and stakeholder input on the proposed performance evaluation system for SNPs prior to implementation and for input on changes to all MA and SNP quality oversight requirements including, but not limited to Star ratings, SNP Model of Care requirements, SNP Structure and Process measures and the SNP approval process by NCQA.

5. **Create a pathway to integration of Medicare and Medicaid benefits,** to simplify beneficiary access and improve administrative and economic efficiencies. To advance these goals, Congress should direct the Secretary to:
    a. Align the Medicare and Medicaid appeals and grievances processes.(MedPAC)
    b. Allow plans to market Medicare and Medicaid benefits as a combined benefit package. (MedPAC)
    c. Allow use of a single enrollment card for Medicare and Medicaid benefits. (MedPAC)
    d. Develop a model D-SNP contract-- in collaboration with state Medicaid agencies.
    e. Exempt plans from MOOP requirements for QMBs and full benefit duals with no cost-sharing obligation.
    f. Establish authority for passive renewal of Medicaid eligibility for qualified beneficiaries.
    g. Authorize CMS to expedite approval of waivers central to dual integration.
    h. Work with states in establishing a simplified and integrated set of administrative and oversight functions such as enrollment, marketing, model of care, network adequacy and quality reporting.
    i. Work with states and plans to advance flexible and aligned 3-way contracting arrangements.

Attachment 1

Interim SNP Performance Measures

Following is a core set of existing measures the SNP Alliance believes could be used to evaluate SNPs on an interim basis, until more appropriate performance measures and methods are developed. These measures are more responsive to the complex care needs of high-risk/high-need persons and include SNP specific measures used by CMS. The SNP Alliance recommends that SNP performance be evaluated, on an interim basis, by comparing the SNP performance on the metrics identified below with comparable Medicare population subsets, where available, adjusted for case mix.

Outcomes Measures For all SNP Enrollees

- Hospital admissions and days per 1,000 (excluding long-term care hospital and rehabilitation hospital days, and observation days)
- Emergency room admissions per 1,000
- Long-term nursing home stays (over 90 days)

Measures for all SNP Enrollees

- Plan All-Cause Readmission
- Annual Monitoring for Patients on Persistent Medications
- Medication Reconciliation Post Discharge
- Access to primary care doctor visits (Part C HEDIS measure)
- SNP Structure & Process Measure 1: Care Management
- SNP S&P 3: Clinical Quality Improvement Measure as replacement for QIP, CCIP, and PIP (or consolidation of the four QI projects into single initiative focused needs of target populations).

HEDIS for SNP Enrollees Over 65

- Potentially Harmful Drug-Disease Interactions in the Elderly
- Use of High-Risk Medication in the Elderly
- Care of Older Adults: functional status assessment, pain screening, advance care planning and medication review
- Reducing the risk of falling

HEDIS for SNP Enrollees with Mental Illness

- Antidepressant Medication Management
- Follow-Up After Hospitalization for Mental Illness

CAHPs for SNP Enrollees (except those with intellectual or cognitive impairments)

- **C24-** Getting needed care
- **C26-** Customer service
- **C27-** Overall rating of health plan quality
- **C28**- Overall rating of health plan
- **C29-** Care Coordination

Unique Measures by SNP Type

Selected measures should be used in evaluating performance by SNP type; e.g.:

- *Dual SNP measures* – S&P 6- Coordination of Medicare and Medicaid benefits and services.
- *Institutional SNP measure* – S&P 5- Institutional SNP Relationship with Facility.
- *Chronic SNP measures* - Measures of unique importance to C-SNP condition focus; e.g. CD4 counts and viral loads for AIDS patients.