SNP Alliance Position on MedPAC Recommendations for SNP Reauthorization

December 20, 2012

Background

Special Needs Plans were established under the Medicare Modernization Act of 2003 with strong bipartisan support. The legislation contained authority to develop targeted clinical programs to more effectively care for: 1) dual beneficiaries; 2) persons living in institutions or in the community with similar needs; and 3) persons with severe and disabling chronic conditions. SNP authority expires at the end of 2013 and needs to be extended for plans to continue operating in 2014 and beyond.

The primary interests of Congress were to: (1) mainstream a variety of national demonstrations, including Evercare; the Wisconsin Partnership Program, Minnesota Senior Health Options and Disability Health Options Programs, and the Massachusetts Senior Care Options Program (i.e., "legacy" integration programs); and the Social HMO demonstration plans; and (2) to enable other programs with similar interests to evolve. High priority was given to using SNPs as a platform for advancing dual integration and improving total quality and cost performance for high-risk/high need persons, such as frail elders, adults with disabilities, and other persons with complex care needs.

SNP Profile and Selected Rules

1. Currently, 507 SNPs offer services to over 1.5 million beneficiaries.
2. Over 90% of beneficiaries, across SNP types, are dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees or MMEs).
3. 83% are enrolled in Dual Eligible SNPs (D-SNPs).
4. 14% are enrolled in Chronic Condition SNPs (C-SNPs).
5. 3% are enrolled in Institutional SNPs (I-SNPs).
6. A significant proportion of SNP sponsors have extensive innovation and demonstration experience.
7. All SNPs are required to provide special benefits and services of unique importance to their target population that exceed standard MA benefits and services, including:
   a) Establishing a population-specific model of care (MOC) for ALL enrollees, including an annual comprehensive health risk assessment, an individual care plan, and an interdisciplinary care team.
   b) Meeting special administrative and reporting requirements, in addition to all general MA requirements, while receiving the same payment.
   c) Meeting additional requirements for coordinating Medicare and Medicaid benefits and services.
8. D-SNPs also must have a State Medicaid contract.

MedPAC Draft Recommendations

On October 4th, MedPAC reviewed options and considerations for SNP reauthorization. On November 2nd, MedPAC Commissioners reviewed draft recommendations made by their Chair. MedPAC Commissioners are expected to vote on final recommendations for SNP reauthorization on January 10 or 11, 2013, with official recommendations to be communicated to Congress as part of MedPAC's March Report to Congress. MedPAC is considering the draft recommendations outlined below.

I-SNP Reauthorization

- Congress should permanently reauthorize Institutional Special Needs Plans.

D-SNP Reauthorization

1. Congress should permanently reauthorize D-SNPs where a D-SNP, or a D-SNP and a Medicaid plan administered by the same managed care organization, assumes clinical and financial responsibility for Medicare and Medicaid benefits. Congress should allow the authority for all other D-SNPs to expire.
2. D-SNPs not meeting these conditions could work with states to establish an integrated plan. If a non-integrated D-SNP converts to a general MA plan it could retain its Medicaid contract, if the state concurs.
3. The Congress should align Medicare and Medicaid appeals and grievances processes for D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits.
4. The Congress should direct the Secretary to allow D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits to market the Medicare and Medicaid benefits they cover as a combined benefit package.

C-SNP Reauthorization

1. Congress should allow authority for Chronic Condition SNPs to expire.
2. Direct the Secretary, within three years, to permit MA plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions.
3. Permit current C-SNPs to continue operating during the transition period as the Secretary develops standards.

SNP Alliance Position

The SNP Alliance appreciates the careful consideration and deliberation that MedPAC has given to issues of importance to special needs beneficiaries. SNP Alliance positions on MedPAC recommendations are outlined below.

Support permanent reauthorization of I-SNPs

1. I-SNPs offer a unique clinical model, usually headed by a physician/nurse practitioner team functioning as de facto staff to I-SNP nursing home partners for I-SNP members and provides enhanced primary care and tertiary prevention services to beneficiaries.
2. I-SNPs serve as a liaison and provide strong support to family members and many have near perfect family satisfaction ratings.
3. According to the SNP Alliance's 2011 annual member survey, the median risk score for Institutional SNPs was 2.14, compared to 1.84 average risk score for Medicare fee-for-service (FFS) beneficiaries living in institutions.
4. In spite of a higher average risk score:
   - I-SNP members had a hospitalization rate of 1,820 days per 1,000 vs. 7,497 days per 1,000 for institutional beneficiaries in FFS—the fourth consecutive year of significantly lower rates.
   - Over 83% of I-SNP enrollees never entered a hospital within a given year, compared with 47% of institutional beneficiaries in Medicare FFS.
   - The 30-day hospital readmission rate for I-SNPs was 54 per 1,000, less than any SNP type surveyed.
5. Persons served by I-SNPs had an average of 351 emergency room visits per 1,000 vs. 714 per 1,000 for persons living in institutional settings in FFS.
6. Over time, I-SNPs have achieved sustained excellence, offering promise for other SNP types with less history.
7. I-SNP reauthorization should include modified marketing and network requirements that are more appropriate for the population being targeted.

Support permanent reauthorization of D-SNPs that integrate financing and clinical services.

1. D-SNPs have provided an important platform for advancing integration, inside and outside demonstration authority. Permanent reauthorization of integrated D-SNPs recognizes the important difference being made by D-SNPs in improving care for dual beneficiaries.
2. Permanent authorization also is consistent with Congress' original intent for SNPs to serve as a vehicle for mainstreaming and expanding fully integrated Medicare/Medicaid plans established under national dual integration demonstrations ("legacy FIDESNPs").
3. Legacy FIDESNPs have provided important support for the latest round of integration efforts advanced by the CMS Dual Integration Office.
4. The 2011 SNP Alliance Annual Survey shows stellar performance by the 10 legacy FIDESNP members as represented by:
   - An average inpatient utilization rate of 2,509 days vs. 3,327 days per 1,000 among MMEs in FFS, even though their average risk score was higher than duals in FFS (1.49 vs. 1.27).
   - Median annual emergency room visits of 574 days per 1,000 vs. an average rate of 844 per 1,000 for MMEs in Medicare FFS.
   - Richer benefits than standard MA plans, a simplified enrollment process, and a more efficient and effective approach to care management, program administration and oversight.

Define clinical and financial integration

1. Consider defining plans with *"clinical and financial responsibility"* as "arrangements involving contracts among one or more plans that:
   - Include a capitated Medicare contract and a capitated contract with a State Medicaid or related agency that includes coverage of specified primary, acute, prescription drug, LTSS and/or behavioral health benefits and services for duals, where such coverage is *consistent with State policy*; and
   - May provide primary contractor authority to direct, manage, coordinate, and/or control operations of Medicare and Medicaid products to the extent needed to ensure integration of Medicare and Medicaid services for persons enrolled in both programs *consistent with state policy*."
2. It is important for integrated SNPs to be able to tailor benefit design to various subgroups targeted by states.
3. This definition is a variation on one of the criteria included in the CMS regulatory definition of a "FIDESNP," except it would allow states to offer LTSS AND/OR behavioral health services. (It is our understanding that MedPAC used "some or all LTSS and/or behavioral health" as a criterion to estimate the number of plans that might currently qualify for being "clinically and financially integrated.") The SNP Alliance believes it is important to recognize different approaches for serving adults with disabilities and frail elders. The definition also covers the MedPAC options for "financial integration" -- a D-SNP with a Medicaid contract OR a managed care organization with a D-SNP and a Medicaid plan serving MMEs in the same service area.
4. The SNP Alliance believes it is important for CMS to provide guidance for advancing integrated programs while recognizing limitations and variances among

states in how they define and address long-term care and behavioral health benefits and services.

Recommend a five-year extension for non-integrated D-SNPs.

1. Eliminating the D-SNP option would require over 1.3 million dual beneficiaries who have voluntarily enrolled in D-SNPs for specialty care to return to the fragmented world of Medicare FFS or enroll in an MA plan with no comparable program for coordinating Medicare and Medicaid benefits or for addressing their unique needs.
2. Many states indicate that *full* integration currently is not possible -- or even desirable, in some cases -- and that time is needed to evolve a staged integration strategy, including the time and flexibility needed to make changes in state laws, rules or administrative policies. Many states also believe that D-SNPs provide significant value to beneficiaries and states *without being fully integrated* by offering a product that exclusively focuses on special needs beneficiaries.
3. While the SNP Alliance is committed to full integration as the ultimate goal, we and many states also believe D-SNPs can provide added value without providing long-term care and/or behavioral health services by coordinating Medicare benefits with other Medicaid benefits such as Medicare cost-sharing, durable medical equipment, transportation, home health, dental, rehabilitation therapies and extended hospital stays.
4. Eliminating the D-SNP option would significantly impede new state integration efforts being pursued outside the FAD as D-SNPs are the only licensed MA platform with authority to exclusively enroll MMEs.
5. Not all D-SNPs have a standard MA plan into which their current beneficiaries could be passively enrolled. Where a companion MA plan does exist, or for transitioning of enrollees from terminated D-SNPs to standard MA plans, changes in statute or regulations would be needed to permit general MA plans to offer different benefits and cost-sharing for MMEs without offering the same options to others. It will be more difficult to offer zero cost-sharing plans once ACA cuts are fully implemented and the Stars bonus demo ends.
6. Restricting reauthorization to plans capable of meeting the proposed integrated plan definition does not recognize that many states have laws or rules that prohibit long-term care from being offered through Medicaid managed care programs; that restrict enrollment in Medicare and Medicaid managed care plans simultaneously; or that include other constraints – such as targeting decisions or resource and capacity limitations requiring a phased-in approach.
7. While some states advancing dual integration under the Financial Alignment Demonstration (FAD) have chosen to build primarily on a Medicaid platform, integration cannot be advanced without a corresponding platform for Medicare managed care, since plans seeking to participate in the FAD can't be approved without meeting a series of D-SNP requirements.
8. Some states will not offer unique benefit packages and cost-sharing arrangements for standard MA plans that they currently offer for D-SNPs. For example:
   - Because CMS permits states to determine coverage of Medicare cost-sharing for MMEs in standard MAPD plans, MMEs would lose state coverage for Part A deductibles and Part B deductibles and may be required to pay any plan premiums deemed necessary to cover supplemental benefits. In Pennsylvania and Minnesota, for example, only MMEs enrolled in a dual SNP can expect the State to cover Medicare cost-sharing or premiums.
   - MAPD plans must submit annual bids to CMS to renew plans. D-SNP bids have very different financial assumptions, including cost-sharing by Medicaid, unique supplemental benefits and other features (such as administrative costs associated with delivery of the MOC) that are not included in a standard plan. Co-mingling MMEs and non-MMEs in a standard Medicare benefit design would fundamentally alter bid assumptions.

   Thus, most if not all D-SNPs would *not* have the option of simply "converting to a general MA plan and retaining their existing state Medicaid contract." In fact, many states feel that rules for D-SNPs need to be even more flexible for serving MMEs and that CMS should have separate policies for D-SNPs in areas such as procurement, marketing, member materials, network requirements and other areas where differences in Medicare and Medicaid requirements preclude offering a seamless product to MMEs. The need for greater flexibility is a concept states continuously reference when asked how CMS could help advance integration. States also request that CMS and Congress seek their input *before enacting new laws or promulgating new rules* to ensure that they understand the potential impact of Medicare rules on Medicaid programs and MMEs.
9. Many MCOs seeking to "*work with states to establish an integrated plan*" (as MedPAC suggests) would need to recreate a D-SNP-like entity capable of meeting financial integration criteria at the same time they are disenrolling thousands of MMEs and dismantling integrated structures created under a D-SNP platform.
10. It would be unfortunate and contrary to MedPAC's expressed integration interests to eliminate the most viable platform for bringing integration to scale, at a time of unprecedented interest in integration, and active engagement of the CMS Dual Office in aligning administrative processes that impede integration.

Recommend CMS Craft Pathway to Integration

CMS should develop a pathway to integration by: 1) helping states advance dual integration efforts inside and outside of demonstration authority; 2) simplifying administrative requirements; and 3) eliminating disincentives for collaboration.

A major impediment to D-SNPs obtaining a Medicaid contract with more robust benefits and services is the presence of deeply entrenched policies, procedures, and structures that cause significant and unnecessary duplication, complications and conflict. MedPAC should expand its recommendations for CMS to align grievance and appeals procedures and marketing rules and provide a more holistic approach to integration and oversight.

1. CMS should:
    - Advance the alignment of Medicare and Medicaid policy by removing regulatory barriers to integration; providing greater flexibility for aligning state and federal Medicaid and MA policies; and providing states and plans technical assistance and support, e.g. guidance, best practices, templates for contracts, integrated member materials, etc., periodic TA calls, webinars and seminars and other relevant support.
    - Ensure that central and regional offices provide consistent policy and direction to states and plans.
    - Provide coordinated CMS central and regional office leadership designated for working with states and plans on efforts to advance dual integration programs.
    - Consult states in the development of integrated functions.
    - Develop a template for MIPPA contracts and a process for working directly with states on approval of all MIPPA contracts instead of requiring states to work with CMS separately on each MIPPA contract without clear direction regarding acceptable contract parameters.
    - Facilitate closer coordination between CMS' Center for Medicaid and CHIP services and Division of Medicare Advantage Operations and states in the alignment of Medicare and Medicaid policies and procedures.
2. In the interim, Congress should:
    a) Direct the Secretary to authorize D-SNPs to integrate administrative and oversight functions, consistent with plans participating in the Financial Alignment Demonstration (e.g., enrollment, marketing, quality reporting, oversight, etc.) and
    b) Authorize CMS to expedite approval of waivers central to dual integration, which historically have taken years for review and approval.

Recommend a five-year extension for C-SNPs with no moratorium on growth.

Persons with severe and disabling chronic conditions are among healthcare's highest-cost and fastest-growing service group. C-SNPs were created to establish new and improved benefit and service arrangements for these persons.

C-SNPs have fueled innovation and advanced specialty care across the spectrum of targeted conditions, with significant improvement in health outcomes for various chronic disease states. Evidence would also suggest it is highly unlikely standard MA plans, on any significant scale, would intentionally seek to attract high-risk/high-need persons and offer service arrangements significantly different from those offered to other plan enrollees. We believe enactment of the proposed MedPAC recommendations would:

1. **Limit patient choice and care options.** Currently, 230,000 beneficiaries have voluntarily enrolled in C-SNPs because the program offers:
    - Benefits and services that are tailored to their unique needs, including more extensive and condition-specific drug coverage.
    - More extensive involvement of professionals with greater expertise directly related to the condition(s) of special concern to them.
    - A higher degree of involvement of care management staff in their ongoing care.

    If C-SNPs are abolished, thousands of vulnerable beneficiaries will have their care disrupted, with no guarantee that standard MA plans will offer the same level of benefits, unique interventions or specialty care.
2. **Eliminate plans that deliver superior health outcomes**. Many C-SNPs have superior outcome to those found in Medicare FFS and/or in general MA plans. There is no evidence that eliminating these plans will result in better health outcomes for those served.
3. **Stifle innovation in care and service delivery.** The evidence is clear that innovation requires a *focused work effort*, with new operating methods crafted *outside* a normative environment. Research would suggest that restricting innovation to a standard MA environment would decrease, not increase, the probability of real change in caring for our nation's most costly and complex care problems. This is particularly problematic for problems such as HIV/AIDS, SPMI and ESRD, where the affected population is relatively small and dispersed, and where their unique care needs are fundamentally different from the norm.
4. **Provide no assurance of cost savings, and potentially increase costs.** Medicare pays no more per C-SNP enrollee than it does for those enrolled in standard MA plans. Eliminating C-SNPs would not result in ANY cost savings and could actually increase costs, as many C-SNP enrollees would go back to fee for service.

Examples of C-SNPs that have crafted specialization with superior outcomes include:

1. A 50% reduction in inpatient admissions in 5 months resulting from a dedicated case manager and nurse practitioner receiving referrals from diabetics in lieu of ER visits.
2. A 56% reduction in hospital admissions in 3 months for CHF patients by equipping each with a wireless scale that alerts clinicians of excessive weight gain and triggers same day visits.
3. 42% fewer inpatient admissions for ESRD patients and a 60% lower rate of diabetic amputations as a result of diabetic management innovations.
4. A 60% reduction in inpatient admissions for beneficiaries with severe and persistent mental illness through unlimited access to psychiatrists with an SPMI subspecialty and assignment of LCSWs, behavioral case managers and additional counselors to all enrollees, with no cost-sharing.

Support Enhanced Access to Specialty Care

We support MedPAC's goal to maximize access to specialty care, but we believe restricting specialization to general MA plans will: 1) unintentionally lower the level of innovation necessary for serving beneficiaries with complex medical needs; and 2) increase the potential for unintended complications.

The re-engineering of care with superior results requires:

1. **Higher levels of expertise**. C-SNPs must limit their enrollment to enrollees with *one* of 15 specific chronic conditions and document having a *higher level* of knowledge and expertise than found in general MA plans. We believe it is unlikely standard MA plans would hire staff with increased levels of expertise for the spectrum of conditions being targeted by C-SNPs.
2. **Population-specific benefits and systems redesign**. C-SNPs are required to develop MOCs of unique importance to their target populations, with detailed and specific MOC requirements. Many C-SNPs have fundamentally redesigned their clinical and primary care models and benefit packages, above and beyond those required by standard MA plans. We do not believe general MA plans would re-engineer specialty care to the same level that plans do that *exclusively* care for persons with unique care needs.
3. **Separate bids and cost-sharing arrangements**. C-SNPs develop bid related to their unique benefit design, including related cost-sharing arrangements. Any standard MA plan establishing unique benefit and cost-sharing arrangements for specific subgroups would require CMS to redesign the bid tools currently used at the plan (PBP) level to avoid cost-shifting to healthier enrollees who wouldn't even have access to the special benefits. This would be a significant CMS undertaking, complicate plan management, and increase plan costs.
4. **Specialty Care Networks.** C-SNPs are required to have care networks with special care expertise of unique importance to the population being targeted, such as cardiologists with expertise in AIDS care or psychiatrists with expertise in SPMI – populations for whom it can be challenging to find willing providers. It would be costly and administratively complex for a standard MA plan to maintain multiple care networks with different contracting, incentives and requirements of unique importance to each subpopulation.
5. **Enrollment and marketing practices tailored to the needs of those targeted.** Moving specialty care inside general MA plans would require multiple enrollment processes and changes in marketing rules that could be cost-prohibitive with the potential for increased costs and unintended effects related to plan selection bias.
6. **Special performance evaluation metrics and oversight.** C-SNPs must collect and report *all* data required of standard MA plans, PLUS *all* data required of *all* SNPs without regard to specialization or added costs. Standard MA reporting, including Stars, does not account for variances associated with certain disadvantaged populations and health conditions. The bias in standard rating methods inappropriately under-values the quality of SNPs. Moving specialization inside general MA plans could reduce incentives to develop new quality metrics for certain subgroups and perpetuate use of metrics that inappropriately evaluate SNPs and specialty care.

In Summary

Restricting specialty care to general MA plans would:

1. Negate choices made by hundreds of thousands of consumers who voluntarily enrolled in specialty plans with benefits and services unique to their care needs.
2. Preclude plans from developing new care models outside a normal practice environment, even where MA plans perceive it to be more effective.
3. Freeze and eventually terminate plans that have demonstrated success, with no evidence they will be able to replicate or recreate something as good or better inside standard MA structures.
4. Require CMS and plans to gear up for major changes in standard MA policy in order to recreate C-SNP like structures on the inside, with little awareness of the unintended consequences and no evidence of the potential for success.

Since retaining C-SNPs would incur NO additional costs to the federal government, we fail to understand the benefit of denying consumer choice, eliminating successful programs, and impeding emerging innovation, with multiple unknowns for consumers, standard MA plans, and the federal government. We believe it is more important to focus first on eliminating financial, regulatory, and oversight barriers to specialized managed care for Medicare's high-risk/high-need subgroups.