The SNP Alliance

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

S. 2110: SGR Repeal and Beneficiary Access Improvement Act

Senators Ron Wyden and Harry Reid

Summary of Medicare Special Needs Plans Provisions and Selected Provisions on Quality and Payment

SPECIAL NEEDS PLANS: CURRENT LAW

Section 231 of the Medicare Prescription Drug, Improvement and Modernization Act of 2008 (MMA, P.L. 108-173) established a new type of Medicare Advantage (MA) coordinated care plan to focus on individuals with special needs. 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). Fully Integrated Dual Eligible SNPs (FIDE-SNPs) are a subset of D-SNPs that must fully integrate Medicare and Medicaid benefits, including long-term care services and supports, and have a contract with the state Medicaid program among other requirements.

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.

Among other changes, the MIPPA required that all SNPs have evidenced-based models of care (MOC). An MA organization must design separate MOCs to meet the special needs of the target population for each SNP it offers. MOCs must have goals and objectives for the targeted population, a specialized provider network, use nationally-recognized clinical practice guidelines, conduct health risk assessments to identify the special needs of beneficiaries, and add services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

The ACA extended SNP authority through December 31, 2013 and temporarily extended authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service area. Other ACA changes applicable to SNPs included the following: 1) required all SNPs to comply with an approval process that will be based on CMS standards and executed by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012. NCQA rating is based on scores for each of eleven clinical and non-clinical elements in each

SNPs MOC; 2) authorized CMS to pay a frailty adjustment payment to Fully Integrated Dual Eligible SNPs (FIDE-SNPs); 3) established new cost-sharing requirements for SNPs; and 4) required CMS to implement new quality-based payment procedures for all MA plans by 2012.

In addition, the ACA required the Secretary to establish the Federal Office of Coordinated Health Care (MMCO) within CMS to facilitate Medicare and Medicaid coordination within CMS for dual eligible beneficiaries.

The American Taxpayer Relief Act (ATRA) extended SNP authority through December 31, 2014, and also temporarily authorized SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas. Beginning January 1, 2015, SNP enrollment will not be restricted only to special needs individuals.

SECTION 206: AMENDMENTS TO SPECIAL NEEDS PLAN AUTHORITY

1. SNP Extension

a. Permanently authorize I-SNPs.
b. Re-authorize D-SNPs through December 31, 2020.
c. Re-authorize C-SNPs through December 31, 2017.

2. Integration

a. **Unify Grievance and Appeals Process**: Establish by April 1, 2015 procedures that would unify the Medicare and Medicaid appeals procedures applicable to D-SNPs, with consideration given to application to I-SNPs and C-SNPs that have a substantial portion of dual enrollees. In establishing unified Medicare-Medicaid appeals procedures, the Secretary would be required to solicit comments from states, plans, beneficiary representatives, and other relevant stakeholders. To the extent compatible with the process for unifying Medicare and Medicaid appeals procedures, the Secretary would ensure that the following requirements were included:
    - Adoption of the most protective provisions for D-SNP enrollees under current law, including continuation of benefits under Medicaid pending timely filed appeals.
    - Differences in Medicaid state plans are taken into account.
    - Be easily navigable by D-SNP enrollees.
    - A single notification of all applicable Medicare and Medicaid appeal rights.
    - Appeals notices written in plain language and available in a language and format that is accessible to enrollees.
    - Unified Medicare and Medicaid timeframes for internal (plan) and external (Medicare and Medicaid) such as the enrollee's filing of appeals, plan acknowledgement, and appeal resolution and notification of appeal decisions.
    - Mechanisms to allow D-SNP plans to track and resolve grievances.
    - Beginning January 1, 2016, D-SNP plan contracts would be required to use the unified Medicare-Medicaid appeals procedures.

b. **D-SNP Integration of Medicare and Medicaid Benefits:**

- Beginning in January 1, 2018, most D-SNPs would be required to integrate all Medicare and Medicaid benefits and meet the requirements for a FIDE-SNP, including, to the extent current state law under the state's Medicaid plan permitted capitated payments for long-term care services or behavioral health services. If the Secretary determines that D-SNPs failed to meet contract requirements for full integration of all Medicare and Medicaid benefits, the Secretary is authorized to impose one of the following sanctions:
  - Plans that fail to integrate by 2018 or 2019:
    - A reduction in payment in an amount at least equal to the bid savings for plans that bid below the benchmark.
    - Closing enrollment in the plan.
    - Sanctioning the plan in accordance with Sec. 1857(g)
    - Other reasonable actions the Secretary deems appropriate.
  - Plans that fail to integrate by 2020 are no longer deemed special needs plans.
- In order to meet the definition of a D-SNP for 2020 and subsequent years, D-SNPs must fully integrate Medicare and Medicaid benefits and meet the current law definition of a FIDE-SNP – i.e., "A specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) (i.e., D-SNPs) that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care." We assume CMS would use the standing Chapter 16b definition of FIDESNP in implementing this requirement that requires plans to:
  - Provide dual eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;
  - Have a capitated contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long term care benefits and services consistent with State policy;
  - Coordinate the delivery of covered Medicare and Medicaid health and long term care services using aligned care management and specialty care network methods for high-risk beneficiaries: and
  - Employ policies and procedures approved by CMS and the State to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement.
- D-SNPs that only enroll Medicare beneficiaries for whom the only Medicaid benefit to which the individuals are entitled is Medicare cost-sharing assistance would not be required to fully integrate Medicare and Medicaid benefits in their contracts effective January 1, 2018.

3. Role of MMCO

1. MMCO would be designated as the dedicated CMS contact to assist states in addressing D-SNP Medicare-Medicaid misalignments. In this role, MMCO would be required to:
   a. Establish a uniform process for disseminating Medicare contract information to state Medicaid agencies as well as to D-SNPs; and

b. Establish basic resources for states that are interested in exploring D-SNPs as a platform for integrating Medicare-Medicaid services for dual eligible beneficiaries.

4. C-SNP Care Management Requirements

Section 206 would add the following requirements for C-SNP care management plans that would begin with contracts effective January 1, 2016:

a. The interdisciplinary provider team that C-SNPs are required to have would include providers with training in an applicable specialty and demonstrated expertise in treating individuals with the chronic conditions the C-SNP would target;
b. Requirements developed by the Secretary to provide face-to-face encounters with the C-SNP's enrollees not less frequently than on an annual basis;
c. A requirement that MOC include the results of the initial assessment and each annual reassessment are addressed in the enrollee's required individualized care plan;
d. The Secretary would be required to ensure that as part of the annual MOC evaluation that whether or not the plan fulfilled the goals identified would be taken into account; and
e. The Secretary would be required to establish a minimum benchmark for each MOC element and to only approve a C-SNPs MOC if each element met those minimum benchmarks.

5. **SNP Quality Ratings**

Section 206 would make changes to the SNP quality ratings and measurement and publication. Beginning with contracts effective January 1, 2016, the Secretary would be required to:

a. Increase emphasis on SNPs' performance improvement or decline as follows when determining a plan's annual Star ratings. Specifically, the Secretary of HHS would be required to ensure that at least 10 percent but not more than 12 percent of the annual Star rating is based on the SNP's performance improvement or decline in plan year 2016.
b. Increase emphasis on SNPs' performance improvement or decline as follows when determining a plan's annual Star ratings. Specifically, the Secretary of HHS would be required to ensure that at least 12 percent but not more than 15 percent of the annual Star rating is based on the SNP's performance improvement or decline in plan year 2017.
c. The Secretary would be required to measure the SNP performance improvement or decline based on the net change in the SNP plan's individual Star rating measures.
d. To ensure that plans are not punished in cases where it is impossible to improve, the Secretary would be authorized to appropriately adjust SNP plan improvement ratings when plans have achieved a 4.5-Star rating or the highest rating overall possible or for individual measures.
e. The increased emphasis on improvement would not apply to SNPs with an overall Star rating below 2.5.
f. Allow the Secretary to report and apply quality ratings of SNPs at the plan level instead of the contract level, as it is under current law. In requiring reporting and applying quality ratings at the plan level, the Secretary would be required to take into consideration the minimum enrollment that would be necessary to enable valid quality measurement at the plan level.
g. If the Secretary reports quality measures at the plan level, the quality measurement must include the Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems

(CAHPS) measures. Also, if the Secretary uses the option to require quality reporting and the application of ratings at the plan level, then payment and other administrative actions linked to quality measurement would be applied at the plan level.

h. Determine the feasibility of requiring reporting for, and applying quality measures, at the plan level instead of the contract level for all MA plans.
i. GAO would be required to conduct a study to determine how the Secretary could change the MA SNP quality measurement system to allow an accurate comparison of the care quality provided by SNPs for individual plans as well as for SNPs overall, to the care quality delivered under Medicare FFS and other MA plans for similar populations. GAO would be required to submit the report on SNP quality compared to other Medicare delivery sources by July 1, 2016. GAO's report would be required to contain recommendations for legislative and administrative action as determined appropriate by GAO.

SECTION 102: PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT

Requires the Secretary to develop a draft plan for the development of quality measures and post on CMS website by January 1, 2015 for stakeholder feedback.

1. The plan would address how:
    a. Measures used by private payers and integrated delivery systems could be incorporated under title XVIII;
    b. Coordination, to the extent possible, will occur across organizations developing such measures; and
    c. Clinical best practices and clinical practice guidelines should be used in the development of quality measures.
2. The plan would incorporate, at the least, the following quality domains: clinical care, safety, care coordination, patient and caregiver experience and population health and prevention.
3. The plan would take into account gap analysis conducted by the entity with a contract under Section 1890(a); whether measures are applicable across health care settings; clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures.
4. The plan would give priority to the following types of measures:
    a. Outcome measures, including patient reported outcome and functional status measures
    b. Patient experience measures
    c. Care coordination measures
    d. Measures of appropriate use of services, including over use.
5. The Secretary is required to accept comments on the draft plan through March 1, 2015 from the public, including health care providers, payers, consumers and other stakeholders on:
    a. Identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D) – measure priorities.
    b. Prioritizing quality measurement development to address such gaps.
    c. Other areas on quality measure development identified by the Secretary.

SECTION 208: QUALITY MEASURE ENDORSEMENT AND SELECTION

1. Requires the Secretary to contract with an entity regarding a multi-stakeholder process for receiving input on the selection of quality measures, to facilitate increased coordination and alignment between the public and private sector on quality and efficiency measures, and to conduct an ongoing analysis of gaps in endorsed quality and efficiency measures. Gap analysis includes measures that are within the priority areas identified by the Secretary under the national strategy established under Section 399HH of the Public Health Service Act (e.g., health outcomes, functional status, patient experience measures, care coordination and care transition measures, meaningful use, safety, effectiveness, efficiency, patient centeredness, equity for health disparity populations, use of innovative strategies, etc.)

SECTION 102(F): IMPROVING PAYMENT ACCURACY

1. Paragraph (1)(A) requires studies and reports (within 2 years) on the effect of certain information on quality and resource use. Would require the Secretary to conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). The study will use individual information such as urban/rural location, and Medicaid or SSI eligibility.
2. Paragraph (1)(B) requires the Secretary to study and report (within 5 years) the impact of risk factors, such as race, health literacy, limited English proficiency and patient activation on quality and resource use outcome measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions).
3. Paragraph (1)(D): If SES studies find a relationship between the factors examined and quality and resource use outcome measures, the Secretary is required to provide CMS recommendations on how to account for the factors in determining payment adjustments based on quality and resource use outcome measures under the eligible professional Merit-based Incentive Payment System under section 1848(q) of the SSA (MIPS) and, as the Secretary determines appropriate, other similar provisions of title XVIII.
4. Paragraph 2(A): HCC Improvement: Accounting for SES studies:
    a. Requires the Secretary, on an ongoing basis to determine, as deemed appropriate, how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, to incorporate information (including care episode and patient condition groups) into provisions of title XVIII similar to MIPS.
    b. Requires the Secretary, as deemed appropriate, to account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustment mechanisms under provisions of title XVIII that are similar to MIPS.
5. Paragraph (3): Within 18 months of enactment, requires Secretary to develop and Report to Congress a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out MIPS and, as the Secretary determines appropriate, other similar provisions of Title XVIII.