SNP Alliance Proposal

Next Stage Efforts to Advance SNP Integration and Specialty Care

September 24, 2014

Persons who are frail, disabled, and have complex medical conditions, such as HIV-AIDS and ESRD, are healthcare's most vulnerable, high-cost and fast-growing populations. Approximately two thirds of all Medicare spending is for those with five or more chronic conditions. In 2013, over $350 billion was spent on care of persons dually eligible for Medicare and Medicaid, with most costs related to caring for frail elders and adults with disabilities.

Our current healthcare system was not designed to meet the volatile, complex and ongoing nature of these complex care problems. About two-thirds of physicians believe their training did not adequately prepare them to educate patients with chronic illness, coordinate home and community-based services, manage the psychological and social aspects of chronic care, provide effective nutritional guidance or manage chronic pain. (Chart book, G. Anderson, 2010)

To adequately meet the needs of these complex care beneficiaries and control future spending, we must fundamentally change how Medicare and Medicaid finance and regulate the full spectrum of primary, acute, pharmacy, behavioral health, and long-term care providers who serve these persons in order to be more person-centered and system-oriented (see below).

Person-Centered, System-Oriented Specialized Chronic Care

Current Approach

- Disease-based, symptom-driven, point-in-time focus
- Provider-centric care
- Fee-for-service financing (treatment and place specific payment rates)
- Component-based performance evaluation
- Separate Medicare/ Medicaid program for duals

New Approach

- Population-based, total care, ongoing focus
- Person-centric care
- Capitated financing (All in, risk adjusted, across care settings and over time.)
- Total quality and cost performance evalution
- Integration of Medicare and Medicaid for duals

SNPs: A Platform for System Change

In 2003, Congress passed legislation to advance specialty care for persons who are dually eligible for Medicare and Medicaid, persons living in institutions or in the community with similar needs, and persons with severe and disabling chronic conditions. A primary objective underlying the new law was to mainstream integration efforts in Massachusetts, Minnesota and Wisconsin, and key elements of the Evercare program, and enable other similar efforts to evolve.

Today, 566 SNPs serve over 2 million complex care beneficiaries throughout the U.S. Over 1.6 million persons are enrolled in Dual SNPs, nearly 300,000 in Chronic Condition SNPs, and over 50,000 in Institutional SNPs. Of these, over 88,000 enrollees are served by Fully Integrated Dual Eligible Special Needs Plans ((FIDESNPs). FIDESNPs are the only MA plans, functioning outside of demonstration authority, able to exclusively enroll duals and provide the full spectrum of primary, acute, pharmacy, long-term care and/or behavioral health services.

Major Impediments to Change Remain

In spite of these developments, major impediments to integration and specialty care remain. Current payment methods, in spite of risk adjusting for age, sex, institutional status, Medicaid status, and chronic illness, continue to generate significant payment differences, relative to FFS, for duals vs. non-duals and for healthy beneficiaries vs. persons with various complex and ongoing care requirements. States advancing dual integration programs, inside and outside of demonstration authority, are concerned that D-SNPs have been extended only through 2016 and worry about pervasive misalignments between Medicare and Medicaid policies. Medicare and Medicaid plans operated by the same entity also experience roadblocks to aligning financial, clinical, and evaluation methods, and to responding to the multidimensional, interdependent, and ongoing care needs of high-risk/high-need persons.

The SNP Alliance believes that further improvements in Medicare and Medicaid financing and oversight must be made in order to eliminate the ongoing confusion and complications encountered by SNPs. To optimize total quality and cost performance, we must:

- Stabilize SNP authority by making SNPs permanent.
- Remove barriers to integration.
- Remove financial penalties for serving duals.
- Restructure Stars for serving high-risk groups.

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Stabilize SNP Authority

In 2013, MedPAC called for permanent reauthorization of integrated SNPs and Institutional SNPs. There has been strong support in Congressional Committees of jurisdiction in both the House and the Senate for a long-term extension of SNPs, including for Chronic Condition SNPs. Recent national efforts by the CMS' Medicare-Medicaid Coordination Dual Office (MMCO) to advance another round of dual integration demonstration under the Financial Alignment Demonstration (FAD) have built heavily off of legacy integration experiences in MA, MN, and WI, and require all plans approved under the FAD demonstration to meet SNP Model of Care requirements.

The National Association of Medicaid Directors and the National Governors Association both have recommended permanency for integrated SNPs, with most states advancing integration outside the FAD national demonstration choosing to build off the D-SNP platform. Many goals and objectives of the Finance Chairman's "Better Care Act" are highly compatible with SNP interests. It is crucial for Congress to provide stability for specialized managed care by authorizing permanency for FIDESNPs and I-SNPs, and a 5-year extension for D-SNPs and C-SNPs.

Remove Barriers to Integration

CMS' MMCO, working in collaboration with 10-15 states, is making important strides in aligning Medicare and Medicaid administrative structures. Yet, the vast majority of administrative and oversight policies and procedures are deeply rooted in a component-based, bifurcated approach to program administration. This causes significant confusion, complication, and waste. It is an impediment to advancing integrated, specialized care, even for FIDESNPs and MMPs with responsibility for the spectrum of Medicare and Medicaid benefits and services.

While important progress is being made, it is impossible for integrated, specialty care plans to establish the person-centered, system-oriented care methods required of complex care beneficiaries, as long as they are required to comply with a plethora of antiqued, program-specific, component-based requirements designed for another purpose. Significant cost savings from dual integration programs cannot be realized without full alignment of Medicare and Medicaid financing, administration and oversight, inside and outside demonstration authority. Priority must be given to integrating plan procurement methods, eligibility determination, marketing and member materials, program policy, reporting requirements, and fiscal management.

Remove Financial Penalties for Serving Duals

While CMS has made significant progress in risk adjusted financing, existing MA payment methods do not fully account for cost differences in serving persons who are poor, frail, and/or disabled, and those with multiple, complex and/or co-morbid illnesses; nor do they fully account for the influence of social determinants of health on costs. They contain significant payment disparities for serving duals vs. non-duals. CMS should apply a predictive bias adjustment factor (PBAF) to the CMS-HCC risk model, along with the normalization factors and the MA coding intensity factors, to eliminate a 7-8% payment bias, relative to FFS, in serving non-duals vs. duals.

Restructure Stars for High-Risk Groups

Both SNPs and MMPs are mandated to provide special benefits and services to their targeted populations, including providing individual assessments, care plans and interdisciplinary care teams for ALL their enrollees. However, SNPs also must comply with virtually all requirements of general MA plans that serve a healthier group of beneficiaries. This includes reporting on a number of STAR measures that may not be appropriate to the populations they serve, leading to lower payment levels and threatening the viability of plans specialize in high-risk care.

Current Star measures are most relevant for plans serving a normal distribution of Medicare beneficiaries and do not include measures that are of central importance in serving certain high-risk subgroups. A recent study by Inovalon shows that plans exclusively or disproportionately serving duals have Star ratings that are half a Star or more lower than general MA plans, after adjusting for differences in plans' enrollees' demographic characteristics and clinical interventions. The National Quality Forum and others have referenced numerous studies showing that the presence of certain social, income, education, behavioral, and environmental factors adversely affects care outcomes, but these remain unaccounted for in the Star system.

CMS should increase the overall Star rating by one-half a Star for plans that exclusively or disproportionately serve dual beneficiaries until such time other options are advanced for addressing existing bias against serving duals. It also should establish additional metrics for targeted high-risk populations and weight these factors more heavily for integrated, specialty care plans targeting these populations.

The Time to Act is NOW!

Poor, frail, disabled, chronically ill people are healthcare's most vulnerable, high-cost and fast-growing service groups. The vast majority of health policy researchers and leaders believe our current operating methods are fundamentally flawed. We cannot bend healthcare's cost curve and provide quality care for these high-cost/high-need people without fundamentally changing the nature of how we finance, administer and deliver care to them.

We can no longer afford to do business as usual. The time to act is now. More details about the above recommendations are provided in related SNP Alliance Position Statements.