SNP Alliance Fact Sheet

How MA-SNPs are Different from Standard MA Plans

June 2015

2003 Legislative Authority

MA-SNPs were established under the 2003 Medicare Modernization Act (MMA). Three SNP types were authorized:

1. **Dual Eligible Special Needs Plans (D-SNPs**): For persons dually eligible for Medicare and Medicaid.
2. **Institutional Special Needs Plans (I-SNPs**): For persons living in institutional settings or living in the community with similar needs.
3. **Chronic Condition Special Needs Plans (C-SNPs):** For persons with severe and disabling chronic conditions. CMS was given the authority to decide what specific conditions would qualify for C-SNP designation.

Except for issues of eligibility and enrollment, SNPs were to be:

- Paid using the same prospective payment and risk adjustment methods as standard MA plans.
- Required to follow all standard MA rules.
- Required to collect and report the same information as standard MA plans.
- Required to cover all Part D benefits.

MMA also authorized "Disproportionate SNPs" for plans serving a disproportionate number of special needs individuals, and a 5-year sunset provision, primarily to address long-term budget considerations, given payment differences between all MA plans and Medicare FFS.

SNPs were established to provide plans "the authority and incentives to develop targeted clinical programs to more effectively care for high-risk beneficiaries with multiple or complex medical conditions." It assumed "the provisions would establish new MA options, such as the Evercare and Wisconsin Partnership demonstrations." MMA Report language also indicated that Congress intended other plans "to serve additional high-risk groups who would benefit from plans offering targeted geriatric approaches and innovations in chronic illness care."

Since 2003, Congress has raised the bar on SNP requirements. It—

- Extended SNP authority through December 2018.
- Rescinded the "disproportionate SNP" designation, requiring *exclusive* enrollment of target groups.
- Narrowed C-SNP eligibility to 15 specific chronic condition categories designated by CMS.
- Required SNPs to establish evidence-based Models of Care (MOC) that require for *every* beneficiary:
  - Annual comprehensive assessment of physical, functional and psychosocial health.
  - Individual care plans developed with input from beneficiaries and, if desired, families.
  - Interdisciplinary care teams with composition based on special needs of targeted enrollees.
- Required all SNPs to receive approval from the National Committee on Quality Assurance (NCQA). (For NCQA approval, SNPs must provide an extensive narrative description and supportive documentation for each of four MOC domains.)
- Required all I-SNPs to validate institutional level of care equivalence by outside agency.

- Required all D-SNPs to establish contracts with their State Medicaid Agency beginning contract year 2013.
- Granted authority as of 2011 to apply frailty adjusted payments to D-SNPs that have PACE frailty levels, are fully integrated, with capitated Medicaid contracts that include long-term services and supports.
- Required the Secretary to refine new enrollee risk factors for C-SNPs to reflect the known risk profile and chronic health status of similar FFS individuals as of 2011.
- Required CMS to evaluate whether HCC risk adjustment methods fully compensate SNPs for care management and medical costs for plans that disproportionately enroll frail elders, those with severe and persistent mental illness and those with multiple complex chronic conditions.

SNP Payment

- SNPs continue to be paid under the standard MA payment methodology.
- Of 37 Fully Integrated Dual Eligible SNPs, a small proportion receive a modest frailty adjustment to their payments.
- C-SNPs are paid a new enrollee factor in year 1 to compensate for the C-SNPs' designated health condition for new enrollees that is not included in standard MA payments during first 12 months.
- ACA-mandated CMS research regarding the adequacy of the existing HCC risk adjustment methodology revealed underpayments for certain payment deciles for frail elderly, those with mental illness, dementia, and AIDS, but risk adjustment methods have not been changed.
- All SNPs must provide additional benefits and services, of unique importance to the targeted population, in addition to all those provided by standard MA plans, without additional payment.

SNP Performance Review and Evaluation

- CMS conducts MOC reviews to ensure SNPs are implementing their MOCs consistent with NCQA approved models, and SNP eligibility reviews to ensure SNPs limit enrollment to eligible beneficiaries and properly document verification of eligibility.
- In addition to reporting all information required of standard MA plans, SNPs also must report on:
  - SNP-Specific HEDIS measures at PBP level for: Colorectal Cancer Screening, Glaucoma Screening in Older Adults, Care for Older Adults, Use of Spirometry Testing in the Assessment and Diagnosis of COPD, Pharmacotherapy Management of COPD Exacerbation, Controlling High Blood Pressure, Persistence of Beta-Blocker Treatment After a Heart Attack, Osteoporosis Management in Older Women Who Had a Fracture, Antidepressant Medication Management, Follow-Up After Hospitalization for Mental Illness, Annual Monitoring for Patients on Persistent Medications, Potentially Harmful Drug-Disease Interactions in Elderly, Use of High Risk Medication in the Elderly, Medication Reconciliation Post-Discharge, Plan All-Cause Readmissions, Board Certification.
  - MIPPA state-level reporting requirements.
- In general, SNPs are not evaluated on the basis of their specialty care mandate but on measures applied to typical Medicare Advantage plans.

Dual Integration

- Over 90% of all SNP enrollees (across SNP types) are dually eligible for Medicare and Medicaid.
- Many States involved in the new integration demonstrations have built upon the SNP platform, and all MMPs are required to adhere to SNP MOC requirements.
- As of June 2015, 336 D-SNPs, including 37 FIDESNPs, and 67 MMPs address the health care needs of over 2 million dual eligibles through specialized managed care programs.