
Special Needs Plans: Building a Successful Care System for High-risk Beneficiaries

Rich Bringewatt

The Medicare Modernization Act of 2003 (MMA) established Special Needs Plans (SNPs) as a vehicle to care for persons with severe or disabling chronic conditions. Three types of special needs individuals were identified for SNP enrollment: 1) institutional beneficiaries, those living in Medicare-certified institutions, and others in the community with similar needs; 2) persons who are dually eligible for Medicare and Medicaid; and 3) persons with severe or disabling chronic conditions, such as end-stage renal disease (ESRD), HIV/AIDS, complex diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). For the most part, SNPs must comply with the same requirements as any other Medicare Advantage (MA) plan. Three key differences include: 1) statutory authority to exclusively enroll a subset of the Medicare population; 2) the ability of institutional and dually eligible beneficiaries to enroll in an SNP at any time; and 3) a requirement that all SNPs offer Part D benefits.

The advent of SNPs resulted in an unprecedented growth in MA plans over a short period of time. While a primary objective of the SNP legislation was to provide a vehicle for Medicare demonstrations for high-risk beneficiaries to transition to permanent status, interest in this new specialty care model has grown exponentially. As of January 2006, the Centers for Medicare and Medicaid Services (CMS) approved 276 SNPs in 42 states, the District of Columbia, and Puerto Rico.¹ Over 80% of these plans are dual SNPs. It is anticipated that CMS may approve

an additional 250 plans for the 2007 contract year, with some projecting a total enrollment of over 500,000 beneficiaries.¹ About 60% of the new approvals may be for dual SNPs, with the remaining 40% split about equally between institutional and chronic condition SNPs. It is anticipated that over 85 institutional SNPs and close to 60 chronic care SNPs will be in operation during 2007. This level of SNP growth in such a short timeframe had not been predicted by anyone.

The Medicare Payment Advisory Commission (MedPAC) provided preliminary findings regarding

the emerging SNP industry in its June 2006 *Report to the Congress on Increasing the Value of Medicare*.¹ In the report, MedPAC raised 3 critical questions:

1. Do SNPs tailor benefit packages to better serve the needs of enrollees than fee-for-service Medicare or regular MA plans?
2. Does risk adjustment result in an appropriate payment amount?
3. Do dual eligible SNPs merge Medicare and Medicaid benefit programs in a way that better serves beneficiaries, and is there cost shifting among payers?

The purpose of this article is not to challenge or answer these questions. There are insufficient data at this early stage to answer them with any degree of certainty. Rather, this article attempts to identify a set of policy and operational issues that are critical for SNP success, given the questions raised.

Although SNPs provide an important foundation for improving care for high-risk beneficiaries, SNP policymakers and plan administrators cannot afford to conduct business as usual. CMS, States, and SNPs must design, develop, and execute new business

models that are more responsive to the unique needs of high-risk beneficiaries.

Priority for High-risk Beneficiaries

People with serious or disabling chronic conditions are health care's highest-cost and fastest-growing service group. This includes the frail elderly, those with complex medical conditions and/or disabilities, and those with progressive conditions, including Alzheimer's disease. They consume the majority of health care dollars and are most vulnerable to health system failures.

A projected growth in the elderly population, a proportional increase in the complexity of chronic conditions, and escalating health care costs in excess of retirement savings will result in a significant increase in demand for public financing. The 20% of people 65 and older with 5 or more chronic conditions account for 68% of Medicare spending.² In 2001, high-cost Medicaid enrollees with over \$25,000 in annual Medicaid spending represented 4% of all enrollees and 49% of all spending. Of these high-cost enrollees, 49% were elderly and 43% were disabled.

In just 5 years, the first of the baby-boomers will turn 65. A recent analysis of projected demands on hospital services over the next 10 years indicated that aging will drive about 75% of annual growth in hospital service utilization.³

One of the primary reasons Congress passed the SNP legislation was to improve care for persons with severe or disabling chronic conditions. The long-term viability of SNPs is dependent on

Projected demands on hospital services over the next 10 years indicate that aging will drive about 75% of annual growth in hospital service utilization.

CMS, States, and SNPs working together to transform standard operating procedures to be more responsive to the unique needs of high-risk beneficiaries.

Critical Success Factors for SNPs

For SNPs to succeed, they must:

- Maintain specialty skills in Medicare and Medicaid managed care, Medicare/Medicaid integration, and specialty care for high-risk beneficiaries
- Establish a unique benefit package within the context of a competitive bid
- Be sensitive to the principles of *critical mass* in changing provider behavior
- Empower primary care practitioners to better manage acute care utilization
- Differentiate between disease management and complex care management
- Integrate care networks for high-risk beneficiaries
- Ensure accurate and timely coding and billing
- Establish system management capabilities for total quality and cost performance

- Empower patients and family caregivers
- Ensure regulatory compliance while enabling health policy transformation

SNP Specialty Skills

Most SNP enrollees are dually eligible, including those enrolled in institutional or chronic care SNPs. Accordingly, all SNPs must have expertise in Medicare *and* Medicaid policy, even absent a Medicaid managed care contract. Medicare and Medicaid financing and policy are highly interdependent in serving high-risk dual beneficiaries. A disregard for this interdependence can result in lost program opportunity or a lack of awareness of a potential adverse impact. SNPs also must possess senior management expertise in high-risk care, with special knowledge in geriatrics, pharmacy management with an emphasis on polypharmacy issues, chronic disease management, and/or care for adults with disabilities. The degree to which each of these skill sets is addressed is dependent, in part, on a SNP's overall focus and mix of enrollees.

A SNP can hire, contract, or affiliate in obtaining this expertise, but it cannot be ignored. It also is important to recognize that Medicare and Medicaid managed care skills are not necessarily transferable, and that knowledge of the relationship (or lack thereof) between the two is as, or more, important in optimizing performance in serving dual beneficiaries than knowing the details of each program.

Unique Competitive Benefit Package

Every SNP must establish a benefit

package that: 1) responds to the unique needs of high-risk beneficiaries; 2) accounts for the greater financial risk of serving special needs individuals; 3) maintains a competitive premium and cost-sharing structure; and 4) differentiates their plan successfully within the target market. For dual SNPs, a competitive cost structure means maintaining cost sharing for Part A and B services that fall within State parameters and premiums for Part D services at, or below, the low-income drug subsidy level. It must be recognized that SNPs generally have a higher administrative cost structure than most MA plans. This is necessary to manage their higher per-enrollee exposure and enable SNPs to retain enrollees, since dual and institutional special needs individuals can opt in and out at any time during the year.

SNPs must fully understand what issues or benefits trigger a person's decision to enroll. This involves understanding the interests of family caregivers and a person's primary care physician as both are frequently involved in the care decisions of high-risk beneficiaries.

SNPs also must pay close attention to the care demands and average utilization trends of their target population within their defined service area because reimbursement is established on the basis of usual geographic care practices. SNPs must understand their potential to influence usual practice patterns for their own enrollment, and define a unique benefit and realistic cost structure for Part A, B, and D benefits.

If the SNP intends to contract with the State for Medicaid bene-



**SNP can
hire, contract, or
affiliate in obtaining
this expertise, but it
cannot be ignored.**

fits, they must know how any contracting arrangement is likely to affect enrollment and cost assumptions associated with their Medicare bid. In some cases, the combination of benefits can enhance a beneficiary's interest in plan enrollment, and the interplay between Medicare and Medicaid financing can enable the SNP to produce overall cost savings that would not otherwise be available. It is important to keep in mind that a SNP's overall financial viability is more dependent on effective management of the target population's medical conditions than on the ability to maximize market penetration or optimize coding practices.

Critical Mass

Three aspects of critical mass must be taken into account: 1) the size of plan enrollment; 2) the degree of market penetration within a given service area; and 3) the percentage of plan enrollees seen by participating providers.

Under current law, SNPs must achieve a minimum enrollment of 1,500 beneficiaries for rural areas and 5,000 for urban areas, although CMS has given 3-year waivers to a number of SNPs that have projected enrollments as low as 300 beneficiaries. Generally, it is understood that SNPs function under a different risk structure

than standard MA plans, but it is still unclear what enrollment criteria are needed to maintain plan viability. Current experience indicates that institutional SNPs are financially viable under a lower enrollment threshold than dual SNPs. Some institutional SNPs appear to be able to maintain financial viability with as few as 300 enrollees. This is consistent with the Program of All-Inclusive Care for the Elderly (PACE) practices, where the average PACE enrollment is around 300 beneficiaries. On the other hand, a dual SNP with a diversified enrollment may need 3,000 to 5,000 enrollees to be financially viable. The relationship of critical mass to plan viability is dependent on a number of variables, including the type of special-needs individuals served, the relationship the SNP sponsor has with the targeted enrollees, the experience of a SNP sponsor, reinsurance arrangements, the degree to which a SNP can share risk with other entities, such as a PACE program or other SNPs, and a variety of other tangible and intangible variables.

To obtain the benefits of critical mass, SNPs that specialize in care for high-risk beneficiaries should target care facilities, programs, and/or neighborhoods where it is possible to attain a high-percentage of plan enrollment. This will allow the SNP to concentrate resources and staff in locations that have a high concentration of needy beneficiaries. This will improve program efficiencies and enable primary care related staff to more effectively monitor and manage the volatile, complex nature of complex chronic conditions.

It also is important to contract



**Critical mass is
necessary for SNPs to
effectively leverage
meaningful changes
in behavior.**

with providers who serve a high percentage of people with similar high-risk/high-cost conditions to SNP enrollees or with providers with a high percentage of patients who are SNP enrollees. This will increase the probability of SNP enrollees obtaining the kind of clinical interventions necessary to reducing medical complications and acute care utilization below normal use rates in the SNPs defined service area.

Empower Primary Care Physicians to Control Acute Care Utilization

Older people whose care requires time-consuming processes, such as history-taking and counseling, are at risk for a poorer quality of care and should be especially targeted for interventions to improve care.⁴ Thus, the burden is on primary care physicians to provide ongoing primary care and manage patients' overall health care needs.⁵ Particular attention must be given to untangling disability, frailty, and comorbid illnesses for improved targeting, diagnosis, and care.⁶

While SNPs are paid on the basis of usual-care practice, they cannot survive if they embrace usual primary care methods. Success largely is dependent on their ability to manage care more effectively than the norm. Critical success factors include:

- Developing close working relationships with physicians who have special expertise in high-risk care, and who know how to work as part of an interdisciplinary care team
- Employing nurse practitioners as primary care practitioners
- Enabling physicians to move be-

yond the simple application of evidence-based guidelines and work as part of an interdisciplinary care team in:

- Assessing and managing the relationship between related conditions
- Establishing ongoing care management methods that prevent, delay, or minimize chronic disease and disability progression across care settings and over time.
- Establishing provider relationships to minimize medical complications, adverse drug events, and avoiding precipitating acute events

Differentiate Between Disease and Complex Care Management

Where there is a high degree of comorbidity, even in a nonelderly population, single disease management does not appear promising as a multidisciplinary treatment approach.⁴ There is some evidence that adhering to current clinical practice guidelines in caring for older persons with several comorbidities may have undesirable effects.⁷

In the care of high-risk beneficiaries, there are 3 types of problems that require special attention: 1) problems associated with a particular disease; 2) those associated with an acute care episode, such as

a stroke or hip fracture; and 3) those due to multiple comorbid illnesses, frailty, or late-stage chronic conditions, such as ESRD and HIV/AIDS.

Standard chronic disease management practices can work fairly well for persons whose primary condition is related to a single chronic condition (eg, diabetes). However, complex care management practices must be established for persons whose conditions involve a significant presence of comorbid illness or where frailty and/or ongoing disability are a major factor. In these cases, care management must be more integral to the ongoing practices of *principal* care physicians and their network of hospital, subacute, nursing home, and community-based long-term care providers. These more intensive care management practices must be responsive to the ongoing and rapidly changing complications common to complex chronic illness.

Since most SNPs have a high percentage of persons with complex care needs, it is vital to give special attention to differentiating between disease management and complex care management. This makes it possible to put in place the infrastructure necessary to optimize total quality and cost performance, where hands-off or collaborative arrangements are made to deal with persons with higher-risk thresholds.

Integrate Care Networks for High-risk Beneficiaries

For specialty care physicians and related interdisciplinary teams to be effective, SNPs need to pay special attention to the relationship

among primary, acute, and long-term care providers who serve the same person. SNPs need to identify hospitals, nursing homes, and home care providers who routinely serve many of the same persons, find the quality performers within these natural care networks, and enable related providers to work together to improve outcomes. This: 1) enables smooth and trouble-free transitions between care settings; 2) optimizes care continuity among related care providers; 3) ensures that ongoing care management methods are in place to minimize iatrogenic illness, errors, and complications; and 4) helps prevent, delay, or minimize chronic disease and disability progression.

Related health care providers must be willing to work with an enrollee's designated principal care physician in accessing and providing ongoing care in accordance with an established care plan. A common medical record, an up-to-date central registry of drugs, and integrated information system supports can help the continuum of providers increase their efficiency and effectiveness.

Ensure Accurate and Timely Coding and Billing

With the advent of health-based, risk-adjusted payment methods, it is critical that physicians under contract with a SNP accurately code current and ongoing conditions that drive SNP payments. The number and type of conditions coded by physicians determine the amount of financing a SNP receives.

Unfortunately, physician coding is generally inadequate to produce fair and appropriate payment under a health-based, risk-adjusted

Since most SNPs have a high percentage of persons with complex care needs, it is vital to give special attention to differentiating between disease management and complex care management.

payment method. As a result, it is important for SNPs to develop an aggressive process of monitoring coding practices, training physicians in proper coding, and maintaining an ongoing oversight process to ensure that coding practices are in compliance with established regulations. SNPs need a high level of confidence in physician coding practices to ensure fair and accurate payments.

Establish System Management Capabilities

Most high-risk beneficiaries have multiple and highly interdependent problems. As a result, it is important to design systems that recognize these interdependent variables and provide more attention to managing the relationships between the various care components than to the specifics of any single provider contract. In serving high-risk beneficiaries, it may be beneficial to spend a higher than average amount of money on a specific component to *reduce aggregate costs* and *total costs* over time.

SNP administrators must know

how Medicare and Medicaid affect each other, how various aspects of the care continuum affect total quality and cost performance, and what interventions affect total quality and cost outcomes as a person's condition evolves. This requires a fundamental change in performance monitoring and evaluation practices.


Under most managed care evaluation methods, MA plans monitor cost and quality by program component or contract. They review cost and quality information separately, and seldom integrate total cost and quality data for the array of providers involved in serving a common high-risk beneficiary. Thus, SNPs can enhance their potential for success by adopting more of a systems management approach to monitoring cost and quality performance.

Empower Patients and Family Caregivers

SNPs can increase their overall effectiveness by being more proactive in helping patients and family caregivers to become more fully informed about the care a loved one receives, more engaged in the ongoing management of chronic illnesses, and by giving them a sense of being part of the person's overall care team. SNPs also can help physicians learn how to function as more of a coach than a medical specialist who simply communicates a diagnosis and writes a prescription.

Ensure Regulatory Compliance While Enabling Health Policy Reform

High-risk care is a highly regulated business. As a result, SNPs are



**SNPs can help
caregivers become
more fully informed
about the care a loved
one receives and give
them a sense of being
part of the person's
overall care team.**

vulnerable to unnecessary costs and administrative complications unless they are fully cognizant of the nuances of regulation and oversight. This means that SNPs need to be actively engaged in the process of policy change when traditional plans and practice providers are solidly entrenched in maintaining existing payment and policy structures. Traditional plans and practice providers easily can see any change in policy or approach as a threat to their market position, even where it evidences a logical approach to care. The more SNPs begin to take market share from standard MA plans, the more SNPs are also likely to hear questions like, “What’s so special?” SNPs need to be ready to demonstrate added value and continue the work of advocating for further improvement in health policy.

Critical Success Factors for CMS and Congress

It is widely known that current health policy, payment methods, and regulatory structures are rooted in an acute-care bias and reinforce a silo-based approach to care.^{8,9} It is also understood that current methods *cause* significant and unnecessary stress, confusion, medical complications, and costs in serving this high-cost/high-risk group.* Millions of dollars are spent each year in administering duplicative and conflicting requirements, with adverse market incentives for *total* cost and quality improvement.

Improving care for high-risk beneficiaries requires a corresponding effort by CMS and Congress

to further refine health policy and financing methods in accordance with the unique care needs of high-risk beneficiaries. It is of particular importance for CMS and Congress to:

- Ensure fair and equitable payment for serving high-risk beneficiaries
- Transform and integrate Medicare and Medicaid
- Establish appropriate system performance measures
- Stabilize SNP policy

Ensure Fair And Equitable Payment

Health-based risk adjustment is good but...

Historically, Medicare has paid health plans in accordance with adjusted average per-capita costs (AAPCC) that recognized expenditure differences among Medicare beneficiaries. Under the AAPCC formula, a plan received a specific per-member per-month payment based on each plan’s enrollee’s age, gender, private insurance coverage, welfare status, institutional status, and county of residence. Many studies have shown that the AAPCC formula

inadequately predicted medical expenditures, creating inequities among HMOs that enrolled healthier or sicker beneficiaries, with large financial incentives for HMOs and attract healthier beneficiaries.¹⁰

Under this demographic-based model, it was generally understood that in relation to fee-for-service financing, CMS overpaid beneficiaries in the lowest cost quintile by approximately 2.5 times and underpaid plans for beneficiaries in the highest cost quintile by approximately 50%. While there have been varying opinions about the degree to which health plans used this differentiated payment to attract or avoid high-risk beneficiaries, health plans commonly talked about avoiding “adverse selection” (attracting too many sick people) as a key element of maintaining financial viability.

In 1997, Congress passed a law requiring CMS to develop a health-based, risk-adjusted payment method, currently known as the CMS-Hierarchical Condition Category (CMS-HCC) payment method. Theoretically, under full implementation of this method, “adverse selection” should disappear and plans serving a sicker or frailer and/or disabled population should not be penalized for their targeting efforts.

In 2007, 100% of a SNP’s Medicare payments will be established

* Research reported in *Hazards of Hospitalization in the Elderly*, by Emese Somogyi-Aalud, MD, at Washington Veteran’s Administration Medical Center and George Washington University Medical Center showed that during 2003, the average hospital caused a significant percentage of new chronic care problems.

using the CMS-HCC method. This is also true for all other MA plans. In addition, CMS has developed a “frailty adjuster” to account for an assumed inability of the CMS-HCC method to fully account for the added cost associated with serving frail elders. At this time, only a few national demonstrations receive added payment based on “frailty.” Although CMS has communicated an interest in applying a frailty adjuster to all MA payments at some point in the future, it is not clear if CMS will follow through with this action and, if it does, what effect it would have on overall payment levels.

It is generally understood that health-based risk-adjustment is among the reasons for the rapid growth in SNPs. However, it still is unclear if this new risk-adjusted payment method *fully* compensates for the added cost of *exclusively* or *disproportionately* serving a high-risk population (relative to fee-for-service financing). There is speculation that some plans still are able to maximize their profit potential by simply targeting or avoiding certain conditions or segments of the population. There also is an indication that current payment methods may still underpay plans in serving certain institutional or disability groups and/or people with chronic conditions. Nevertheless, SNPs will not survive in their effort to specialize in care for high-risk beneficiaries without a health-based, risk-adjusted payment method. The key is refining risk adjusted payment to fully account for risk associated with diagnoses, frailty, and disability factors.

In 2007, 100% of a SNP's Medicare payments will be established using this new health-based, risk adjusted payment method.

CMS Actions to Ensure Fair and Equitable SNP Payments Over Time

Refine the CMS-HCC Coding Structure

CMS and Congress must ensure that SNPs are paid fairly in relation to the population they serve. CMS must eliminate the ability of any plan or provider to optimize their financial performance by simply targeting the most profitable conditions or subgroups or avoiding the least profitable ones. They also must enable SNPs that choose to serve a specific high-risk group to fairly compete with other MA plans and fee-for-service providers on *total* quality and cost performance measures in serving a *comparable subgroup*.

To ensure fair and equitable financing of SNPs, it is recommended that CMS carefully review the effects on their current payment structure for high-risk patients and further differentiate levels of financial risk associated with certain high-cost chronic conditions or combinations of chronic illnesses. For example, there is only a single cost category for CHF, and careful diagnosis of persons with CHF at early stages of the condition can cause an inappropriate

cost differential for plans serving a high percentage of persons treated at later stages of the disease. CMS also may need to add selected conditions to the CMS-HCC payment method to account for selected geriatric syndromes associated with high-cost/high-risk Medicare beneficiaries. Additional evaluation of payment adequacy also is needed for plans serving adults with disabilities.

Refine the Current Frailty Adjuster

Since their inception, PACE and a number of other chronic care demonstrations have received a frailty adjuster as compensation for the inability of traditional payment methods to fully cover the added cost of serving frail elders. In 2008, CMS is planning to move all chronic care demonstrations into the mainstream of MA plan payments. CMS is considering the application of a frailty adjuster to payment for all MA plans, but it has not recalibrated the existing frailty adjuster to account for recent changes in the Medicare market. It also has not assessed the degree to which the existing CMS-HCC payment method succeeds in adequately compensating for the added cost of serving frail elders.

The degree to which the absence of a frailty adjuster adversely affects plans serving high-risk beneficiaries and the extent to which the revised CMS-HCC model adequately compensates for frailty are not clear. Many existing demonstrations would see their payment significantly reduced if they no longer received a frailty adjustment payment. However, it is also uncertain how they would fair under the revised CMS-HCC payment method.

Given the added risk that many SNPs have taken in targeting and serving high-risk beneficiaries as a matter of priority, it is absolutely vital that CMS expedite its efforts to assess the added effects of frailty and disability on Medicare costs and modify the CMS-HCC payment method and/or add a frailty adjuster to the SNP payment structure to ensure fair and accurate compensation. CMS also should consider modifying the elements used to define “frailty,” as the current frailty adjuster is based exclusively on a defined set of disability factors (ie, ability to walk independently) associated with the HOS survey. Recent research by Linda Fried and others has demonstrated clear differences between frailty, disability, and comorbid illness, with significant differences between frailty and disability that may have statistically significant cost implications.⁶

It is also important to reassess: 1) cost differentials for institutional versus noninstitutional beneficiaries; 2) the impact of moving pharmacy benefits for dual eligibles from Medicaid to Medicare; 3) the interdependence between Medicare and Medicaid, with particular attention to establishing a compatible risk adjustment method for dual eligibles receiving long-term care benefits under Medicaid; and 4) the interdependence between risk-adjusted methods used under Part D and those used for Parts A and B in serving high-risk beneficiaries.

CMS and Congress have asked SNPs to serve the sickest of the sick. It is only right that they provide fair and equitable payment for doing so.

In 2008, CMS is planning to move all chronic care demonstrations into the mainstream of MA plan payments.

Establish an Independent SNP Bidding Process

Currently, SNPs are asked to compete with all other MA plans in submitting bids for the cost of benefits provided. CMS should consider establishing an independent bidding process for SNPs in recognition of their unique cost structure. It is important to compare plans in terms of addressing comparable issues and concerns. In addition, it is important for CMS to recognize the added administrative requirements that SNPs have in serving a high-risk population, and enable SNPs to allocate costs between Medicare and Medicaid in a fair and equitable manner while optimizing opportunities for pooled funding, to the degree possible, to maximize total cost and quality performance.

As an example, to survive, it is critical that SNPs invest more fully in the ongoing management of care. These costs are usually identified as SNP administrative costs and consume a higher percentage of a plan’s per-member per-month cost allocation than a mainstream MA plan. Care managers and/or nurse practitioners serving a dual beneficiary population do not organize their care planning activity according to which program most

likely benefits from a given intervention. These individuals seek to do what’s right to optimize total cost and quality outcomes. As a result, they have a difficult time distinguishing how their time and effort impact Medicare versus Medicaid costs, making it hard to allocate case management costs through some type of time management system. Requiring SNPs to fully separate costs for services and functions that are highly interrelated adversely affects their ability to develop and manage care in a cost-effective manner. CMS should identify bidding and related accounting practices that allow SNPs to pool related costs where such practices affect the total cost and performance of care, and allocate costs between Medicare and Medicaid in a simple and logical manner, using a reasonably defined cost allocation methodology.

Eliminate or Scale Copayments for Dual Beneficiaries Using Multiple Drugs

It is well documented in the literature that the amount of money beneficiaries must pay affects the extent to which they are likely to comply with pharmaceutical regimens. With high-risk beneficiaries, medication compliance can be a matter of life and death.


Although it is reasonable for the government to assume that consumers should bear some costs associated with their care, requiring a dual beneficiary who needs 10 to 15 different drugs to pay \$1 to \$3 for each prescription results in an unreasonable and unfair cost burden given the limited resources and chronic conditions of these people. The net effect is an

increased probability for medical complications to occur, resulting in significant and unnecessary added costs and potentially life-threatening acute events for the beneficiaries.

To maintain the principal of shared cost while being sensitive to the unique conditions of high-risk dual beneficiaries using multiple medications, Congress should consider establishing a maximum copayment threshold or a sliding scale that reflects the added cost burden on these individuals with complex medical conditions.

Share Medicare Cost Savings With States

Recently, CMS took a major step forward in opening up the SNP bidding process to closer coordination with States. This effort should provide new opportunities for States and the federal government to more easily explore possible ways to institute cost sharing. However, there remain multiple issues for States and CMS in the battle over perceived cost shifting. Much of the problem of cost shifting is related to Medicare and Medicaid having fundamentally different cost and benefit structures. Part of the problem is due to Medicare's inability or unwillingness to share its cost savings with States, where Medicaid expenditures are clearly part of the reason for Medicare's cost savings. As a step toward establishing a full alignment of Medicare and Medicaid interests, Congress should consider allowing States to share in some of the cost savings that are accrued to the federal government through the efforts of plans at risk for both expenditures.



CMS and Congress have asked SNPs to serve the sickest of the sick. It is only right that they provide fair and equitable payment.

Transforming and Integrating Medicare and Medicaid

We're moving in the right direction but...

In 2002 (the most recent data available), dual eligibles accounted for 16% of Medicare beneficiaries and 22% of Medicare spending. For Medicaid, based on FY 2003 data, dual eligibles comprised 13% of Medicaid beneficiaries and 41% of Medicaid expenditures.¹¹ In 2005, over \$200 billion was spent on the care of persons dually eligible. This represents approximately one-third of all Medicare and Medicaid expenditures. In most cases, high-cost/high-risk beneficiaries require services from multiple providers who provide care under Medicare and Medicaid financing, regulations, and oversight structures that impede their ability to work together to improve total quality and cost performance.

With Medicare focused primarily on acute care benefits and Medicaid focused on long-term care, government and plan administrators unknowingly disregard the pervasive interdependence between primary, acute, and long-term care providers in serving millions of high-risk beneficiaries as their con-

ditions evolve. Medicare and Medicaid also use different provider-centric approaches to health care policy and financing, with strong incentives for plans and providers to suboptimize cost and quality outcomes within specific care settings, and shift costs between programs and providers without regard to their cumulative effects.

Medicare alone has over 22 different sets of "conditions of participation" for health care providers, with different rules governing their behavior in areas such as intake, assessment, care planning, discharge planning, quality assurance, and record-keeping. A piecemeal approach to health policy reinforces a silo-based approach to care that causes significant and unnecessary confusion, medical complications, and increased costs.

Current law requires Medicare and Medicaid to use different payment methods, administrative structures, and care approaches.¹¹ Yet, it is critical for CMS and SNPs to do everything they can, within the context of current law, to integrate services for persons who require an array of Medicare and Medicaid benefits.

Historically, only PACE and health plans operating under Medicare/Medicaid demonstration authority have been able to integrate practices to any measurable degree. PACE is the most fully integrated and perhaps most successful Medicare/Medicaid integration program. However, PACE market penetration has remained relatively small. Although Evercare Choice, Medicaid/Medicaid Integration Programs in Minnesota, Wisconsin, and Massachusetts, and other chronic care demonstrations appear to have

developed models of integrated care that may be more transferable to other settings, they are still somewhat limited in scope and are experiencing difficulties in transitioning from demonstration to SNP status. Other States are beginning to evolve integrated programs, but the programs being proposed for most of these new State entrances are much more limited in their Medicare interface and have very little penetration into the long-term care market, where most problems and opportunities exist for improving total quality and cost performance.

Recently, CMS took a major step forward in improving access to integrated care for dual beneficiaries by promoting:¹²

- The promulgation of “How-to Guides” for marketing, enrollment, and quality
- Opportunities for States to support targeted enrollment of aged, disabled, and other special dual beneficiary groups
- The opportunity for a coordinated bidding and contracting process
- A model 3-way agreement among SNPs, States, and CMS to streamline administrative procedures
- Improved quality measures, particularly related to SNP populations
- Education and outreach to States and beneficiaries regarding integration opportunities

CMS Imperatives to Integrate Medicare and Medicaid Strengthen CMS Internal Operating Capabilities for Administrative Simplification

CMS’ plan to integrate Medicare and Medicaid is a huge undertak-

A piecemeal approach to health policy reinforces a silo-based approach to care.

ing. It involves a plethora of policy and process issues, with every decision seemingly linked to another issue not previously identified. To ensure success in integrating Medicare and Medicaid, CMS should establish a unit or office with full-time staff that reports to the Administrator to facilitate the integration effort. This office should work with designated Medicare and Medicaid leadership to address the complexities of simplifying the interface of Medicare and Medicaid policy oversight, and lay the groundwork for next-stage efforts to improve total quality and cost performance for high-risk dual beneficiaries.

Build on the Learning of State Demonstrations

Medicare/Medicaid Integration Programs in Minnesota, Wisconsin, and Massachusetts have accrued significant experience in the integration of Medicare and Medicaid. It is important to build upon this experience, transfer acquired learning where it applies, and advance the overall effort to streamline and integrate administrative oversight. Given recent policy decisions that make the transition to Medicare/Medicaid integration less cumbersome, a number of new States are beginning to explore such options. CMS should do everything they

can to build upon the learning of those who have gone before, and enable these flagship operations to flourish in moving integration to its next level.

Reassess Primary Care Requirements

Physicians serving persons with comorbid illnesses, frailty, and/or disability must vary their use of traditional clinical practice guidelines. The customary micromanagement approach to physician payment, documentation, and oversight impedes the ability of physicians to provide quality care to patients with multiple problems. Moreover, new pay-for-performance requirements focused on advancing clinical practice guidelines for specific chronic conditions (eg, diabetes) are often irrelevant or counterproductive to the ongoing management of care for persons with comorbid illnesses, frailty, and disability.

In light of current best-practice assumptions for high-risk beneficiaries, CMS should re-evaluate its entire scope of primary care policies, and change regulations and oversight methods to account for differentiated ongoing primary care management needs. CMS must keep in mind that practice methods established under fee-for-service payment structures affect the care provided under MA plans or SNP contracts, where a broader fee-for-service financing environment significantly influences physicians and physician groups.

Reassess Transitional and Continuity of Care Requirements

Current provider oversight is defined primarily by separate

“conditions of participation requirements” for each provider segment (eg, hospital or nursing home). These separate requirements reinforce a silo-based approach to care and impede the ability of related providers within a person’s care continuum to work together around a common care plan.

In seeking to optimize total cost and quality performance, CMS should implement a process to review all provider requirements for Medicare and Medicaid, with particular regard to their adverse effect on a group of primary, acute, and long-term care providers serving the same chronically ill person. CMS should also consider establishing a uniform policy for continuum providers in serving high-risk beneficiaries to simplify transitions, maximize care continuity, and optimize total cost and quality performance.

Provide Visionary Leadership

In solving problems as complex as those in the integration of Medicare and Medicaid, it is easy to become consumed by the details of a particular issue and lose the sense of how any single effort relates to the issue of system improvement as a whole. As a result, it is important to establish a clear vision and define problem-solving priorities in the context of the desired result, rather than what problem seems to be most important at any point in time.

Under an ideal Medicare/Medicaid integration model,[†] all administrative, financial, and delivery structures would be fully aligned across Medicare and Medicaid, with special regard for the volatile, complex, and ongoing

Physicians serving persons with comorbid illnesses, frailty, and/or disability must vary their use of traditional clinical practice guidelines.

care needs of high-risk dual eligible beneficiaries. In such a model:

- Dual eligible beneficiaries would be able to receive *all* their benefits from a SNP offering a single program that transparently combines all Medicare and Medicaid benefits and services
- Integrated SNPs^{††} would be able to use a coordinated enrollment process with a single enrollment form
- All benefits would be described by a single set of marketing materials and a standardized enrollee communication process
- Integrated SNPs would be at risk for both Medicare and Medicaid costs and allowed the flexibility to better rationalize benefits across the programs
- Payments would be fair and equitable, taking into account the added risk burden of exclusively or disproportionately serving a high-risk population
- CMS and States would use

compatible contracting provisions, as well as standardized and coordinated grievance and appeals procedures for both Medicare and Medicaid

- Medicare and Medicaid would use compatible performance measures, using a single, integrated quality improvement plan to target the unique needs of chronically ill dual eligible beneficiaries
- Federal, State, and SNP methods would be uniquely designed to meet the multidimensional, interdependent, and ongoing needs of people with serious and disabling chronic conditions
- All care for high-risk dual eligible beneficiaries would be provided under an integrated regulatory and oversight structure

Dual eligible demonstrations have made significant progress toward this vision. CMS Administrator, Dr. Mark B. McClellan and other senior CMS staff have made important strides toward a more rationalized system of policy and financing for dual eligible beneficiaries. CMS should consider using the vision outlined here to help guide future decision-making.

Changing Performance Measurement Methods

Performance measurement is good but...

Specialized care is a systems problem that requires a systems solution. As mentioned previously,

[†] Members of the SNP Alliance developed this model definition as part of a blueprint for CMS to facilitate the integration of Medicare and Medicaid.

^{††} It is important to recognize that most dual SNPs are at risk only for Medicare services, whereas most institutional SNPs and some chronic care SNPs also serve a high percentage of dual eligible beneficiaries. Whenever a dual, institutional, or chronic care SNP contracts with CMS and the State for Medicare and Medicaid financing to serve dual eligible beneficiaries, it is important for these “integrated SNPs” to be afforded an opportunity to function under integrated financing and oversight structures.

managing the relationships among the various components is as, or more, important than managing individual contracts. In serving high-risk beneficiaries, it may be beneficial to spend more money on a single component to reduce total costs over time.

Under traditional MA evaluation methods, plans and administrators monitor cost and quality per program or per care component. They uncouple cost and quality information, even for the same person. They seldom look at total cost and quality performance across settings and over time, even though the vast majority of beneficiaries receive care from multiple providers for the same or a related problem. Further, the performance measurement system is based on an acute care model, whereas SNP beneficiaries' health concerns are predominantly chronic in nature.

MA plan performance evaluation relies primarily on these measures: the Health Plan Employer Data and Information Set (HEDIS®), the Hospital Outcomes Survey (HOS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Program. Each of these tools has limitations as measures of a health plan's effectiveness in meeting the needs of chronically ill beneficiaries with complex medical conditions. None measure some of the most critical factors to effective chronic care management, such as care continuity and safe and effective transitions across settings of care.

Important limitations of HEDIS reduce its appropriateness for SNP measurement. HEDIS measures focus on an acute care model, have not been validated for the over-75

It is important to establish a clear vision and define problem-solving priorities in the context of the desired result.

population, and are not conducive to timely interventions for enrollees whose volatile health conditions can change frequently.

HOS was designed for the Medicare population, includes chronic condition measures related to frailty and functional capacity, and is designed to monitor health care trends at the individual person level. HOS is a self-report survey, however, and the risk of nonresponse bias among high-risk beneficiaries may result in survey response rates insufficient to assure reliability and validity.

A major limitation of the CAHPS Program is that it is physician-focused and not a relevant measure of *plan* performance. For example, it does not include questions about care management, care transitions, long-term care-related issues, and other important health plan measures. Data are not reported at the individual physician level, are not readily "actionable" for plans that contract with physician groups, and do not include key characteristics that would allow CMS to evaluate consumer satisfaction in relation to a SNP's ability to address the unique concerns of special needs populations more effectively.

A shortcoming of each of these measures is that none focus on

care components that are most relevant to frail seniors including continuity of care, care transitions, geriatric syndromes, end-of-life care needs, comprehensive advance care planning, comorbidity management, and polypharmacy issues. CMS should limit the evaluation of SNP performance to measures that are appropriate for serving high-risk beneficiaries. The SNP Alliance recommends that CMS rely on a limited number of HEDIS measures that are relevant to a high-risk population, the modified version of HOS, selected outcome measures related to utilization, and a new set of quality domains unique to the management of complex chronic conditions.

Limit the Use of HEDIS Measures

The SNP Alliance recommends that CMS use a limited set of HEDIS measures for plans serving the frail elderly, consisting of:

- Annual monitoring for patients on persistent medications
- Drugs to be avoided in the elderly
- Flu shots for older adults
- Pneumonia vaccinations
- Osteoporosis management in women with a previous fracture
- Antidepressant medication management

Establish New Processes for Measuring System Performance

The SNP Alliance has developed a set of process measures that it considers more appropriate than the current measures for addressing the multidimensional and ongoing care needs of high-risk beneficiaries. The new measures were developed through a consensus process, based on the experience of medical

directors of plans specializing in programs for the frail elderly and adults with disabilities. Goals, objectives, and quality indicators were developed for each of the following domains:

- End-of-life care
- Continuity of care
- Safe and effective care transitions
- Functional independence
- Member choice and quality
- Medication management
- Population-specific medical conditions
- Management of multiple and/or comorbid conditions
- Mental illness/behavior
- Family caregiver support

These domains are consistent with ACOVE measures and others recommended by the American Geriatric Society, and various disability groups. However, they are streamlined to help simplify data collection efforts and target those issues that are the most important for optimizing total cost and quality performance.

Identify SNP Benchmarks

The SNP Alliance also recommends that CMS give consideration to a limited list of “dashboard indicators” for SNP performance measurement, recognizing that any comparison of results must be based upon comparisons between groups serving similar types of beneficiaries. These measures are more “outcome”-oriented and relate to issues that are particularly important in the care of high-risk beneficiaries. Specifically, they measure the rates of:

- Inpatient admissions and readmissions for ambulatory care-sensitive conditions

Important limitations of HEDIS reduce its appropriateness for SNP measurement.

- Emergency room visits
- Nursing home admissions for nursing home-certifiable beneficiaries
- Inappropriate drug use/medication errors
- Family and beneficiary satisfaction

Stabilize SNP Policy

It is clear that SNPs have become a major force in high-risk care. While it takes time to change policies and operational procedures central to improving total quality and cost performance, it also is clear that given proper policy and operating structures, SNPs have the potential for achieving significant improvement in care of high-risk beneficiaries. In order to provide some stability for this system transformation process to unfold, it is important for Congress to eliminate the SNP sunset provisions and the existing minimum enrollment requirements. Standard enrollment assumptions regarding plan viability do not apply to plans serving a high concentration of high-risk beneficiaries, particularly those targeting persons living in nursing home facilities, as has been evidenced through the PACE program. Congress should allow certifying state agencies and SNPs to resolve this issue through development and demonstration of alternative enrollment targets for defined special needs individuals and related plan strategies.

Next Steps

A little less talk and a lot more action...

In the care of high-risk beneficiaries, quality and cost considerations can represent compatible interests.

The MMA provisions that allowed for the evolution of SNPs represent an important foundation on which to build a specialty care approach to transforming health care’s highest-cost and fastest-growing service group—persons with severe or disabling chronic conditions. However, this is only the beginning.

Unless SNP public policymakers and plan administrators seek to change the fundamentals of how care is financed, administered, and delivered, specialty care will not survive. For high-risk care to survive and thrive, it is important for SNPs and CMS to:

- Adopt a new vision of care more in keeping with complex chronic care needs-based demands
- Identify barriers and opportunities to implement a new vision of care for this high-risk group
- Focus on the system, not the parts, by strengthening relationships and provider linkages
- Target high-leverage, short-term interventions with lasting impact
- Develop a plan for business transformation with deadlines and action steps
- Assume multiple player involvement and obtain buy-in from key stakeholders
- Create a sense of urgency and understanding—it’s the fuel for progress
- Establish best-practice care

PROVIDER ACTION

Impact to You

Special Needs Plans (SNPs) were established under the Medicare Modernization Act (MMA) of 2003 to allow for managed care programs for 3 unique groups: institutionalized beneficiaries, the dually eligible, and persons suffering from chronic conditions. The latter group was developed because 20% of Medicare beneficiaries have 5 or more chronic conditions, which account for 68% of Medicare spending. Over a half a million Medicare beneficiaries are enrolled in SNPs, and growth is expected to continue.

What You Need to Know

SNPs are likely to be responsible for the care management for a growing number of frail Medicare beneficiaries. The success of SNPs will depend to a great extent on empowering providers to better manage acute care utilization and establish systems of care to prevent failings from progression or acute determinations of chronic conditions.

What You Need to Do

Providers should consider developing special expertise that can be utilized by SNPs in the care and management of high-risk Medicare beneficiaries. Such providers should develop close working relationships with area SNPs for the care of their patients.

methods consistent with a new vision of care

- Advocate for legislative and regulatory change to help lay a foundation for the future

To produce better total cost and quality performance outcomes in the care of high-risk beneficiaries, SNPs and CMS cannot afford to conduct business as usual. They must actively seek to change the usual care practices of the entire spectrum of primary, acute, and long-term care providers. SNPs and CMS must establish new care management policies and procedures that are:

- *Person-centered*, where all care providers of high-risk beneficiaries: 1) respond to the personal needs and interests of each person served; 2) mirror the multi-dimensional, interdependent, and ongoing nature of chronic illness; 3) strengthen a patient's health reserves; 4) compensate for biological and physical dysfunction or disease; 5) enable

consumer clarity and understanding about their health condition, best-practice definitions, and service options; and 6) place patients and caregivers at the center of the care team

- *System-oriented*, where care providers work together to: 1) improve their collective performance, rather than suboptimizing cost and quality at the expense of the whole; 2) define interventions in the context of a person's history and the expected trajectory of the presenting chronic condition; 3) perfect and standardize practices across related care settings; and 4) continually monitor and adapt to changing circumstances

Simple implementation of prevailing health policies and managed care practices without change will not solve the current chronic care dilemma. Specialty care in name only will fail in serving high-risk beneficiaries. The time to act is now! **MPM**

Rich Bringewatt is President of the National Health Policy Group (NHPG) and Chair of the Special Needs Plan (SNP) Alliance, located in Washington, DC. The NHPG founded and manages the SNP Alliance.

References

1. Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Increasing the Value of Medicare*. Washington DC: MedPAC; June 2006. Available at: <http://www.medpac.gov/>. Accessed August 9, 2006.
2. Partnership for Solutions, National Program Office. *Chronic Conditions: Making the Case for Ongoing Care, September 2004 Update*. Princeton, NJ: Robert Wood Johnson Foundation; 2004. Available at: <http://www.rwjf.org/research/researchdetail.jsp?id=1502&ia=142>. Accessed August 10, 2006.
3. Bradley C, Strunk PB, Ginsburg, Banker MI. The effect of population aging on future hospital demand. *Health Aff*. 2006;25:141-149.
4. Min LC, Reuben DB, MacLean CH, et al. Predictors of overall quality of care provided to vulnerable older people. *J Am Geriatr Soc*. 2005;53:1705-1711.
5. Starfield B, Lemke KW, Bernhardt T, Foldes SS, Forrest CB, Weiner JP. Comorbidity: implications for the importance of primary care in 'case' management. *Ann Fam Med*. 2003;1:4-7.
6. Fried LP, Gerrucci L, Darer J, Williamson JD, Anderson G. Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *J Gerontol A Biol Sci Med Sci*. 2004;59:255-263.
7. Boyd CM, Darer J, Boulton C, Fried LP, Boulton L, Wu AW. Clinical practice guidelines and quality of care for older people with multiple comorbid diseases. *JAMA*. 2005;294:716-724.
8. Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001. Available at: <http://www.nap.edu/books/0309072808/html/>. Accessed August 10, 2006.
9. Eichner J, Blumenthal D, eds. *Medicare in the 21st Century: Building a Better Chronic Care System*. Washington, DC: National Academy of Social Insurance; January 2003. Available at: http://www.nasi.org/usr_doc/Chronic_Care_Executive_Summary.pdf. Accessed August 14, 2006.
10. Pope GC, Adamache KW, Walsh EG, Khandker RK. Evaluating alternative risk adjusters for Medicare. *Health Care Financing Review*. 1998;20:109-129. Available at: <http://www.cms.hhs.gov/apps/review/98Winter/98Winterpg109.pdf>. Accessed August 10, 2006.
11. Tritz K. *Integrating Medicare and Medicaid Services Through Managed Care*. Washington, DC: CRS Report for Congress, Congressional Research Service, Library of Congress; June 27, 2006. Order Code RL33495. Available at: http://www.ancor.org/issues/medicaid/crs_integrate_medicaid_medicare_06-27-06.pdf. Accessed August 10, 2006.
12. Centers for Medicare and Medicaid Services. Medicare nursing home payments to increase in 2007, CMS announces. CMS Office of Public Affairs. Press release. July 27, 2006. Available at: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1918>. Accessed August 10, 2006.