

# Medicare Special Needs Plan Extension and Amendments Act of 2008

H.R. 6365

Original Cosponsors: Ron Kind (D-WI) and Jim Ramstad (R-MN)

## *Section by Section Summary*

### **Section 1: Short Title and Table of Contents**

**Section 2: Extension of SNP Authority.** Extends the authority of Special Needs Plans to limit enrollment to special needs beneficiaries through December 31, 2012.

### **Section 3: Targeting and Specialization for High Risk.**

#### **a. Minimum Enrollment of Special Needs Beneficiaries:**

- Requires 90% of new SNP enrollees to be from the targeted SNP category after December 31, 2008 (i.e., institutionalized, dually eligible or persons with serious or disabling chronic conditions).
- Exempts SNPs previously operating under Sec. 2355 of the Deficit Reduction Act.

#### **b. Agreements:** SNPs must have agreements with State Medicaid Agency in 3 years to:

- provide for coordination of care and financing;
- describe Medicaid services covered by the plan;
- describe how states will fulfill Medicare cost-sharing obligations and payment for Medicaid services;
- require plans to disclose Medicaid benefits and contracted providers;
- exempts plans from agreements if states do not have the administrative capacity to enter into an agreement, limit the number of Medicaid managed care contracts or otherwise are unwilling or unable to enter into an agreement.

#### **c. Cost-Sharing Limits:** Requires SNPs to limit dual beneficiaries' out-of-pocket costs for Medicare services to the amount they would have paid under fee-for-service.

#### **d. Chronic Condition SNPs must:** specialize in care of individuals who are permanently disabled, have end-stage renal disease; specialize in care for those with comorbid or complex chronic conditions that influence other aspects of health and have a high risk of hospitalization or other significant adverse health outcomes; or to have an average plan level risk score of 1.35 or greater.

#### **e. Care Management:** All SNPs must have complex care management capacities:

- conduct an initial assessment and annual reassessment of enrollees' physical, social, medical and function needs;
- develop individual care plans with measurable outcomes;
- use interdisciplinary in management of care;
- develop interventions based on population-based protocols and best practices, to extent available;
- assure access to appropriate clinicians and specialty care networks;
- assure coordination across care providers;
- assist dually eligible beneficiaries in accessing and coordinating Medicare and Medicaid benefits.

#### **f. Quality Standards and Reporting:**

- Requires the Secretary to develop quality measures appropriate to the needs of institutionalized, dually eligible and chronically ill beneficiaries.

- SNP-specific quality measures must take into account current SNP-specific HEDIS and structure and process measures.
  - Secretary is not required to impose additional requirements on SNPs beyond what CMS and NCQA already have undertaken.
  - SNP reporting requirements must not be more burdensome to SNPs than the reporting burden imposed on all MA plans.
- g. Effective Date:** Except as otherwise noted, effective date for Section 2 provisions is on or after January 1, 2010.
- h. Grandfathering for Dual Integration Demonstrations:** SNPs offered under a dual eligible integration demonstrations approved before the effective date of this Act, or expansions to the program after the effective date will be permitted to maintain policies and procedures in effect at the time of enactment.
- i. Transition Clause:** Requires the Secretary to provide for an orderly transition for plans and enrollees that no longer qualify for SNP status or enrollment.

**Section 4: Study on MA Risk Adjustment:**

- a.** Requires the Secretary report to Congress within one year on the need to improve the MA risk adjustment adequacy: for beneficiaries with sustained high risks and costs, comorbid chronic conditions, diagnoses excluded from risk adjustment methodology, disabilities, or frailty; for new enrollees to Medicare; to better reflect condition severity of condition; and to enhance coding persistency through risks scores based on 2 years of data.
- b.** Requires the Secretary to refine risk adjustment payment methods, as appropriate, within two years of enactment of the Act.

**Section 5: Advance Alignment of Medicare and Medicaid**

- a.** Allows Secretary to modify Medicare and Medicaid administrative policies to simplify enrollee access and coordination of Medicare and Medicaid services.
- b.** Requires Secretary to establish an Office on Medicare/Medicaid Integration to simplify access, improve care continuity, eliminate Medicare and Medicaid cost-shifting and regulatory conflicts and improve quality and cost performance. The Office must develop policies and procedures to support state integration, to coordinate state and federal oversight and to align Medicare and Medicaid administrative rules.
- c.** The Secretary is required to report to Congress on statutory changes needed to align dual policies; to work with CBO to evaluate total Medicare and Medicaid spending and savings for duals; provide states and SNPs with tools to align benefits for duals; and to identify state incentives for developing integrated approaches for duals.