The SNP Alliance

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

Executive Summary

SNP Gold Standards Framework

The Gold Standards Framework for Specialized Managed Care was developed by The SNP Alliance's Medical Director Leadership Group to provide guidance to Special Need Plans (SNPs), consumers, health policy leaders and other SNP stakeholders for advancing SNPs as ***the*** vehicle of choice in high-risk care. Our goal is not to recommend new minimum SNP requirements, but to use the strengths of managed care principles and the best of what we know about clinical practice for persons with serious chronic conditions ***to help SNP policy and practice leaders reengineer usual payment, regulatory and care management practices.***

In implementing these recommendations, The SNP Alliance assumes the current fragmented, acute care oriented, medical model established and maintained under traditional fee-for-service and Medicare Advantage financing structures ***causes*** significant and unnecessary confusion, medical complications and costs for persons with complex care needs. We believe implementation of the proposed gold standards can reduce medical errors, iatrogenic illnesses and other system failures and significantly improve clinical and cost outcomes. Some SNPs already have embraced many of the principles identified in the Gold Standards Framework. Other SNPs have built their programs on more traditional Medicare Advantage (MA), disease management and/or fee-for-service structures.

The SNP Alliance assumes that no one size fits all. All SNPs must be afforded the opportunity to establish their own operating methods, in light of its SNP type and prevailing State and community conditions. As a result, the SNP Gold Standards Framework is offered as a lens for consumers, policy-makers and SNPs to use in analyzing and changing SNP policy and practice to be more consistent with the needs of Medicare's most frail, disabled and chronically ill beneficiaries. It draws upon evidence-based guidelines, to the extent available, recognizing that chronic care systems research is frequently inconclusive and incomplete. It also draws upon the knowledge and insights of health care professionals with extensive experience in and peer recognition for their skills in high-risk care.

Chronic illness care is a *systems* problem and requires a *systems solution*. All aspects of our health care system need changing. Since all stakeholders play a role in reinforcing the status quo, all stakeholders must work together to find new ways to improve total quality and cost performance in high-risk care. They must assess the adequacy of existing practices, in light of these standards, and work together to reengineer payment methods, oversight structures, plan administration and care management processes to be more consistent with the special care needs of frail elders, adults with disabilities and other persons with severe or disabling chronic conditions.

We offer this framework as a stimulus for discussion about ways to improve the total quality and cost performance of SNPs and welcome suggestions from all those who share our vision and values.

Consumer Empowerment

Goal: *To enable persons with serious chronic conditions and their family caregivers to optimize their health and well being within the limits of their prevailing condition, with full recognition of the values and preferences of plan enrollees.*

- Simplify and facilitate member enrollment and communications.
- Enhance self-care capabilities.
- Improve access to needed benefits and services.
- Provide family caregiver support.

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SNP Gold Standards Framework Continued

Specialized Care System Expertise

Goal: *To ensure that benefits and services are designed, implemented and maintained according to the unique needs of the high-risk group(s) being targeted, and in accordance with evidence-based guidelines, to the extent they are available and appropriate.*

- Address co-morbid illnesses.
- Manage beneficiary use of multiple medications.
- Integrate mental, behavior and physical health.
- Respond to the volatile, complex and ongoing nature of frailty.
- Manage illnesses within the context of disability.
- Address the unique needs at the end of life.

High-Risk Screening, Assessment and Care Management Processes

Goal: *To identify high-risk beneficiaries and help them and their family caregivers get access to and receive the right care, at the right time, in the right place, given the nature of their condition, the trajectory of their illness, and their care preferences, with emphasis on preventing, delaying and/or minimizing disease and disability progression.*

- Identify high-risk beneficiaries for specialized care.
- Advance interdisciplinary care teams.
- Provide comprehensive assessment and reassessment.
- Establish principal care management leadership and support.

Aligned Care Providers

Goal: *To ensure that provider arrangements are aligned in accordance with the volatile, multidimensional, interdependent and ongoing care needs of high-risk beneficiaries as a person's care needs evolve across time, place and profession.*

- Establish and maintain *enhanced* medical homes.
- Establish and maintain integrated care networks.
- Partner with community programs.
- Employ specialty care protocols and advance practice methods.
- Ensure safe and effective transitions.
- Increase continuity of care.

System Management Methods

Goal: *The goal of system management is to enable the spectrum of Medicare and Medicaid programs, disease management initiatives and care providers serving a common group of high-risk beneficiaries to work together to optimize total quality and cost performance for high-risk beneficiaries.*

- Align Medicare and Medicaid.
- Align financial incentives.
- Advance inter-provider communication.
- Align medical records and informatics.
- Provide ongoing training and support.
- Monitor and document total quality and cost performance.