SNP Alliance Issue Brief

Improving Medicare Payment for High-Risk/High-Need Beneficiaries

June 2012

Background

SNPs were established to enable plans to specialize in care of high-risk/high need persons. However, SNP statutory authority does not require CMS to use a different payment or risk adjustment methodology to account for financial risk and cost differences associated with plans specializing in care of high-risk/high-need populations. CMS has indicated that, without specific Congressional authority, it must use the same payment methods for SNPs as it does for standard MA plans that serve a relatively healthy population with very few dually eligible enrollees. As numerous studies show, for certain groups, these payment limitations under value the costs of serving certain subgroups and create disincentives for specialization. Hopefully, this experience can help inform payment policy for the Financial Alignment Initiative and other Medicare specialty care programs.

SNP Payment Methods

- **All SNPs are paid under the standard MA payment methodology**. The MA payment adjusts health risk based on demographic factors (age, sex, Medicaid, institutional status) and 70 disease-based diagnostic categories (HCCs). All payments are adjusted by the same rate within a single HCC, disadvantaging plans that focus on the sickest beneficiaries. Notably, HCCs do not account for functional impairment or frailty, even though Medicare spending for beneficiaries with chronic conditions *and* functional limitations averages about twice the amount as for beneficiaries with 3 or more chronic conditions and no functional limitations. [i]
- **4 fully integrated D-SNPs (out of 500 SNPs) receive a modest frailty adjustment** to payments to account for a relatively high level of functional impairment.
- **C-SNPs are paid a new enrollee factor** in Year 1 to compensate for the C-SNPs' designated health condition for enrollees new to Medicare, since the standard HCC payment method requires 12 months of data before any health risk adjustments are made. The new enrollee factor is based on the average risk factors for all new enrollees, not the specific condition targeted by the C-SNP. As a result, plans targeting conditions with higher than average new enrollee costs will be underpaid and those targeting conditions with lower than average costs will be overpaid. DSNPs do not receive a new enrollee adjustment even though many DSNPs have a significant number of enrollees who are new to Medicare as a result of their disability-related eligibility.

SNP Payment Challenges

- MIPPA requires SNPs to offer evidence-based Models of Care (MOC) that meet the specialized needs of high-risk/high need beneficiaries. Plans must conduct annual comprehensive health risk assessments and provide individual care plans and interdisciplinary care teams for all enrollees.
- CMS requires that SNPs attest to over 350 SNP-specific requirements consistent with MOC domains such as care management staffing and roles, health risk assessment, individual care plans, interdisciplinary care teams, provider networks, provider training, care management for most vulnerable, and others.
- Model of Care rules require SNPs to provide specialized add-on benefits/services identified by mandatory comprehensive health assessments, in addition to standard MA benefits.
- To receive NCQA approval, SNPs must provide an extensive narrative description of their MOC and supportive documentation for the 11 MOC domains.
- SNPs receive no additional payment for SNP-specific requirements or extra benefits and services.
- Only one SNP-specific measure is included in plan ratings used for consumer comparison-shopping. As a result, consumers do not have an accurate basis for comparing SNPs to standard MA plans on issues of primary importance to high-risk/high-need beneficiaries and SNPs are forced to focus on quality improvements for the general population instead of the unique needs of the special populations they enroll.

Selected Payment Research for High-Risk/High-Need Populations

- ACA mandated CMS research regarding the adequacy of the existing HCC risk adjustment methodology. While the CMS report indicated no change in payment methods was needed, detailed analysis in the Report's tables revealed underpayments for certain payment deciles for frail elderly, those with mental illness, dementia, and AIDS.
- MedPAC found that adding a risk factor for the number of conditions improves the accuracy of HCC risk

adjustment for the sickest beneficiaries (8+ chronic conditions) by about 5% and using two years of diagnostic data instead of one year improves payment accuracy for the sickest beneficiaries by about 2%.[ii]

- GAO found the revised MA risk adjustment community model would improve payment accuracy by about 16% for enrollees with dementia, and reduce accuracy by about 1% for enrollees with multiple chronic conditions.[iii]
- GAO found that the C-SNP new enrollee model substantially improves payment accuracy compared to the general new enrollee model, but still needs work, since it leads to considerable inaccuracy for certain populations. For example, it would:[iv]
    - Improve accuracy by about $2500 for 14 severe or disabling chronic conditions.
    - Reduce accuracy for new enrollees with 1 severe or disabling condition by about 62% of average actual expenditures.
    - Improve accuracy for those with 4 or more conditions by about 8%, while continuing to underestimate expenses by about $20,000 for this group.
- Research conducted by Johns Hopkins University estimated that MA risk adjustment overpays beneficiaries with no chronic conditions by about 40%; underpays SNPs by about 70% during the last six months of life when costs are highest; and under predicts frailty-related costs, consistent with numerous other studies.[v]
- Research conducted at the University of Rochester found that the HCC model under predicts expenses of beneficiaries with CHF and osteoporosis by about 30% and significantly under predicts expenses for patients with hypertension, lung disease, CHF and dementia, after adjusting for disability levels.[vi]
- Research by Ingenix Consulting found that the HCC risk adjustment methodology under predicted costs for beneficiaries who were consistently high-cost/high-risk beneficiaries for a 2-3 year period and that the under prediction increased the longer enrollees were high/cost/high-risk.[vii]

SNP Payment Recommendations

To correct these deficiencies, the SNP Alliance recommends the following changes be made in Medicare payment methods used to pay plans serving high-risk/high-need beneficiaries:

- Establish new risk-adjustment metrics for persons with multiple conditions; various types of severe disabilities such as serious and persistent mental illness; dementia; AIDS; and other high-risk/high-need subgroups for which the existing HCCs under predicts risk, disadvantaging plans exclusively or disproportionately serving these groups.
- Adopt MedPAC recommendations to add new risk factors to HCC risk adjustment for number of chronic conditions and two years of data to advance appropriate payment for high-risk enrollees.
- Incorporate an individual level frailty adjuster to SNP payment for beneficiaries with PACE level frailty to address gaps in the HCC. It does not adjust risk for frailty/functional impairments, nor fully account for costs for plans specializing in care of frail elders and physically disabled.
- Extend the new enrollee factor to all new SNP enrollees as plans must have 12 months of data to receive payment for specific conditions, penalizing plans that target high-cost beneficiaries by denying diagnosis-based payments until year 2 of enrollment.
- Include updated HCCs in SNP payment for conditions such as Alzheimer's disease, to fully account for related Medicare costs, consistent with PACE.
- Stratify risk-scores and risk-based payments for conditions such as CHF and COPD that currently have a single payment adjustment to better account for differences in burden of illness.
- Permit all SNPs to offer expanded supplemental benefits, based on the type of benefits most relevant to the target population, not a predefined CMS list.
- Establish a single capitated, risk-adjusted payment for Medicare and Medicaid benefits for persons dually eligible for Medicare and Medicaid, on a cost neutral basis for combined Medicaid and Medicaid costs to eliminate perverse incentives for cost shifting.
- Establish standards or metrics for bonus/incentive payments that are more relevant to targeted high-risk/high-need beneficiaries than the current Star bonus structure.
- Develop alternative plan rating system for subpopulations with different primary care requirements so persons with special care needs can comparison-shop or compare plans using information that is more relevant to their unique needs and circumstances.

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[i] Komisar and Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across all Services*, October 2011, Georgetown University.

[ii] Zabinski, *Issues for Risk Adjustment in Medicare Advantage,* March 9, 2012 staff report to MedPAC.

[iii] General Accounting Office, *Medicare Advantage: Changes Improved Accuracy of Risk Adjustment for Certain Beneficiaries,* December 2011.

[iv] Ibid.

[v] Anderson, *SNP Payment Should Reflect the Expected Cost of People Who Actually Enroll,* December 2008.

[vi] Noyes, et al, *Medicare Capitation Model, Functional Status, and Multiple Comorbidities: Model Accuracy,* The American Journal of Managed Care, Vol. 14, No. 10.

[vii] Hoffman, *MA Payment Accuracy for High-Cost, High-Risk Beneficiaries,* presentation by Ingenix Consulting at October 2008 SNP Leadership Forum.