

## SNP Alliance<sup>1</sup> Proposed Enhancements to HR 3162 for Special Needs Plans

### SNP Extension

Retain 3-year extension as established in HR3162.

### Clarification of Payment Issues

**HR 3162 requires** that not later than 1 year after the date of the enactment of the Act, the Secretary of HHS shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system. It requires the report to include an evaluation of at least the following:

- The need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with co-morbid conditions and associated cognitive impairments.
- The need and feasibility of including further gradations of diseases and conditions (such as the degree of severity of congestive heart failure).
- The feasibility of measuring difference in coding over time between Medicare part C plans and the Medicare traditional fee-for-service program and, to the extent this difference exists, the options for addressing it.
- The feasibility and value of including Part D and other drug utilization data in the model.

**The SNP Alliance recommends** that Congress:

- *Expand the CMS study to include an assessment of the adequacy of payment as it relates to frailty and disability.* (Frailty—using a disability measure—was the basis for modifying payment for the legacy demonstrations that preceded the SNP law).
- *Include a date certain of 2010 for implementation of risk adjustment refinements to ensure adequate payment for high-cost Medicare beneficiaries.* (A report on the adequacy of payment will not ensure that plans exclusively serving a high-risk population will be adequately compensated for this added risk burden or that it will happen on a timely basis. CMS has been talked about further refinements for frailty and other high-cost conditions since 2003).
- *Require CMS to modify payment methods to pay plans appropriately for new enrollees in the first year of enrollment (e.g., concurrent coding for new enrollees would be one option).* (Enrollees with no history are paid below average FFS costs which is not sustainable for plans targeting high risk populations, particularly for plans targeting beneficiaries who become Medicare eligible because of their conditions, e.g. persons with AIDS or serious and persistent mental illness.)
- *Require CMS to pay SNPs no less than FFS rates for a comparable population.* Not all plans are overpaid in relation to FFS. Plans with an average enrollment in the top 20% cost quintile are actually underpaid by 14%. It is not fair to require SNPs to target as high-risk population and provide added benefits and then not only pay them the less that other MA plans but least that what Medicare would have paid if the beneficiary was in fee-for-service Medicare.)

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<sup>1</sup> The SNP Alliance is an alliance of special needs plans that include all SNP models and all legacy demonstrations that have laid the foundation for specialty care. Members are committed to keeping the bar high for SNPs by targeting high-risk beneficiaries, promoting innovation in care of frail, disabled, medically complex and dually eligible individuals and committing to SNP Alliance quality standards.

## **Coordination of Medicare and Medicaid Benefits for Dually Eligible**

### **Modify Medicaid Contracting Requirements**

**HR 3162** requires dual and institutional SNPs to have a Medicaid contract. However, this requirement is unlikely to foster coordination of Medicare and Medicaid benefits and services unless CMS and states align Medicare and Medicaid financing policy and oversight functions and establish the infrastructure needed by SNPs to obtain a Medicaid contract and align related benefits and services. Medicaid contracting requirements also will be a problem for states that do not have enabling legislation and for SNPs in states that limit the number of Medicaid MA contracts (e.g., Utah has a 2 plan limit, NM and NV have 3 plan limits, etc.) In addition, some states may not be prepared to enter into capitation contracts or may prefer fee-for-service contracts.

#### **The SNP Alliance recommends that Congress:**

- Allow SNPs to offer a Medicare-only program for dual beneficiaries without an agreement or contract if the State has not established SNP contracting provisions or an infrastructure for advancing the integration of Medicare and Medicaid in support of and in accordance with these requirements.
- Authorize CMS to share with States 25% of the 25% in savings that accrues to the federal government where States participate in integration efforts.
- By January 1, 2011, require agreements with state Medicaid agencies to provide for capitation payments *or other payment arrangements* to cover costs of supplemental benefits for duals.
- Require plans to have an agreement with the State Medicaid agency that:
  - includes provisions regarding cooperation on the *coordination of care* and the coordination of the financing of care for such individuals;
  - includes a description of the manner that the State Medicaid program under title XIX *will fulfill its cost-sharing responsibilities under Section 1902 of the Social Security Act*;
  - *includes a provision identifying the Medicaid services that the plan has agreed to provide and the payment for those services*; and
  - effective January 1, 2011, provides for capitation payments *or other payment arrangements* to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).
- Provide that the beneficiary liability for qualified Medicare beneficiaries, for services under parts A and B, may not exceed the amount paid by the State Medicaid agency in accordance with its obligations under Section 1902 of the Social Security Act.

### **Establish CMS Office on Medicare/Medicaid Integration**

**HR 3162** does not contain explicit requirements for Medicare/Medicaid Integration. Currently, there is no full time CMS person or unit with sole responsibility for aligning Medicare and Medicaid financing, administration, and oversight, even though over \$200 billion is spent each year on care for persons dually eligible for Medicare and Medicaid. While CMS appears supportive of advancing M/M integration, lack of centralization among Medicare and Medicaid staff and administrative structures at CMS in relation to policy development for dual eligibles makes it difficult to recognize, let alone address, conflicts in program requirements and oversight. The significant and unnecessary confusion, medical complications and costs caused by program fragmentation cannot be addressed without dedicated CMS staff responsible for monitoring and aligning Medicare and Medicaid financing policy and oversight requirements.

#### **The SNP Alliance recommends that Congress:**

- *Establish a CMS office on Medicare/Medicaid Integration (OMMI) that reports directly to the CMS Administrator and is charged with aligning Medicare and Medicaid financing, administrative and oversight rules and policies.*
  - *The goals of the CMS effort would be to:*

## SNP Alliance Proposed Enhancements to HR3162 – 9/19/07

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- *Simplify beneficiary access to Medicare and Medicaid benefits and services;*
- *Improve care continuity and ensure safe and effective care transitions;*
- *Eliminate cost shifting between Medicare and Medicaid and among related care providers;*
- *Eliminate regulatory conflicts between Medicare and Medicaid rules; and*
- *Improve total cost and quality performance.*
- *The responsibilities of CMS would be to develop policies and procedures that:*
  - *Support State efforts to coordinate and align acute and long-term care benefits for dual eligibles through a state plan option or other means.*
  - *Provides support for coordination of state and CMS contracting and oversight for dual integration programs supportive of the goals outlined above.*
  - *Align Federal rules for Medicaid managed care and Medicare Advantage Plans to include methods for integrating marketing, enrollment, grievances and appeals, auditing, reporting, quality assurance and other relevant oversight functions.*
- *CMS also would be required to:*
  - *Report to Congress on statutory changes needed to facilitate the alignment of Medicare and Medicaid benefits, financing and oversight functions for the dually eligible.*
  - *Work with the Congressional Budget Office and the Office of Management and Budget to establish a process for measuring budget neutrality for the dually eligible as a function of total aggregate spending for both Medicare and Medicaid for comparable risk groups.*
  - *Provide states with education, tools and incentives for enrolling dual eligibles into integrated managed care plans.*
  - *Take affirmative steps to ensure dual beneficiaries are aware of and have simplified access to all Medicare and Medicaid benefits available to them, including Medicare Part D, as well as information regarding a beneficiary's rights related to enrollment, access to services, grievances and appeals, etc.*

### **Provide Protection for Medicare/Medicaid Integration Demonstrations**

**HR 3162 indicates** that the provisions contained within it shall not apply to:

- A Medicare Advantage plan with a contract with a State Medicaid integrated Medicare-Medicaid plan program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004; and
- Plans that are operational as of the date of the enactment of this Act as approved Medicare demonstration projects and that provide services predominantly to individuals with end-stage renal disease.

We understand the House established these provisions to protect demonstrations transitioning to SNP status from losing important program innovations advanced through waivers. The current provisions do not appear to provide any protection in this regard for dual eligible demonstrations since the SNPs for which this exemption was intended are already in full compliance with the provisions outlined.

**The SNP Alliance recommends** the following provision as a substitution for the grandfathering provision for SNPs evolving from MMI demonstration status.

EFFECTIVE DATE; GRANDFATHER.--

(A) Medicare Advantage dual eligible special needs plans that are offered under a State Medicaid integrated Medicare-Medicaid program that had been approved by the Centers for Medicare & Medicaid Services in

cooperation with State Medicaid agency prior to the date of the enactment of this Act may continue the policies and procedures in effect on the date of enactment of this Act.

(B) Medicare Advantage dual eligible special needs plans described in subparagraph (A) shall be entitled to continue to receive a frailty adjuster until CMS has implemented an adjustment factor that adequately takes into consideration the added cost burden for SNPs that enroll a significant proportion of high-risk and/or high-cost beneficiaries including costs associated with comorbidity, frailty, disability, late stage conditions, dual eligibility and such other factors as the Secretary may deem appropriate.

### **Definition of C-SNP**

**HR 3162 defines** C-SNPs in relation to 6 specific conditions, a risk plan level risk score of 1.35, a minimum enrollment requirement of 90% for the targeted population, a requirement that SNP chronic care improvement programs exceed those of standard MA plans and a requirement that SNP networks provide adequate geographic coverage of primary care and specialty physicians. While the list narrows the number of conditions to be approved by CMS, it excludes a number of complex chronic conditions that require specialty care interventions to optimize total quality and cost performance and that are not well served by existing FFS and managed care methods.

#### **The SNP Alliance recommends that Congress:**

- Authorize CMS to approve C-SNPs for persons with severe or disabling chronic conditions for plans that:
  - Enroll 90% of their population from the targeted special needs beneficiary group;
  - Target a population that requires complex care management capabilities to reduce medical complications, hospitalizations, adverse drug interactions or other costly acute care events;
  - Report to Congress on the quality measures outlined below; and
  - Meet one of the three following criteria as a proxy for medical complexity of the population:
    - i. Specialize in care of persons who are eligible for Medicare by way of disability or ESRD status; OR
    - ii. Specialize in care for persons who have a chronic condition with comorbidities; OR
    - iii. Achieve an average plan level risk score established by Congress (but no greater than 1.35).

We propose Medicare eligibility based on disability or ESRD status as additional risk proxies since these populations have complex care needs but plan level risk scores may be lower than plans serving seniors due to differences in age factors for younger disabled adults and a different risk adjustment method for ESRD. We propose alternative requirements for specialization since the key issue for optimizing quality and cost performance in specialty care is not *the number* of providers involved but *their special care capabilities*. Complex care management capabilities and other chronic care oriented specialty interventions are more targeted approaches than network requirements that differ little from standard MA requirements.

**The SNP Alliance also recommends** two technical corrections to this section also are needed. First, the bill includes transition language for existing and new C-SNPs that won't meet the new criteria. Under current provisions, SNPs that were approved prior to January 1, 2008 but that do not meet the new C-SNP criteria would be prohibited from enrolling new members after January 1, 2008 as well as prohibited from expanding their service area. Assuming Congress does not act on Medicare legislation before CMS issues new SNP contracts for 2008 and before the 2007 open enrollment period, some approved SNPs would have to shutdown plans right at the time they have entered the market with virtually no time for developing and implementing transition plans for targeted beneficiaries. To order to give SNPs adequate time for making a transition and avoid unnecessary disruptions for enrollees, Congress should:

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- Change the transition date for implementing new eligibility criteria for C-SNPs from 1/1/08 to 1/1/09; and
- Reference the criteria for SNPs in the transition section of the bill to protect the class of C-SNPs moving forward from the restrictions set forth for non-qualifying C-SNPs.

## **Advancing Specialty Care through Appropriate Quality Standards**

**HR 3162 does not require** SNPs to establish or evidence any specific specialty care interventions.

**The SNP Alliance recommends** strengthening the SNP provisions by requiring all SNPs to:

- Establish complex care management capabilities which include:
  - Assessment of health and functional needs of beneficiaries
  - Development of a plan of care that defines goals and objectives
  - Application of protocols for achieving desired objectives and outcomes
  - Assignment of appropriate clinical staff to meet health care needs
  - Coordination of clinical staff and other service providers involved
  - Periodic reassessment of individuals' health care needs and modification of care plans to reflect changing conditions
  - Periodic measurement of the effectiveness of plans of care.
  - Assisting dual beneficiaries in accessing and coordinating Medicare and Medicaid services.
- Report to CMS on steps taken to improve outcomes in the following domains as a measure of effectiveness of complex care management approaches:
  - Continuity of care
  - Safe and effective care transitions
  - Functional independence
  - Medication management for polypharmacy
  - Co-morbidity management
  - Mental illness and behavioral health management,
  - Member choice
  - Family caregiver support and
  - Reduction of avoidable hospitalizations.

Existing research and leading providers of care for high-risk beneficiaries have consistently identified complex care management and the indicators outlined above as critical to effective care of those with specialty care needs.

If these two recommendations are adopted, the House language would need to be modified by:

- Adding the two requirements at the end of the “additional requirements” sections of the dual and institutional SNPs as new paragraphs (D) and (E); and
- Substituting new paragraphs on complex care management and reporting requirements in place of existing paragraphs(C) and (D) on chronic care improvement programs and network capacity requirements, respectively.