MEDICARE ADVANTAGE SPECIAL NEEDS PLANS: WHAT CONGRESS NEEDS TO KNOW

In 2003, Congress authorized a new kind of private Medicare Advantage (MA) plan called a Special Needs Plan (SNP). SNPs differ from regular private MA plans in that they are intended to enroll, exclusively or disproportionately, only specific high-needs subpopulations of the Medicare population. Such focused enrollment is prohibited for regular MA plans.

SNPs operate with few requirements from the law or from the Centers for Medicare & Medicaid Services (CMS). CMS does not define key terms, allowing SNPs to operate without standards. Nor does CMS collect meaningful data on the services SNPs provide, allowing SNPs to operate without oversight of how or whether they deliver what they promise. The Secretary of Health and Human Services is required to report to Congress by December 31, 2007 about the impact of SNPs on the cost and quality of services provided to enrollees, but, to date, little is known about what SNPs are doing and whether they are meeting the special needs of the medically complex populations they serve.

The authorization for SNPs ends in December 2008. Below is a brief description of SNPs and suggested considerations for Congress in its deliberations concerning whether to extend authorization for SNPs, and, if so, under what terms and conditions.

What Populations do SNPs Serve?

Three groups are identified in law and regulation as special needs populations:

- Individuals dually eligible for Medicare and Medicaid,
- Individuals residing in specified institutions for extended periods, and
- Individuals with a specific severe or disabling chronic condition identified by the SNP.

The three populations identified are the frailest, sickest, and most disabled Medicare beneficiaries. They are also the highest users of health care services. Dually eligible people, for example, use 24% of all Medicare dollars, but represent only 16% of the Medicare population. While dual eligibles are a separate population for purposes of designing a SNP, the other two populations include many dual eligibles as well.

How Have SNPs Grown Since Their Inception?

The number of SNPs providing services to Medicare beneficiaries has grown exponentially between 2004, their first year of operation, and 2007, due in part to the revenue they generate for plans. In 2004, 11 SNPs were approved by CMS. In 2007, 476 SNPs were approved, enrolling
over 800,000 beneficiaries. This represents an increase in plans of over 4000% in four years. The breakdown for 2007, for different types of SNPs, is:

- For dually eligible people: 321 plans serving 621,986 enrollees
- For institutionalized people: 84 plans serving 139,761 enrollees
- For people with chronic conditions: 71 plans serving 81,093 enrollees

What is, and is Not, Required of an MA Plan to be a SNP?

A SNP must be a “coordinated care” plan, either a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), not a Private Fee-for-Service or Medicare Savings Account plan. Unlike other MA HMOs and PPOs, a SNP must provide coverage for Part D, as well as for Parts A and B. Beginning in 2008, SNPs must also state what their “model of care” is; however CMS imposes no requirements for either the content or the performance of the models of care. CMS imposes no other requirements on SNPs. Since SNPs began operating in 2004, CMS has taken no action to enforce any obligations that SNPs meet the special care needs of their members.

Plans serving dual eligibles (regardless of whether they are considered Dual Eligible SNPs) are not required to coordinate care and payments between their members’ Medicare and Medicaid coverage, even though the lack of both care coordination and integration of payment systems are the structural “gaps” that promote fragmentation in care for dual eligibles. Plans are also not required to include Medicaid providers in their plan networks, or to inform enrollees of their Medicaid coverage and how to access it.

How are SNPs paid?

SNPs are paid just like other private MA plans: through a monthly amount per beneficiary that is “risk adjusted” to reflect the likely utilization of services of each enrollee. All MA plans receive “bonus” payments for their enrollees who are dual eligibles or institutionalized. As a result, because nearly all SNP members, by definition, fit these categories, SNPs receive a higher average payment than regular MA plans.

What are Considerations for the SNP Reauthorization Debate?

- SNPs should be offering care and services that are better at meeting their members’ medically complex “special needs” than what is offered by traditional Medicare or by a regular MA plan.
  - What is, and what should be, required of plans applying to be SNPs? What standards exist and what are needed to measure SNP performance?

- Many of the needs of dually eligible beneficiaries that are not included in Medicare are covered by their state Medicaid program.
  - What additional services are Medicare SNPs providing that are not already covered by traditional Medicare and by Medicaid?
How can any SNP with dually eligible members provide better care if SNPs are not required to ensure that care is coordinated with their members Medicaid coverage or to include Medicaid providers in its network?

- Individuals eligible for an institutionalized SNP may reside in institutions that are not subject to Medicare payments, such as Intermediate Care Facilities for people with Mental Retardation, nursing facilities, or in home or community-based settings where they receive primarily Medicaid services.
  - How can an institutionalized SNP add value for these populations?

- SNPs should be improving beneficiaries’ access to primary care and services and to other providers they need, including specialists and social services.
  - How do SNPs guarantee that care coordination services already in place will continue after enrollment?
  - How do SNPs guarantee that members continue to receive services from trusted providers?

- Adequate information should be communicated to potential SNP enrollees and members about all that is or is not covered by the SNP and about how accessing services through the SNP differs from accessing services through Original Medicare or through other Medicare Advantage plans.
  - Do SNPs accurately explain the interaction between Medicare coverage available through the SNP and Medicaid?

Conclusion

Medicare Special Needs Plans have been a costly addition to Medicare. Because they serve populations whose complex care needs have been a challenge to health care policy makers and providers for decades, it is hard not to conclude that their exponential growth is due more to their generation of revenue than to their success at meeting the challenge of the populations they are intended to serve. Special Needs Plans need to be carefully examined to ensure that any additional costs associated with them translate into valuable additional coverage for the populations they purport to serve.

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