



# SNP Alliance

**MARCH 2017**

## **SNP Alliance Legislative Priorities**

### **1. Permanently Authorize Special Needs Plans (SNPs).**

- SNPs are the only specialized Medicare managed care plans for poor, frail, and chronically ill beneficiaries, but they are set to expire at the end of 2018. Congress should permanently authorize all SNP types – D-SNPs (including FIDE-SNPs) C-SNPs, and I-SNPs. Permanent authorization provides stability to states, Medicare beneficiaries, and plans, and enables Congress and CMS to make long-term changes to these specialized managed care plans.
- Congress should pass the SNP permanency legislation that was included in the CHRONIC Care Act of 2016 (S. 3504), with the following changes:
  - Maintain the ability of C-SNPs to specialize in the care of persons with severe and disabling chronic conditions, as defined in current law. Congress should also give C-SNPs the flexibility to modify standard MA benefits and service arrangements (such as reducing cost-sharing on certain items or services, and providing non-medical supplemental benefits) to allow the plans to better meet the unique needs of their enrollees.
  - Allow I-SNPs that serve frail elders in the community to modify standard MA benefits and services to meet the needs of nursing home eligible beneficiaries living in the community. In addition, in order to have consistent payment methodologies for frail elders enrolled in FIDE-SNP, PACE providers, and I-SNPs, Congress should permit I-SNPs to receive a frailty adjuster.

### **2. Expedite Medicare and Medicaid Integration by Strengthening the CMS Medicare-Medicaid Coordination Office (MMCO).**

- Congress should enhance the role of MMCO to help plans and states move towards increased Medicare and Medicaid integration. A strengthened MMCO can also eliminate unnecessary duplication and complexities for states and plans. Congress should build upon the enhanced role of the MMCO in S.3504 and add the following:
  - Align procurement and contracting schedules and processes between CMS and states;
  - Coordinate enrollment processes, including use of a single enrollment card when feasible;
  - Enable joint CMS and state review of member materials and coordinate member notices and communications;
  - Integrate plan assessments and model of care requirements;
  - Align program oversight, performance measurement, data collection and reporting, and consumer protections;
  - Align payment incentives;
  - Permit modification of care plans to better serve enrollees' needs; and
  - Extend MMCO responsibility for C-SNPs and I-SNPs that mostly serve dual-eligible beneficiaries.

### **3. Remove the Disadvantage in MA Star Ratings for Plans Serving Low-Income Beneficiaries.**

- Congress should require CMS to adequately adjust the Star Ratings for social risk factors, such as by stratifying measures by plan type (e.g. comparing D-SNPs to each other). Recent research by ASPE proves an inequity in the Star Rating program for plans that enroll low-income beneficiaries. The Star Rating program must account for social risk factors to accurately measure these plans' quality of care. The Star Ratings should also include quality measures that are relevant to the populations served by SNPs (e.g. beneficiaries with HIV/AIDS or those with severe and persistent mental illness).
- In the interim, Congress should direct CMS to adjust the plan all-cause hospital readmission measure for social risk factors, and require CMS to modify the HOS survey to improve validity and reliability for individuals who do not speak English, have low levels of health literacy/education, or significant levels of cognitive/memory impairment.

### **4. Continue to Improve the Accuracy of the CMS-HCC Risk-Adjustment Model.**

- Through 21<sup>st</sup> Century Cures, Congress took important steps to improve the accuracy of the risk-adjustment model. Congress should direct CMS to continually evaluate the accuracy of the model for high risk, high need populations, such as the frail elderly.