SNP Alliance Position Statement

OCTOBER 2017

SNP Alliance Legislative Strategy

Background

In 2003, Congress authorized Special Needs Plans (SNPs) to exclusively enroll: (1) persons who are dually eligible for Medicare and Medicaid; (2) persons living in institutions or in the community with similar needs'; and (3) persons with severe and disabling chronic conditions. (Medicare Modernization Act of 2003, Section 231) Senators Hatch (R-UT) and Nelson (D-FL) and Representatives Ramstad (R-MN) and Cardin (D-MD) were the original co-sponsors of the SNP legislation.

The purpose was to mainstream successful dual integration demonstrations in MA, MN, and WI and the Evercare and Social HMO demonstrations, and allow other plans with similar interests to evolve. The initial legislation limited implementation to three years in order to reduce total funding costs, given major cost disparities at the time between Medicare FFS and general MA plans — which has subsequently been aligned.

Congress has since passed provisions to extend SNP authorization, strengthen the quality of services provided, and enable better alignment of Medicare and Medicaid, including establishing the Federal Coordinated Health Care Office in 2010 (Patient Protection and Affordable Care Act, Section 2602) to address these concerns. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

CHRONIC Care Act (S.870)

In Sept. 2017, the Senate unanimously approved the CHRONIC Care Act, which included permanent authorization of all SNP types. This is a landmark bill for advancing chronic illness care.

For Dual Eligible SNPs (D-SNPs) to maintain authorization beyond 2021, they must: (1) meet the requirements of a fully integrated plan, other than the requirements to have a similar aggregate level of frailty as determined by PACE; (2) enter into a capitated contract with the State Medicaid agency to provide long-term services and supports or behavioral health services or both; or (3) to the extent the State does not allow for or require a SNP to enter into a capitated contract, they must enter into another type of integrated arrangement determined by the Secretary.

For 2020 and beyond, Chronic Condition SNPs (C-SNPs) must: (1) have an interdisciplinary team that includes certain specialized training; (2) provide face-to-face encounters not less frequently than on an annual basis, and (3) include in their model of care that the results of the initial assessment and annual reassessment of each individual enrolled are addressed in the individual's care plan.

As part of the Secretary's annual evaluation of the model of care, the Secretary shall take into account whether the plan fulfilled their previous year's goals. The Secretary will only approve a plan's model of care if they meet minimum benchmarks established by the Secretary. On or after 2022, C-SNPs must have one or more comorbid and medically complex chronic condition that meets newly defined severe and disabling chronic conditions.

The provisions require the Secretary, working through the Medicare-Medicaid Coordination Office (MMCO), to align grievances and appeals procedures by no later than April 2020; and require SNPs to use these procedures by 2021 and beyond. The provisions also require that the MMCO serves as the point of contact for states to address Medicare-Medicaid misalignments for D-SNPs, disseminate information regarding SNP contracts, and provide support in advancing integration on the SNP platform.

The provisions allow the Secretary to consider requiring SNPs to report data at the plan level instead of at the contract level and authorize a GAO study on state-level integration between Dual SNPs and Medicaid. In a related provisions, for 2020 and beyond, MA supplemental benefits shall not be limited to being primarily health related as long as there is a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee; and the Secretary may waive uniform requirements for MA plan enrollees.

House Ways and Means Committee (H.R. 3168)

The House Ways and Means Committee has approved H.R. 3168 that includes a number of provisions similar to S. 870, except it extends D-SNPs and C-SNPs for only five years. In addition, it expands the role of the MMCO to include developing regulations and guidance related to the integration and alignment of Medicare and Medicaid policy and oversight. For 2021 and beyond, it also allows the Secretary to provide sanctions against the MA organization that don't meet quality measurement specification, including civil money penalties, suspension of enrollment, or suspension of payment, if the Secretary determines that a SNP fails to comply with the integration provisions. H.R. 3168 also strengthens the integration reform analysis of the GAO study and makes explicit that the supplemental flexibility provided to general MA plans in S.870 also applies to SNPs.

House Energy and Commerce Committee

The House Energy and Commerce Committee has not officially weighed in on SNP legislation, but appears to remain open to SNP permanency. We applaud the Energy and Commerce and Ways and Means Committees for trying to find common ground and work with the Senate to expedite the approval of SNP and integration provisions ASAP.

Position on Current Legislative Provisions

1. Permanently Authorize Special Needs Plans (SNPs).

SNPs are the best vehicle for managing the chronic care needs of frail, disabled, and chronically ill people. SNPs provide a more sophisticated approach to care management than what is available in Medicare FFS or general MA plans. All beneficiaries receiving SNP services receive individual care plans supported by interdisciplinary teams of specialized care providers, and team-based care management tailored to individuals with special needs.

SNPs' capitated financing structure incentivizes the appropriate level of care for beneficiaries living with chronic disease. Unlike traditional FFS Medicare, SNPs are responsible for a patient's total array of care needs and design an individual care plan for them, resulting in cost-efficient and quality care. Because SNPs enroll a disproportionate number of dual eligible beneficiaries, there are significant benefits to Medicaid as well, making SNPs a model invested in by States.

A national network of SNPs exists today, providing a foundation to facilitate next generation delivery of high-quality care and offering marketplace choices. Today, more than 580 SNPs nationwide provide specialty care to over 2.4 million beneficiaries. These include SNPs specializing in care of patients with certain diseases, such as diabetes, end-stage renal disease, mental illness, and HIV-AIDS (C-SNPs); SNPs specializing in care of patients in need of nursing homes or living in the community with similar needs (I-SNPs); and SNPs dually eligible for Medicare and Medicaid (D-SNPs). More than 85% of SNP enrollees are dual eligible beneficiaries, many of whom have disabilities and social factors that complicate clinical care.

Temporary extensions of SNP authority create uncertainty for States and sometimes discourage them from investing significant time and resources in this model to advance integration. Making SNPs permanent would signal to States that they have a reliable option for their efforts.

Bipartisan and Diverse Support for Making SNPs Permanent The Senate CHRONIC Care Act of 2017 (S. 870), provides permanent authorization of all SNP types and strengthens the Federal Coordinated Care Office at CMS to advance Medicare/Medicaid integration. Many in the House of Representatives have reached similar conclusions. MedPAC has also called for making integrated and institutional SNPs a permanent part of the Medicare program. The Bipartisan Policy Center has recommended permanently authorizing dual-eligible SNPs and authorizing CMS to align the Medicare and Medicaid grievance and appeals processes and HHS to ensure the combined benefits offered through SNPs are seamless for beneficiaries and providers. In addition, several consumer groups, patient organizations, and health care providers — such as physicians, nurses, and mental health advocates — also support permanent authorization of SNPs in advancing dual integration efforts and specialized care.

Many individual States as well as the National Association of State Medicaid Directors have called for permanent SNP authority so that States can build from the D-SNP platform to advance integration of Medicare and Medicaid.

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

S. 870 and H.R. 3168 both contain provisions to strengthen the role of the Medicare-Medicaid Coordination Office. We support both House and Senate provisions, but suggest adding language contained in the H.R. 3168 to any final SNP legislation, indicating the MMMCO should "be responsible for developing regulations and guidance related to the integration or alignment of policy and oversight under Medicare and Medicaid."

3. Time to Act on Social Risk Factors.

Neither the Senate nor the House SNP bills address the adverse effects of social risk factors on health and healthcare outcomes for dual eligible beneficiaries. Congress has been waiting for ASPE to complete its report on this issue. Now that ASPE has released its report, which shows that dual status is the most significant predictor of poor health outcomes as measured by Medicare Star Ratings, it's time for Congress to act.

We advocate that Congress should require CMS to: (1) stratify populations into high dual/low dual groups to compare quality ratings for similar beneficiary populations; (2) redesign the Star Medicare Star Ratings methods and measures by adding additional exceptions and exclusions; (3) improve the effectiveness of the CAI by adding additional measures and incorporating additional complexity of care and functional factors in the CAI; (4) issue guidelines for Star measure developers and stewards in their re-testing of measures for effects of SDOH/SES factors; (5) re-examine the validity and reliability of self-reported HOS and CAHPS surveys; and (6) provide guidance and technical support to improve data availability and standardization to obtain individual and community-level social risk factor information and use it to stratify, analyze, and report on beneficiary populations and quality measurement results.

4. Other Senate/House provisions.

Lastly, the SNP Alliance does not believe it is appropriate to apply administrative sanctions, as specified in H.R. 3168, on D-SNPs that fail to meet the integration criteria as specified by 2022, particularly where failure to comply is not within their capability. We also support provisions in H.R. 3168 that expand GAO's study requirements on integration and clarify that supplemental benefit flexibility provided to general MA plans in S.870 also applies to SNPs.