The SNP Alliance

A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

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Submitted electronically via chronic_care@finance.senate.gov

The Honorable Orin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
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The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
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The Honorable Mark R. Warner
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

Thank you for the opportunity to submit comments to the Senate Finance Committee's Chronic Care Working Group. We commend the Committee for its efforts to improve care for Medicare beneficiaries living with chronic illness.

The Special Needs Plans Alliance (SNP Alliance) believes that if the Committee is to be successful in its efforts, then it must attend to issues of chronic illness care among persons dually eligible for Medicare and Medicaid. Dual eligible beneficiaries have the highest rates of chronic illness among Medicare beneficiaries, as explained below. The SNP Alliance offers the following recommendations to help the Committee develop transformative policies for the most costly, fast-growing, and vulnerable segment of the chronically ill population. They build on Special Needs Plans (SNPs) as a platform for transformation, although elements and principles of SNPs can be applied to other programs in Medicare.

The SNP Alliance is a national leadership organization dedicated to representing 31 health plan organizations and the populations they serve. Our members offer over 250 plans in 39 States and the District of Columbia and enroll over one million Medicare beneficiaries. Members in the SNP Alliance share a commitment to improving total quality and cost performance through specialized managed care, and to advancing integration of health care for individuals who are dually eligible for Medicare and Medicaid. About three-quarters of the Alliance's members operate fully-integrated, dual-eligible SNPs (referred to as FIDESNPs) or plans in the CMS Financial Alignment demonstration (See Appendix A).

As a subset of MA plans, SNPs exclusively serve beneficiaries who are:

- Dual eligible for Medicare and Medicaid benefits (D-SNP)
- Diagnosed with chronic illness (C-SNP)
- Living in or eligible for nursing home care (I-SNP)

OVERVIEW

Congress established SNPs as part of the Medicare Advantage (MA) program in order to focus on improving care delivered to Medicare beneficiaries who have higher medical and social risk and more complex conditions on average. In some cases, a chronic illness can be a relatively straightforward clinical issue: the focus is on diagnosing the problem, prescribing the right regimen of medication, and monitoring the patient. If the patient is engaged with providers and can comply with prescribed treatment, chronic illness can be managed. Chronic illness care becomes more complicated when multiple chronic conditions, frailty, and/or disability are present. Under these circumstances, not only are more providers and services involved, but also chronic illness care must deliver services across multiple providers and settings, including the home and inpatient settings. Chronic illness care becomes even more complex when an individual with multiple chronic conditions also has sociodemographic characteristics, i.e., low income and education, which make understanding, navigating and complying with intensive health care more difficult.

Over 80 percent of all SNP enrollees are dual eligible beneficiaries (See Table 1). SNPs are distinguished from traditional Medicare and general MA plans by a high percentage of dual eligible enrollees across all SNP types. Nationwide, SNP enrollment has grown steadily since Congress established the program in 2003, with enrollment growing by 12% in 2014. Over 2 million beneficiaries are now enrolled in SNPs.

Table 1: Percent Enrollment of Dual Eligibles

	Percent Dual Eligible
Medicare Population*	20%
Medicare Advantage (includes SNPs)**	16%
Special Needs Plans***	90%

*Source: MedPac DataBook January 2014: Beneficiaries Dually Eligible for Medicare and Medicaid
**Source: Based on AHIP Medicare Advantage Demographics Report 2015
***Source: Based on the Menges Group 2014 SNP Alliance Profile and Advanced Practice Report

The recommendations outlined in our comments represent the SNP Alliance's best ideas to improve outcomes for Medicare patients who live with chronic conditions. In submitting these ideas, we carefully considered the three goals outlined in your May 22nd letter to stakeholders. We believe SNPs are an ideal platform to provide high quality, cost effective care for Medicare beneficiaries with multiple chronic conditions. As described below, the SNP concept is grounded in the principles of evidence-based chronic illness care, and has all the elements of risk-based accountable care. For over a decade, legislative changes to the SNP program have been limited by the constraints of temporary fixes to Medicare physician payment. **We recommend the Committee build on the SNP model as part of its efforts to improve chronic care by 1) making SNPs a permanent part of Medicare and 2) making key policy changes in the areas of risk adjustment, care delivery systems, Medicare/Medicaid integration, and performance measurement outlined below.**

PREVALENCE OF CHRONIC ILLNESS AND SOCIAL FACTORS

Nearly 90 percent of Medicare beneficiaries enrolled in SNPs are dually eligible for Medicare and Medicaid based on their income and disability status. According to the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC), dual eligible beneficiaries have higher rates of chronic illness and multiple chronic conditions, as compared to non-dual eligible beneficiaries in Medicare (See Table 2). Behavioral health conditions—anxiety disorders, bipolar disorder, depression, and schizophrenia and other psychotic disorders—are consistently more common among the dual-eligible population, especially those under age 65, according to the Centers for Disease Control.

Table 2: Prevalence of Chronic Conditions Among Dual and Non-Dual Eligibles

	Dual Eligible	Non Dual Eligible
Chronic Conditions*		
Depression	27%	11%
Diabetes	36%	25%
Alzheimer's Disease	20%	9%
Heart Failure	23%	14%
Having at Least 4 Chronic Conditions**		
Age 65-74		
Men	46%	27%
Women	51%	25%
Age 75-84		
Men	58%	43%
Women	62%	40%
Limits on ADLs***		
No ADLs	45%	70%
3-6 ADLs	29%	10%
Percent Prescribed Medication***	75%	38%

**Source: CMS Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012*

***Source: 2013 CDC Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, 2010*

****Source: MedPAC June 2014, Section 4. Analysis of Medicare Current Beneficiary Survey, 2010*

In addition to higher rates of chronic conditions, dual eligible beneficiaries are more likely to have sociodemographic factors impact an individual's utilization of health care services and health outcomes (See Table 3). Long-standing research links low income, education, and occupational status of an individual to lower use of preventive care, higher risk factors (such as poor nutrition and smoking) that lead to higher rates of chronic illness (such as diabetes and COPD, and worse health outcomes as compared to non-dual eligibles.

Table 3: Sociodemographic Factors of Dual and Non-Dual Eligibles

	Dual Eligible	Non Dual Eligible
Poverty Below 100%	54%	8%
Poverty Below 200%	39%	27%
Employer Sponsored Insurance	0%	35%
No High School Diploma	50%	19%

Source: MedPAC June 2014, Section 4. Analysis of Medicare Current Beneficiary Survey, 2010

PRINCIPLES OF CHRONIC ILLNESS CARE

Chronic illness care must provide appropriate patient assessment, care planning, care transitions, medication reconciliation, and education across the continuum of settings in which a patient lives and obtains medical care. In short, care must meet patients where they are. The principles, outlined below, are centered on four components:

1. **Care Systems**

   Designation of chronic care teams. Effective chronic illness care encompasses primary, acute, behavioral health, and long-term care providers that work together to treat, monitor, and manage care for the same patients. Chronic care teams are different from provider networks offered under general MA plans in that they align providers that serve the same person, rather than simply ensuring an enrollee has access to a general array of medical benefits. In team-based care, standard care protocols are re-designed to align clinical interventions around a common plan of care. They address the unique and interrelated needs of high-need and high-risk subgroups, such as frail elders, adults with certain types of disability, such as SPMI, and persons with certain complex medical conditions, such as ESRD and HIV-AIDS. SNPs are able to align care teams through different contractual arrangements, including delegated risk to providers, pay-for-performance incentives, and employed networks, depending on the health care community they operate in. SNPs are required, for example, to provide care through inter-disciplinary care teams around a common plan of care for each enrollee. SNPs are also required to provide "Models of Care" that engage care teams in person-centered planning and develop individual care plans across multiple settings and services.

   Extended care pathways. Chronic illness care requires coordinated health care to be delivered where the patient is – in physician offices, hospital ERs, skilled nursing facilities, homes, or unstable locations. Care teams along with care coordinators (i.e., extensivists, intensivists, nurse practitioners) follow and interact with patients beyond primary care to manage transitions across settings and over time. Patients with multiple chronic conditions can experience complications that require changes in care settings, treatment, and medications. Extended care pathways help reduce acute episodes, minimize complications that can unintentionally result from inappropriate care transitions, and prevent or minimize progression of chronic illness over time.

   Integrated information systems. Interoperable health information systems that share and integrate data from multiple settings should be designed to reinforce chronic care teams and extended care pathways to improve the total quality and cost outcomes of chronically ill patients. Such systems should minimize duplication and enable all related providers to be informed of patients needs, using a common and consistent data structure. Improving care for chronically ill persons will depend in part upon a new generation of technology and information systems that allows plans and their providers to follow the comprehensive needs of the patient.

2. **Payment**

   Capitated payment. A fixed payment per individual for the full set of Medicare benefits transfers financial risk to entities responsible for the full cost of care, such as health plans under the MA program. Capitated payment allows delivery of a combination of medical and social services for each patient population's needs. It allows flexible benefits designs, services, and interventions that reflect total care needs of chronically ill patients compared to payment for care delivered on a fee-for-service basis. For example, capitated payment

enables sustainable nurse practitioner models that can monitor and engage patients in office, home, and nursing home settings. Capped payment enables the innovative use of practitioners, such as physician extensivists and intensivists, to treat and coordinate care of beneficiaries admitted to hospitals and other facilities. We believe capitated payment should include the full spectrum of care to be delivered and coordinated for chronically ill patients.

Risk adjustment. Capitated payment must be properly risk adjusted to enable health plans to serve persons with complex conditions. Risk adjustment should reflect costs associated with a broad spectrum of chronic illnesses, as well as the influence of multiple conditions, frailty, disability, and social economic status. Health spending for individuals with chronic illness can be 1.5 to 4 times higher than spending for the average Medicare beneficiary. For dual eligibles, average Medicare spending ($19,400) is more than 2 times spending for non-dual eligibles ($8,800) in most recent MedPAC estimates.

3. Integration of Medicare and Medicaid for Dual Eligibles

Integration of Medicare and Medicaid coverage helps dual eligible persons access two sets of benefits and services (which are sometimes conflicting and overlapping) that otherwise must be accessed separately. Dual eligibles have more chronic conditions and complexity than other Medicare beneficiaries, and thus benefit from coordinated and streamlined systems of care. Congress authorized fully integrated SNPs, called FIDESNPs, to integrate the full spectrum of Medicare and Medicaid services and provide patient centered care systems for dual eligibles. FIDESNPs evolved through Medicare demonstrations with States seeking integration of Medicaid and Medicaid benefits in managed care plans. The belief is that the combination of integration and managed care would improve access to services and reduce duplication and conflicts between Medicare and Medicaid in ways that improve quality and cost trends for dual eligible beneficiaries and create overall program efficiencies. CMS recently initiated a Financial Alignment demonstration to test other ways of integrating Medicare and Medicaid for dual eligibles. Many of these demonstrations are similar to FIDESNPs, but have payment arrangements that differ from MA.

4. Performance Measurement

The SNP Alliance fully supports linking payment to performance of health plans and providers to hold them accountable for the quality of the care they provide. Performance measurement for chronic illness care should differ, however, from performance measurement used to assess general patient care. First, a core set of measures specifically relevant to chronic care should be used. Second, measures should focus on total cost and quality to encourage movement away from fragmented care by encouraging collective performance of related care providers. Without ignoring the importance of individual provider accountability, the evaluation of chronic illness care must focus on monitoring *system* performance and patient-centered outcomes. Third, measures must be risk adjusted or stratified for the health and social status of patients, and to account for the more complicated circumstances of individuals with chronic illness – such as co-morbidity, frailty, disability, and low socioeconomic status.

SNPs AND CHRONIC ILLNESS CARE

Principles of chronic illness care are imbedded in the SNP model through federal statute and regulation. SNPs offer a complete framework for delivering and improving care for their enrollees with chronic illness. The current SNP framework includes:

- Authority to target enrollment and create benefit designs to meet the needs of enrolled populations.

- Payment and program requirements of general MA plans. SNPs follow the same rules regarding consumer protections, payment, bids, marketing, contracting, audits, and compliance. There are no exceptions for SNPs.
- Additional statutory requirements that reflect the core principles of chronic illness care. Congress added requirements for SNPs to differentiate them from general MA plans on clinical grounds not just based on populations served or benefits offered. In addition to MA requirements, SNPs must:
    - Implement "Models of Care, " evaluated and approved by CMS and NCQA, describing in detail the characteristics of the populations they serve and specific approaches they use to provide care and assure quality;
    - Delivery and coordinate care through inter-disciplinary care teams;
    - Conduct health risk assessment of enrollees upon enrollment and each year;
    - Develop and update individualized care plans for each enrollee every year;
    - Report specified quality measures to CMS and NCQA on structure and process care delivered by their plans;
    - Report 3 additional quality measures at the plan benefit package level. In addition to Star measures for all MA plans, SNPs are evaluated on four SNP-specific measures in the Star Ratings system.

RECOMMENDATIONS

While SNPs provide a solid framework to deliver chronic illness care in the Medicare program, modifications are needed to make SNPs a sustainable platform for improving outcomes for patients with chronic illness.

1. **Permanently authorize SNPs.**
   SNPs offer the most comprehensive system for delivering chronic illness care in Medicare. Yet SNP authority only extends through 2018, as further extensions were limited by legislation to temporarily fix Medicare physician payment. One of the most important steps Congress can take now to improve care for chronically ill patients is to make SNPs a permanent part of the Medicare program. Permanent SNP authority would:
   - Create stability for beneficiaries and their families by ensuring that SNPs they chose will not sunset.
   - Enable Congress to build upon plans that are grounded in the principles of chronic illness care and that serve high-need and high-cost patients.
   - Give more certainty to States seeking to integrate Medicaid and Medicare for dual eligible beneficiaries through D-SNPs. Temporary extensions of D-SNP authority have created uncertainty for many of the States that want to integrate Medicare and Medicaid via D-SNPs. States must devote resources and time over several years in order to integrate with Medicare, in some cases needing up to 5 years for planning through implementation. Giving permanent authority for SNPs is the best way Congress can give certainty to States that want to use the D-SNP platform to integrate care for dual eligibles.
   - Encourage States and plans to make needed long-term investments in chronic care systems that are most important to ensuring Medicare's and Medicaid's long-term financial viability.

2. **Improve MA Risk Adjustment for Chronic Illness.**
   Chronic illness care is more intensive and costly than general health care for Medicare beneficiaries. Yet the MA current risk adjustment model under predicts spending for high cost chronic conditions and dual eligible beneficiaries relative to Medicare fee-for-service according to analysis conducted by MedPAC and Milliman, Inc. As a result, risk adjustment for MA plans does not accurately allocate

payments for beneficiaries with the most complex chronic illness. To reduce disincentives to enroll and serve these populations in MA, Congress should take steps to require CMS to:

- Remove the disparity in MA payment for dual eligibles and non-dual eligibles that exists in the aggregate under the current MA risk adjustment model. CMS could apply an additional factor to the raw risk scores as described below. The factor would be applied along with the FFS normalization and MA coding intensity factors.
    - Milliman actuaries found the payment disparity in a recent analysis of the impact of the 2014 CMS-HCC model on populations served by SNPs. Specifically, Milliman found that in 2016 MA risk-adjusted benchmarks for dual eligibles are 3.4% below Medicare spending for dual eligibles in FFS, while MA risk adjusted benchmarks for non-dual eligibles are 4.7% above Medicare spending for non-dual eligibles in FFS. Correcting this disparity in the risk adjustment model would be budget neutral and ensure payment equity for plans that exclusively or disproportionately serve dual eligibles.
- Add specificity of chronic conditions prevalent among dual eligibles to the risk adjustment model.
    - Interact more conditions in the MA risk adjustment model to better reflect cost of patients who have multiple chronic conditions.
        - The CMS-HCC model should adjust payments for the presence of common groupings of multiple chronic conditions, such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Diabetes, as well as the presence of mental illnesses with common chronic conditions.
    - Add indicators of disability, dementia, chronic kidney disease stages 1-5, and diabetic neuropathy.
    - Indicate whether a beneficiary has a high number of chronic conditions in the risk model.
        - Over 80 percent of Medicare patients have more than one chronic disease.
- Account for more sociodemographic characteristics of beneficiaries in the risk model.
    - Chronically ill patients are often dual eligible, disabled, and have sociodemographic characteristics that affect their use of health care and health outcomes. The current CMS-HCC model only includes SSI status as a proxy for low income. Indicate whether a beneficiary qualifies for Medicare based on disability in the risk model and consider including separate HCCs for full and partial benefit dual eligibles. .
- Require CMS to implement Section 1853(a)(1)(C)(iii) of the Social Security Act that requires revision of the MA risk adjustment model to account for chronically ill populations. The current Advance Notice process limits transparency and provides only a two-week period for comments to proposals by CMS.
    - This provision requires CMS to conduct reviews and revisions of the risk model to account for higher medical and care coordination costs associated with "individuals with multiple, comorbid chronic conditions, individuals with mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions." CMS issued one evaluation report in 2010 pursuant to this provision but has not issued any further reviews or reports. Require changes to the MA risk model be made with 30 to 60 day comment periods.

3. Allow Greater Flexibility in Delivering Chronic Care Services.

Although capitated payment gives MA plans (including SNPs) greater flexibility to deliver services, limits imposed by statute and regulations create barriers to delivering care for chronic illness. Current standards used to regulate benefit designs and provider networks are geared toward a general MA population, rather than a chronically ill population. Options for permitting greater flexibilities in ways that could improve health outcomes for chronically ill beneficiaries include:

- Allow plans that extensively serve certain chronically ill populations to offer benefits and

services using MA rebates that improve health outcomes for targeted chronically ill enrollees. Allow plans to offer non-medical items and services as supplemental benefits, as long they are known to improve health outcomes.
    - CMS has put limits on the items and services plans offer through rebates in ways that constrain chronic care.
- Allow plans to cover technologies such as telehealth that serve chronically ill patients in their bids.
    - Plans can use Medicare covered services more extensively than FFS providers to help manage chronic illness. Currently plans can include such services as supplemental benefits. Greater flexibility to include technology like telehealth in bids could improve access and outcomes for chronically ill patients.
- Give plans that serve chronically ill populations greater flexibility to design benefits, services, and provider networks that meet patient needs using criteria that differs from that used for general MA plans. What works best for plans serving a predominately chronically ill population often differs from what works for a general MA population.

4. Remove Barriers to Medicare and Medicaid Integration through SNPs

Integrating Medicare and Medicaid benefits through SNPs could improve quality and cost trends for dual eligible beneficiaries, who have much higher rates of chronic illness than non-dual eligibles. Delayed, duplicated, and fragmented care for dual eligibles can result from having two separate health benefit programs. Separate programs require duplicative administrative structures, allow cost shifting between providers, and can result in over and under use of health services, regardless of the long-term cost implications for patients and taxpayers. Integrated programs through SNPs, such as FIDESNPs, combine the full range of medical and social services covered under both programs to create a more holistic, patient-centered, and accountable delivery system. Integrated plans increase access to care and reduce duplication and fragmentation by integrating care networks and interdisciplinary care teams required under SNP statute.

Medicare and Medicaid integration requires intensive operational coordination between CMS, States, and health plans because many program requirements are not aligned or consistent. States would be more able to integrate Medicaid with Medicare through SNPs if program requirements were aligned. To that end, the SNP Alliance recommends that Congress:

- Require the Medicare and Medicaid Coordination Office (MMCO) in CMS to serve as the primary contact and technical liaison to work in partnership with States interested in pursuing integration with Medicare through D-SNPs and FIDESNPs, including States operating outside of the Financial Alignment demonstration.
- Amend the Medicare statute to authorize the MMCO to develop program and operational policies that differ from MA to facilitate Medicare and Medicaid integration through SNPs, such as:
    - Aligned enrollment, use of a single enrollment card, joint federal/state review of member materials, coordination of member communications, and plan contracting schedules.
- Amend the Medicare statute to integrate and align respective Medicare and Medicaid requirements for models of care, performance measurement, data collection and reporting, plan oversight, consumer protections, and appeals and grievances.
- Require MedPAC to conduct study of fully aligning Medicare and Medicaid risk and case-mix adjustment for integrated, capitated payment for dual eligibles.

5. Account for Characteristics of Dual Eligible Patients in Performance Measurement

Dual eligible beneficiaries have higher rates of chronic illness and sociodemographic circumstances that negatively impact their health outcomes. Research shows that low socioeconomic status (SES), i.e. lower income, education, and occupational status, raises risk factors (smoking, poor nutrition, substance abuse, etc.) for chronic disease and lowers individual's use of health care services and health outcomes.

Consider the following research findings:

- Low SES is linked to less use of preventive care, including screenings, vaccinations, and primary care visits;
- Lower educational and health literacy levels negatively impact navigation, compliance with the medical system, and ability to adhere to prescribed treatments;
- Low occupational status is associated with prolonged stress which can lead to high blood pressure and diabetes;
- Residents of impoverished neighborhoods have less access to healthy foods, access to parks for exercise; and access to medical providers, resulting in declining health and higher mortality.

The SNP Alliance supports linking Medicare payment to quality performance of health plans and providers. We have concerns that SNPs are systematically disadvantaged in the current MA Star rating system because quality measures do not adequately account for factors that significantly affect individual health outcomes. In addition, the current Star rating system uses measures relevant for a general Medicare population, rather than patients with complex chronic illness. Given their patient populations, SNPs have difficulty keeping up with quality outcomes achieved by a general MA population – which has less chronic illness, less disability, and higher income. For several years, SNPs that exclusively serve dual eligible beneficiaries have lost ground on Star ratings, while plans that serve a general MA population have gained ground. Interventions needed for SNP populations require greater investments in non-traditional forms of care coordination and patient engagement – most of which are not covered by Medicare and therefore not reflected in MA payment. Yet, quality performance is graded on curve including all MA plans. This results in lower Star ratings and often no quality incentive increases in payments to SNPs, thereby reducing the resources available to deliver and improve outcomes for their patients, many of whom live with chronic illness.

CMS has begun to examine the association between sociodemographic characteristics and quality measures in Medicare's value-based purchasing program. The results of this research have not been shared publicly to date. Other researchers have also conducted rigorous analyses. For example, in Inovalon's recent report, "An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on the CMS Five-Star Quality Measures," determined that lower quality scores for dual eligibles is not related to individual plan characteristics or the proportion of dual eligible beneficiaries enrolled in a plan, but to a common set of risk factors for dual eligible beneficiaries. This finding holds true even for the measure of "all-cause readmissions," which is the only quality measure under the Star Rating system that is partially risk-adjusted for beneficiary age, gender, and chronic health conditions. The study concludes that if Star measures were adjusted for identified risk factors, then 70% of the performance gap observed between dual eligible and non-dual eligible beneficiaries would be closed.

The SNP Alliance urges the Senate Finance Committee to consider the following recommendations to address SES disparities in Star ratings:

- Direct HHS to fully account for sociodemographic factors that significantly affect quality measures in MA Star ratings by 2019.
- Establish short-term policies that remove the financial disadvantage for SNPs and plans serving the most vulnerable patients in Medicare until a permanent solution is reflected in MA Star ratings.
    - Greatest relief should be given to plans with the higher than average percentages of enrollment by dual eligibles. Plans should be held accountable for targeting increased resources under an interim policy to provide high-quality coverage to low-SES members. Plans could be required, for example, to use added resources to fund specific interventions provided they do not result in higher premiums or cost sharing for dual eligibles.
    - Postpone policy to terminate MA plans from the program based on Star ratings until permanent policies are established in 2019.
- Direct HHS to convene an advisory group and public discussion panels over the next 5 years, including experts and plan stakeholders, to consider evidence and modifications to the MA Star rating system and account for social determinants of health, including risk-adjustment of measures and population-based quality ratings.

Thank you for considering these ideas for improving care for Medicare beneficiaries with chronic illnesses. Although our recommendations represent a comprehensive set of revisions, we understand the Committee will be looking to further specify and prioritize legislative solutions that have been offered. The SNP Alliance staff stands ready to discuss any concepts or recommendations outlined in its comments. Should you have any questions, please contact me at Rich@nhpg.org or Shawn Bishop at Shawn@sbhealthpolicy.com.

Sincerely,

Rich Bringewatt
Chairman

APPENDIX A: SNP ALLIANCE MEMBERSHIP, 2015

SNP Alliance Member Organization	Special Needs Plans by SNP Type				State(s) in which SNPs operate[1]	State(s) in which MMPs operate
	D-SNP	FIDE SNP	C-SNP	I-SNP		
AIDS Healthcare Foundation			x		CA, FL	
AmeriHealth Caritas	x				PA	MI, SC
Anthem (including CareMore Health System and Amergroup Corporation)	x		x	x	AZ, CA, CT, FL, GA, IN, KY, ME, MO, NJ, NV, NY, OH, TN, TX, VA, WA, WI	CA, TX, VA, NY
ArchCare				x	NY	NY
Blue Cross & Blue Shield of MN		x			MN	
Brand New Day	x		x		CA	
Care 1st Health Plan	x				AZ, CA	CA
CareOregon	x				OR	
Care Wisconsin		x			WI	
Centene Corporation	x	x			AZ, FL, GA, OH, TX, WI	IL, OH, SC, TX
Cigna-HealthSpring	x		x	x	AL, AR, AZ, DC, DE, FL, GA, IL, MD, MS, NC, PA, TN, TX	IL, TX
Commonwealth Care Alliance		x			MA	MA
Community Care, Inc.		x			WI	
Elderplan	x	x	x	x	NY	NY
Family Choice of New York	x			x	NY	
Gateway Health Plan	x		x		KY, NC, OH, PA,	
Health Care Service Corporation	x				NM	IL
HealthPartners		x			MN	
Health Partners Plans	x				PA	
Independent Care Health Plan (iCare)	x	x			WI	
Kaiser Permanente	x				CA, CO, GA	
L.A. Care Health Plan						CA
Medica Health Plans		x			MN	
Molina Healthcare	x				CA, FL, MI, NM, OH, TX, UT, WA, WI	CA, IL, MI, OH, SC, TX
SCAN Health Plan	x	x	x	x	CA	
Senior Whole Health		x			MA, NY	NY
South Country Health Alliance		x			MN	
Tufts Health Plan		x			MA	MA
UCare Minnesota		x			MN	
UnitedHealthcare	x	x	x	x	AL, AR, AZ, CO, CT, DC, DE, FL, GA, HI, IA, IL, IN, KS, MA, MD, MI, MO, NC, NE, NJ, NM, NY. OH, OR, PA, RI, SC, TN, TX, VA, WA, WI	OH, TX
UPMC Health Plan	x		x	x	PA	

[1] Not all SNPs operate in each state.