

Special Needs Plans (SNPs)

Overpayment Debate Ignores Need for Reform to Achieve Original Program Goals

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The Special Needs Plan Consumer Education Project is an initiative of Community Catalyst that seeks to educate state and federal payers, advocates, health care providers and the public on the opportunities and risks that come with SNPs. The Project is funded by the Retirement Research Foundation.



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Recent debate about the payment to Medicare Advantage (MA) plans has brought these managed care plans into the spotlight. While evidence seems to indicate that MA plans are indeed overpaid as a whole, the debate ignores critical distinctions between categories of plans. Special Needs Plans (SNPs) were created to provide coordinated care to high-need, chronically ill Medicare beneficiaries. These beneficiaries require care that accounts for their complex health needs, coordinates among providers, and, for those who are dually eligible for Medicare and Medicaid, has integrated benefits. This brief discusses how SNPs may offer a means of providing this level of care while also preventing hospitalizations and nursing home stays. It also suggests ways of ensuring that SNPs are able to fulfill their original promise at the same time as increasing their accountability to Congress, CMS and the beneficiaries they serve.

Recent Congressional debate has centered on the payment of Medicare Advantage (MA) plans.¹ MEDPAC, a federal group that advises Congress on Medicare, and other researchers have found that on average MA plans are being overpaid.²

Medicare beneficiaries with complex health needs account for a disproportionate share of Medicare costs.³ These beneficiaries need options that specialize in chronic illnesses and clinical case management of multiple care needs. Congress created Special Needs Plans (SNPs) specifically to improve services for Medicare beneficiaries with serious health conditions who need coordinated, high quality care and to reduce expensive, avoidable emergency room visits and inpatient hospital and nursing homes admissions. Although the SNP program is still relatively new and undergoing evaluation, there is reason to believe that at least some SNPs are fulfilling this important promise.

This brief describes SNPs and the populations they are meant to serve. It then suggests ways to ensure that SNPs bring high quality care to beneficiaries with complex care needs while also receiving appropriate compensation.

What's Special About SNPs?

While the traditional Medicare fee-for-service program has worked for some Medicare beneficiaries, it has not well served many people with serious and concurrent health problems.⁴ Especially for persons requiring multispecialty services and frequent interactions with different providers, medical care has too often been uncoordinated, inaccessible, impersonal, unresponsive and ineffective. As a result, they often experience a loss of autonomy, function, and independence as well as unnecessary hospitalizations and lengthy nursing homes stays.

Congress created SNPs as a means to improve the quality and efficiency of care for individuals with multiple health needs by developing specialty care approaches that better meet their unique needs.

¹ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created new managed care plan options for Medicare enrollees. MA allows enrollees in the Medicare program to opt into private managed care plans, rather than traditional fee-for-service Medicare.

² The Medicare Payment Advisory Commission (MedPAC) found that CMS likely overpays MA plans by between 12 and 19 percent more than the fee-for-service Medicare program. See Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2007.

³ Robert A. Berenson and Jane Horvath. Confronting the Barriers to Chronic Care Management in Medicare. Health Affairs, January 2003.

⁴ Berenson and Horvath.

SNPs, unlike other MA plans, may limit enrollment to:

- ✓ People that are **living in institutions**, such as nursing homes;
- ✓ People who receive both Medicare and Medicaid (“**dual eligibles**”); and
- ✓ People with **severe or chronic disabling conditions** such as end-stage renal disease, HIV/AIDS, complex diabetes, or congestive heart failure.⁵

Limiting enrollment in this manner allows SNPs to specialize in benefit design, treatment approaches and coordinated care for people with complex care needs.⁶

Research on how well SNPs are fulfilling the mission envisioned by Congress is still incomplete. Documentation of certain demonstration projects⁷ as well as anecdotal reports indicate that some are providing high quality care while others offer no special services or service models. Nevertheless, the SNP model is promising and, when done right, can offer a higher level of comprehensive and coordinated care to the high-risk populations they serve than can fee-for-service Medicare or other MA plans. (See box at right for an example of coordinated care for an individual with special needs.)

A threshold question, however, is whether SNPs are even enrolling the beneficiaries they were meant to serve. A look at risk scores, which are one important element in setting MA reimbursement levels, suggests that at least a subset of SNPs are, in fact, serving the intended population of high-cost Medicare beneficiaries.

Are SNPs Targeting the Right People?

All MA plans, including SNPs, receive a monthly capitation payment for each enrollee, based on a “risk score” that accounts for his/her health status and diagnoses. The Centers for Medicare and Medicaid (CMS) supplies the risk score based on its risk adjustment formula. CMS bases the risk adjustment formula for MA plans on diagnoses from hospital inpatient and ambulatory settings through a model called the CMS-Hierarchical Condition Category (HCC).⁸ The

SNP Case Study: Commonwealth Care Alliance (CCA) Massachusetts

PL is a 44-year-old woman with cerebral palsy, a severe speech impediment, spastic quadriplegia, moderate mental retardation, a complex seizure disorder and depression living in a group home in the greater Boston area.

Before becoming a member of CCA, PL had no consistent primary care and received care through multiple uncoordinated specialty clinics at a Boston teaching hospital. Her group home staff had no option but the emergency room for all clinical issues--minor or serious. As a result, PL was hospitalized multiple times for seizures, aspiration pneumonia, and urinary tract infections. There was little attention paid to PL's psychosocial issues.

Since enrolling with CCA, PL has a primary care team made up of her physician and a nurse practitioner, who evaluate PL in her group home or work site. PL's care team provides 24/7 personalized support for her and responds to problems raised by her group home staff members. An integrated psychiatric nurse clinician and psychopharmacology management oversees her complex psychiatric and seizure medications. As a result, PL's emergency room and hospital use has fallen dramatically.

⁵ See Section 1859 (b) (6) of the Social Security Act.

⁶ CMS Special Needs Plans Guidance. January 2006.

<http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FinalSNPGuidance1-19-06R1.pdf>

⁷ William Clark, et al. Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers. Brandeis University, March 2007.

⁸ Prior to the Balanced Budget Act (BBA), CMS primarily used demographic data to account for costs in enrollees' care. The BBA created the principal inpatient diagnostic cost group (PIP-DCG), using data from inpatient hospital stays. MMA then mandated the use of data from hospital inpatient and ambulatory settings. CMS has phased in the

CMS-HCC model uses these diagnostic codes to predict medical costs for an individual, and thus determines adjustments to payment for each MA enrollee.⁹

Because Congress created SNPs with the mission of caring for people with complex health needs, risk scores are critically important to understand whether a SNP is targeting the intended populations. A risk score of 1.0 generally predicts the average cost of a Medicare fee-for-service enrollee in the region. Individuals with risk scores of less than 1.0 have lower predicted health expenses than average, while scores above 1.0 have higher estimated costs due to complex health needs.¹⁰ For instance, enrollees with risk scores well above 1.0 typically have single diagnoses that require very expensive treatments or multiple, coexisting diagnoses that generate considerable service use and health care expenditures. Therefore, SNPs with higher cumulative risk scores are serving enrollees with more complex – and expensive -- health needs, the population Congress intended.¹¹ (See information on risk scores in box at right.)

Risk Scores:

Average Medicare community risk score: 1.0

Some risk scores for SNPs:

- Minnesota Senior Health Options risk scores: **1.43 - 1.56**
- Massachusetts Senior Care Organization risk scores: **1.51 - 2.05**

Therefore, participants in these SNPs have health needs that translate to 143% to 205% of those in the average Medicare population.

Source: Clark, et al, 2007.

Risk scores, however, don't tell the whole story. They don't take into account, for instance, factors indicating functional debilities not captured by diagnosis codes or how frail an enrollee is. More significantly, however, they don't measure how well these high-need populations are being served. While some evidence suggests that a subset of SNPs is mission driven and providing the kind of specialty care envisioned by Congress when it first authorized SNPs (see case study below), SNP-specific quality/performance measurement standards have not yet been implemented.

SNP Case Study: Community Living Alliance, Wisconsin Partnership Program (WPP)

"Helen" is a woman with morbid obesity, on oxygen, with significant anxiety issues. Within her first year in the Community Living Alliance Wisconsin Partnership Program, Helen fell and the leg fracture prevented her from walking. Her leg became infected, requiring IV antibiotics. Helen's electricity was then disconnected. Loss of electricity meant Helen's antibiotics could not be kept in her refrigerator, her oxygen concentrator did not work, preparing foods was very limited, and her mobility was compromised. Helen was terrified of going to a skilled nursing facility.

Helen's Partnership team recognized the serious risks of Helen staying at home, talked with her about their concerns, and worked with her to minimize those risks. The Nurse Practitioner ordered an antibiotic that did not require refrigeration and arranged temporary home delivered meals; the personal care worker came twice daily and remained in close contact with the nurse. Helen received more frequent in-home mental health care to help her manage stress and anxiety, and the social worker aided in working out a budget and negotiating a payment plan with the electricity company. These interventions were more cost-effective than a nursing home stay and were responsive to Helen's safety and quality of life.

CMS-HCC risk adjustment formula since the passage of the MMA, and 2007 is the first year of fully adjusting payments to MA plans based on the CMS-HCC risk score.

⁹ Gregory Pope, John Kautter, et al. Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. Health Care Financing Review, Summer 2004.

¹⁰ Clark, et al.

¹¹ By contrast, MA plan enrollees tend to be in better health and have fewer chronic diseases. These plans also enroll a smaller share of beneficiaries who are under age-65 who have permanent disabilities. Testimony of Patricia Neuman, Kaiser Family Foundation, before the House Ways and Means Subcommittee on Health, May 2007.

Making SNPs Work

As the overpayment debate continues, Congress should seize the opportunity to help SNPs fulfill their original promise while also increasing their accountability to Congress, CMS and the beneficiaries they serve. Congress should direct CMS to work with consumer advocates and other stakeholders to address structural weaknesses in the SNP program, including:

✓ *Establishing Stricter Standards for Approval*

When SNPs were created, plan sponsors had very few requirements to demonstrate how they would offer specialized care to their target populations. Although the SNP application has improved somewhat over the last two years, the standards for approval of new SNPs could be significantly expanded and tightened. For example, applicants should be required to demonstrate that (1) their marketing and summary of benefit materials are understandable and transparent; and (2) they have a sufficient provider network for the target population.

✓ *Creating Enforceable Quality/Performance Standards*

Aside from standard MA reporting requirements, CMS has virtually no standards to measure the level and quality of specialty care SNPs provide to their enrollees. While a SNP may claim to provide “coordinated” care, this can mean anything from having a telephone hotline to assigning a team of caregivers to each enrollee. CMS should require SNPs to provide regular reports on the effectiveness of the care they provide. CMS should create a set of standards to measure SNPs, including the continuity of care in a variety of settings, the provision of social support services, and the methods for gathering and responding to member grievances. CMS should also explore payment adjustments based on these quality/performance measurements.

✓ *Designing Initiatives That Will Encourage Formal Medicare/Medicaid Coordination*

While dual eligibles are only a small percentage of Medicare (14%) and Medicaid (17%) beneficiaries, they account for a disproportionate share of program spending: 40% for Medicaid and 24% for Medicare. The vast majority of SNPs today serve dual eligibles. Yet very few have formally contracted with their state Medicaid departments to offer coordinated benefits to their enrollees. This lack of coordination, resulting in two separate payment, delivery and oversight systems, causes enormous administrative waste. The most serious consequences, however, befall the dual eligible beneficiaries, for whom a lack of continuity of medical, behavioral health and long-term care services can have enormous personal and clinical costs. CMS should take steps to encourage states and SNPs to formally coordinate care between Medicare and Medicaid.

✓ *Refining the Risk Adjustment System to Ensure Appropriate Payment*

SNPs should target beneficiaries with the greatest care needs. And, those that meet the needs of the most vulnerable individuals while minimizing use of costly services should be reimbursed appropriately. CMS should conduct a sophisticated review of the current risk adjustment system with the goal of developing more accurate and transparent methods of paying for quality care provided to the highest cost and highest need beneficiaries.

The Special Needs Plan (SNP) Consumer Education Project seeks to educate state and federal payers, advocates, health care providers and the public on the opportunities and risks that come with SNPs. Along with education, this Project promotes best practices that enhance patient care within a state’s health care framework. Funded by the Retirement Research Foundation, the SNP Consumer Education Project is a project of Community Catalyst, a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system. For more information about the Project or about Community Catalyst, visit our website at www.communitycatalyst.org.