Medicare Special Needs Plans:
A Critical Need for Quality Standards of Care

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

Congress established Special Needs Plans (SNPs) in 2003 to promote health plans that would deliver specialized care to certain categories of high-risk Medicare beneficiaries with the goal of improving quality of care. SNP enrollees require coordination among providers and, for those dually eligible for Medicaid and Medicare, integration of benefits. These needs have largely been unmet, in part because of the lack of strong federal quality requirements for SNPs. This brief discusses problems encountered by SNP enrollees and offers recommendations for developing federal standards to ensure that beneficiaries receive appropriate, coordinated and integrated care to manage complex health needs.

Background

As health care costs continue to rise, policymakers are rethinking strategies to deliver care in the most efficient manner, while also ensuring this care is high quality. One critical method of addressing both cost containment and quality of care is to provide appropriate care for the most chronically ill. When people with complex health needs do not receive coordinated care, their health status declines and they often end up in hospitals or nursing homes. These outcomes could be prevented by better quality care.

Nationally, a small proportion of Medicare beneficiaries account for the majority of the program's costs.[1] Medicare enrollees with five or more chronic conditions comprise 20% of enrollment and 68% of spending.[2] Although Medicare is the primary insurer for this population, it does not cover substantial cost-sharing or benefits such as medical equipment and nursing homes. Individuals with complex health needs often supplement Medicare with Medicaid to cover these gaps. People dually eligible for Medicaid and Medicare comprise only 14% of the Medicaid population, but account for 40% of costs.[3]

Special Needs Plans (SNPs) offer one potential model to provide coordinated care to people with chronic conditions. In 2003, Congress created SNPs explicitly to improve care for Medicare beneficiaries with complex health needs. The assumption was that improved quality of care would help reduce avoidable emergency room visits and nursing home admissions, thus also resulting in Medicare cost savings. SNP enrollees must be: 1) people living in institutions; 2) people dually eligible for Medicaid and Medicare; or 3) people with chronic disabilities. There are now 769 approved SNPs, the vast majority of which serve individuals dually eligible for Medicare and Medicaid.[4] Yet Congress recently imposed a moratorium on new SNPs due to concerns about rapid program growth and uncertainty whether the program has achieved improved quality outcomes for its beneficiaries.[5]

This brief discusses the risk that exists to beneficiaries without a comprehensive set of federal quality guidelines for SNPs. It then highlights best practices for providing quality care through SNPs and suggests standards to ensure that SNP enrollees receive coordinated, integrated care. Given the recent surge in interest among state and federal policymakers to promote "medical homes" and other "integrated health delivery systems," these SNP quality standards may also be used as a blueprint for coordinated care across an array of care settings that serve populations with complex care needs.

The Problem: Inadequate Quality Standards of Care for SNPs

While SNPs hold promise for delivering high quality care to people with complex health needs, there are currently limited criteria to evaluate the level of care coordination, case management and, for those who are dually eligible, the integration of Medicaid and Medicare benefits. Without quality standards tailored to the specific needs of the populations enrolled in SNPs, too many plans fail to offer a model of care that adequately addresses the difficulties beneficiaries encounter in the current fragmented system.

Although the legislation that created SNPs required the Centers for Medicare and Medicaid Services (CMS) to develop regulations, only informal guidance has been provided to date. CMS is now working with the National Committee for Quality Assurance (NCQA) to develop measures to evaluate SNPs and this year has begun to

require some additional SNP-specific quality reporting. The process of establishing and implementing standards, however, is occurring in phases over three years and currently focuses mainly on complex case management.[6] While this is an important step, the NCQA proposes identifying only *certain* SNP enrollees for case management. Because SNP enrollees are typically people with multiple health conditions or complex medical problems, such standards should apply to all. Many question whether the new measures will be appropriate to ensure that SNP enrollees receive the kind care of care that will improve their health status, increase their autonomy, and keep them out of hospitals and nursing homes.

In a promising step, CMS has recently proposed new rules for SNPs.[7] In these regulations, CMS attempts to address two critical areas of SNP quality: care coordination and integration. In addition, there are three bills pending in Congress that, in varying ways, would require all SNPs to adhere to certain standards of care for beneficiaries.[8] While these proposals may represent moves in the right direction, it is unknown to what extent they will actually improve standards for SNPs.

The Solution: Developing Appropriate Standards of Quality for SNPs

There are numerous excellent resources that identify quality measures for people with complex health needs (see, e.g., box below).[9] Highlighted in this section, however, are specific standards that, if adopted, would drastically improve the health outcomes for the vulnerable populations enrolled in SNPs.

Quality Indicators for a Disability-Competent Health System

1. Primary care team expedites referrals and prescriptions
2. Providers have disability-accessible facilities
3. Extended appointment times accommodate members
4. Services address members' full psychosocial needs
5. Services address members' needs and are not merely restricted by benefit limits
6. Tools and training aid providers in understanding needs of members with disabilities
7. Clinical support for primary care providers treating members with specific chronic conditions
8. Medical technology and equipment support for providers
9. Health education for members
10. Accessible websites for members
11. Comprehensive information systems to manage and support care coordination

Adapted from *Disability-Competent Health Systems,* Palsbo, S. and Kailes, J., Disability Studies Quarterly Vol 26, No. 2 Spring 2006.

***Care coordination*:** Quality care for beneficiaries with special needs begins with coordinated care.[10] Yet, there is evidence that SNPs do not always provide care in a coordinated manner, often to the detriment of the beneficiary.[11] SNP enrollees often have multiple health conditions that require alternatives to the standard model of managed care. SNP enrollees' care should be managed by a team of providers to ensure appropriate responses to their health needs.[12, 13]

While there are varying ways to coordinate patient care, an effective model used by some SNPs is an interdisciplinary care team comprised of clinical staff, providers and social workers to address the needs of enrollees.[14] This model is supported by the performance standards developed by the Medical Director Leadership Group of the SNP Alliance, a coalition of plans.[15] As an example, the Commonwealth Care Alliance in Massachusetts uses a care delivery team that includes nurse practitioners, nurses, behavioral health clinicians and peer counselors to support the care for people with complex health needs. Importantly, the SNP Alliance also suggests integrating family caregivers as part of the care team.[16]

A critical point in care coordination for SNP enrollees is during 'care transitions,' or the movement of enrollees between care settings as their health needs change.[17] Successful care transitions require preparation of and coordination between enrollees, caregivers and the clinical team. Researchers at University of Colorado Health Sciences Center have developed a consumer survey to determine adequate coordination during time of care transitions.[18] SNPs must be required to provide enrollees with continuity of care and continued care coordination as they experience care transitions.

Access to patient information: A care coordination plan must be supported by health systems that are accessible to the entire care delivery team to allow prompt response to the needs of SNP beneficiaries. One important tool for ensuring appropriate care coordination is a centralized electronic medical record system. Electronic medical records allow providers and on-call staff with 24-hour, immediate, up-to-date and accurate access to information about a members' medications, treatments, and other services. This record may be used to aid in early intervention of enrollees' potential health problems. For example, the Denver Health Plan allows clinicians full access to members' electronic records and the plan is currently devising methods for health 'coaches' to use the electronic record to focus on issues such as lapsed prescriptions directly with enrollees with the goal of avoiding preventable hospitalizations.

Seamless integration of benefits: Because the majority of SNP enrollees are dually eligible for Medicaid and Medicare, it is critical for SNPs and the providers in their networks to integrate program benefits. However, to date, few SNPs have formally contracted with their state Medicaid agencies to facilitate integration of benefits for enrollees. But some SNPs across the country are utilizing various models of integration. For example, until recently, the Minnesota Senior Health Options program, under which AXIS Health Care operates (see box below), received a single combined capitated payment from the state and from CMS.[19] A similar model has been used in Massachusetts. Different models exist in Texas, Wisconsin and Arizona, and other approaches are currently being developed in other areas.[20] The Medicare Payment Advisory Commission (MedPAC) also recommends that SNPs be required to coordinate with Medicaid programs.[21]

Providers working within SNP networks must also understand the complexities of integrating benefits. Beneficiary advocacy organizations have found that some SNP providers do not understand what Medicaid covers and have billed enrollees for Medicaid-covered services.[22] SNP providers have referred enrollees to specialists who do not accept Medicaid. To remedy these issues, SNPs should be required to ensure their network providers accept Medicaid or otherwise pay for services in full. SNPs should also be required to provide accurate billing and cost-sharing information to providers, as well as information on Medicaid benefits.[23]

Case Study: AXIS Healthcare

Jane is a young woman who, due to injures from a car accident, has a complex array of health problems, including spinal cord and traumatic brain injury, paraplegia, asthma, depression and personality disorder. Before joining AXIS, Jane frequently changed physicians and sought care at emergency rooms. Jane's AXIS care coordination team was successful in stabilizing her provider network and integrating her physical and mental health needs.

Jane was at risk of recurring and life-threatening urinary tract infections and had often been hospitalized for treatment. At AXIS, her primary care physician learned best treatment protocols for early signs of UTIs. Her care providers were trained, along with Jane, in recognizing symptoms. An after-hours RN was available from AXIS to triage early signs and implement orders from the primary care physician to ward off serious infection. In the traditional health care system, Jane's symptoms would often go untreated until she visited an emergency room with an infection spreading to her blood. With support from AXIS, her providers could properly identify and treat her infection early and prevent hospitalization.

Jane now participates in the AXIS member advisory group each month; she has a flair for design and has helped redecorate the apartments of her friends and neighbors. Jane is actively seeking vocational rehabilitation for the first time since her injury.

Specialized provider networks: It is critically important that SNPs identify appropriate networks of providers who understand the particular needs of the target population and the coordinated care model.[24] Commonwealth Care Alliance in Massachusetts, for instance, has successfully worked with primary care practices, medical and behavioral health specialists, durable medical equipment vendors, and other providers that share its commitment to bringing decision-making to the member and focusing on home and community-based services. To date, Commonwealth Care Alliance contracts with 11 primary care networks, including non-profit medical practices and community health centers. Other SNPs including Mercy Care in Arizona and Affinity Health Plan in New

York have found that using their already-existing network of Medicaid providers ensures provider commitment to care coordination models.[25]

Consumer engagement: SNPs must create formal systems to ensure consumer guidance and engagement in all aspects of the plan—from enrollment, to plan design, to care coordination. SNPs should both provide information to SNP enrollees and also create systems for on-going consumer feedback.

SNP enrollees may not understand managed care and provider networks or their care coordination plan. Therefore, SNPs should be required to provide informational materials to all members upon enrollment that include: a guide to managed care, what it means to enroll in a SNP, discussion of the provider network, how to contact the SNP, and -- for any SNP serving dually eligible beneficiaries -- the intersection of Medicaid and Medicare. The information should be available in multiple languages and culturally appropriate for the enrollee population. For example, the care team at AXIS Healthcare in Minneapolis prepared educational materials for enrollees that outlined symptoms for certain conditions and when it is most appropriate to contact providers.[26] In addition, Inland Empire Health Plan sends a newsletter to all enrollees with patient education materials and information on navigating managed care.[27] MedPAC also recommends that SNPS provide benefit and plan information to beneficiaries and their caregivers.[28]

It is also essential that SNPs create formal processes to proactively seek enrollee feedback about care coordination, provider networks, and methods to improve plan design. There are different mechanisms for inducing consumer involvement, from holding meetings with consumers and caregivers to forming advisory committees.[29] For example, Affinity Health Plan of New York convened consumer focus groups during its planning stages and continues to actively engage members through storefront service centers in members' neighborhoods. Commonwealth Care Alliance (CCA) contracts with Health Care for All, the consumer health advocacy organization in Massachusetts, to facilitate regular meetings with members and solicit information on care. CCA also has a Patient Care Assessment and Consumer Advisory Committee to gather greater feedback.

Case management: While some enrollees may need more complex case management, all SNP enrollees should have individualized case management plans that are regularly updated to best serve their needs.[30] Beneficiary advocates have found that not all SNP enrollees have been provided with case management, even when they requested it.[31] Beneficiaries should not have to request case management; rather, it should be provided as a core component of what makes SNPs "special." Lack of case management for people with complex health care needs often results in poor health. For example, without a plan and a team of providers working with them to manage their care, enrollees may have difficulty finding appropriate referrals for treatment or carrying out follow-up steps recommended by providers. SNPs should ensure that individuals' case management plans accurately reflect their needs and include proactive systems for feedback on coordination, care delivery and provider networks from beneficiaries, their families and caregivers. Further, the care delivery team should make certain that beneficiaries understand their care plans, are involved in any changes, and are empowered to manage their own care.

Conclusion

Quality standards are always important, but for individuals with complex health needs, these standards are even more critical. In the absence strong federal quality guidelines, SNPs provide dramatically varied levels of coordination, integration, and consumer involvement. For some enrollees, this means less-appropriate care and unnecessary hospital stays. For government, it means public funding going to lower quality care and missed opportunities at containing costs. CMS must develop specific quality standards tailored to SNPs.

Finally, these quality standards, while critical to SNP enrollees, are also applicable to other care systems for people with complex health needs. Especially for beneficiaries dually eligible for Medicaid and Medicare, integration of benefits and coordination of care are essential, but often overlooked and implemented poorly. Developing strong quality standards for SNPs will provide a blueprint for creating system changes across

different care settings for advocates and policymakers to determine the best care for individuals with complex health needs.

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[6] See NCQA evaluation of Medicare Special Needs Plans. Available at http://www.ncqa.org/tabid/620/Default.aspx.
[7] 42 CFR Parts 422 and 423.
[8] See S. 3101 (Baucus), H.R. 6331 (Dingell/Rangel) and S. 3118 (Grassley).
[9] See also, Tobias, C., Palmer, L., Llanos, K., and Bella, M., "Integrated Care Program: Performance Measures and Recommendations," Center for Health Care Strategies, Inc. Resource Paper, June 2006. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=379026.
[10] Center for Health Care Strategies, Inc., "Medicaid Best Buys: Improving Care Management for High-Need, High-Cost Beneficiaries," March 2008. Available at www.chcs.org.
[11] Halperin, A., "The Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania," Center for Medicare Advocacy, Inc. Special Needs Plan Conference materials, October 2007. Available at www.medicareadvocacy.org.
[12] Tobias, C., et al.
[13] The recently proposed CMS regulations would require SNPs to develop models of care to serve the needs of SNP enrollees, including care coordination among clinical staff. See 42 CFR Parts 422 and 423.
[14] Clark, W., et al. "Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers." Brandeis University, March 2007.
[15] Memorandum from Wilbur, V. and Bringewatt, R. *Performance Measures for Special Needs Plans*, National Alliance of Specialty Healthcare Programs (SNP Alliance), January 2006. Available at www.nhpg.org/media/3014/snpalliancedsnpperfromancemeasures.pdf.
[16] Ibid.
[17] Tobias, C., et al.
[18] Ibid.
[19] The Minnesota program operated under a Medicare waiver that is now expiring. This program, along with the program in Massachusetts, is now moving to a system under which the plans will receive two separate capitated payments from the state and CMS.
[20] Milligan, C.J. and Woodcock, C.H., "Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans," The Commonwealth Fund, February 2008. Available at www.commonwealthfund.org.
[21] MedPAC, Report to the Congress: Medicare Payment Policy Chapter 3. March, 2008. Available at www.medpac.gov.
[22] Halperin, A., "The Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania."
[23] The recently proposed CMS rules would require SNPs to formally contract with state Medicaid agencies, and ensure that enrollees and providers understand payment structures for program cost sharing. See 42 CFR Parts 422 and 423.
[24] As a part of the recently proposed CMS regulations, SNPs would be required to develop models of care that include networks of providers with clinical expertise in the health needs of the specific enrollee population. See 42 CFR Parts 422 and 423.
[25] Lukens, E., Murphy, L., and Bloom, J., "Medicare Advantage Special Needs Plans: Six Plans' Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries' Health and Outcomes," Association for Community Affiliated Plans, November 2007.
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