The Future of Special Needs Plans: Advancing Integration

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Who is the SNP Alliance?

The SNP Alliance is a national leadership organization representing specialized managed care plans that serve high risk and vulnerable populations.

We represent all 3 SNP types and Medicare-Medicaid demonstration plans (MMPs)

We currently have over 390 plans in 44 states and the District of Columbia, serving over 1.9 million individuals.
How do SNPs Stack UP Nationally?

Total National SNP Enrollment Feb, 2019 = 3,064,311
40% of Full Benefit Duals Are Enrolled in D-SNP, FIDE SNP, MMP, and PACE Programs

Mathematic Policy Research: March 2019

Notes: D-SNP total does not include FIDE SNP enrollment and does not include D-SNPs in Puerto Rico. D-SNP total includes 95 enrollees in plans with under 11 enrollees. D-SNP enrollment may include partial benefit dual eligibles.

CMS Quarterly Enrollment Updates, Jun 2018: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html
88% of states have a PACE, FIDESNP, SNP, and/or MMP program. 40% of full benefit duals are enrolled in one of these specialized managed care programs. CMS has been funding dual integration demonstrations for over 3 decades.
The Bi-partisan Budget Act of 2018 Laid a Foundation for Next Steps

Passed by unanimous consent. *Miracles do happen!*

Made SNPs a permanent part of the Medicare program.

Strengthened the role of FCHCO to address alignment of Medicare and Medicaid.

Directed Secretary to establish unifying grievance and appeals for duals.

Provided a pathway for integration through D-SNPs.

Expanded supplemental benefit opportunities for SNPs and general MA plans.

Required GAO to study status, barriers and opportunities for advancing integration.

Required MedPAC to study SNP quality.
Two Dimensions of Integration Require Attention

PROGRAM INTEGRATION
The integration of Medicare and Medicaid policy, financing and oversight.

CARE INTEGRATION
The integration of care for complex care beneficiaries as their care needs evolve over time and across care settings.

Both are interdependent and necessary to optimize total quality and cost performance.
We’ve only just begun!
Where do We go on the Policy Side?
New Frontier for Program Integration

1. Fully aligned federal/state partnership.
2. All benefits and services in the mix.
3. Single plan offers all benefits and services with aligned enrollment.
4. Incentives to advance rather than retreat from full integration.
5. Strong consumer protection.
6. “All in” risk-adjusted, capitated financing.
7. Integrated, systems-oriented performance metrics.
Where do We go with Care Integration?
Population-based Care Networks

1. **Chronic condition focus**: Frailty, physical disability, and conditions, such as ESRD, SPMI, and HIV/AIDS. – *Beyond disease management.*

2. **Single primary care/care manager/interdisciplinary team**. *Avoid provider/discipline-centric behavior.*

3. **Use of extended care pathways** for managing all benefits over time and across care settings. *Cut through care silos; follow the problem.*

4. **Align care methods/incentives** for network providers.

5. **Use common informatics and system performance metrics**. Recognize influences related to social determinants of health.
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