BETTER MEDICARE
ALLIANCE

Medicare Advantage Special Needs Plans

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Overview

Special Needs Plans (SNPs) are a specialized type of Medicare Advantage plan designed to serve the health care system's fastest growing population – frail, disabled, and chronically-ill individuals.[1] Over 4 million Traditional Fee-For-Service (FFS) Medicare beneficiaries in 2014 had six or more chronic conditions, representing 51% of FFS Medicare spending.[2] SNPs enable Medicare Advantage plans to target care to high risk beneficiaries. SNP Medicare Advantage plans tailor care to the needs of a targeted population with complex conditions. SNPs are designed to manage and treat beneficiaries through approved Models of Care. The program aligns incentives and contains costs by emphasizing primary care, chronic care management, and integrated health care services.

Over 18.5 million Medicare eligible beneficiaries have chosen Medicare Advantage, and over 2.4 million of those beneficiaries are in SNPs.[3] SNPs are required to offer all Medicare Part A and B benefits and serve beneficiaries who are dually eligible for Medicare and Medicaid, have certain chronic conditions, or receive long-term care in an institutional setting such as a Skilled Nursing Facility. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018.

Policy Recommendations

1. **Permanently Authorize the SNP Program:** Congress should permanently authorize SNPs before expiration in 2018. Long-term authorization recognizes SNPs as a valuable care delivery model for high risk beneficiaries and offers continuity and stability for SNPs and the beneficiaries they serve.

2. **Provide SNPs with More Flexibility in Benefits:** Increasing flexibility in benefit design and supplemental benefits would help plans tailor services to specific populations to improve health outcomes for beneficiaries. SNPs must adhere to Medicare Advantage design regulations that limit plan ability to tailor networks, cost sharing, and supplemental benefits.

3. **Provide Beneficiaries with More Information About SNPs:** CMS should provide more information on SNPs to beneficiaries by more clearly identifying options in the "Medicare & You 2018 Handbook" and on the Medicare.gov Plan Finder.

4. **Ensure Effective Implementation of the Model of Care:** Establish accountability mechanisms to ensure the Model of Care that SNPs are required to submit is being implemented consistent with the approved plan.

5. **Strengthen the CMS Medicare-Medicaid Coordination Office (MMCO):** Modifying the eligibility requirements for dual eligible beneficiaries should capture all variations of models achieving improved integration. The MMCO should be strengthened to act as the dedicated point of contact to assist states and plans in addressing contract, alignment, and service integration.

6. **Ensure Accurate Payment and Quality Measurement for SNPs:** Conduct a transparent evaluation of the Medicare Advantage Risk Adjustment system and Star Rating system to ensure payment accuracy for dually enrolled and chronically ill beneficiaries. Ensure the systems are accurately recalibrated to obtain accurate risk adjustment for high risk beneficiaries.

7. **Utilize Demonstration Authority to Test Community-Based Institutional SNPs (I-SNPs):** Establish a Community-Based I-SNPs demonstration program to target home and community-based services to eligible Medicare beneficiaries.

8. **Update Report to Congress Evaluating SNPs Impact on Cost and Quality of Beneficiary Care:** Congress should require CMS to conduct an assessment of the impact of SNPs on the cost and quality of services to beneficiaries by updating the 2003 report released in 2008 that evaluated the SNP program.

9. **Utilize Demonstration Authority to Simplify Criteria for Institutional Equivalent SNPs (IE-SNPs):** A demonstration could help develop appropriate criteria for IE-SNPs that is consistent across states.

10. **Reinstate Seamless Conversion with Appropriate Protections:** CMS should work with consumer advocates and health plans to reinstate and update the seamless conversion program to ensure continuity of care for these beneficiaries with appropriate consumer protections.

Background

Legislative History

The Medicare Modernization Act of 2003 established the SNP program and since then Congress has continued to reauthorize the program while creating more sub-types of SNPs and adding requirements to the three core types of SNPs. The Act granted the Secretary of Health and Human Services (HHS) authority to define the conditions that could be served by C-SNPs. CMS also defined D-SNPs to help facilitate the development of fully integrated Medicare and Medicaid managed care contracts.[4]

The State Children's Health Insurance Program (CHIP) Extension Act of 2007 extended SNP authorization until January 1, 2010.[5] In 2007, the National Committee for Quality Assurance (NCQA) released proposed SNP-specific evaluation measures. In 2008, CMS required SNPs to provide a more detailed Model of Care that clearly identified process and outcome measures to determine if structures were in place to care for the targeted population.[6]

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the SNP program to December 31, 2010. The Act added new requirements that I-SNPs use a state assessment tool and an independent entity to determine SNP eligibility to provide care to a beneficiary living in the community. D-SNPs were required to have a state contract that provided benefits under Medicaid consistent with state policy. CMS was also required to convene a panel to approve clinical conditions for C-SNPs, and ensure plans had evidence-based Models of Care and annual beneficiary assessments in place.[7]

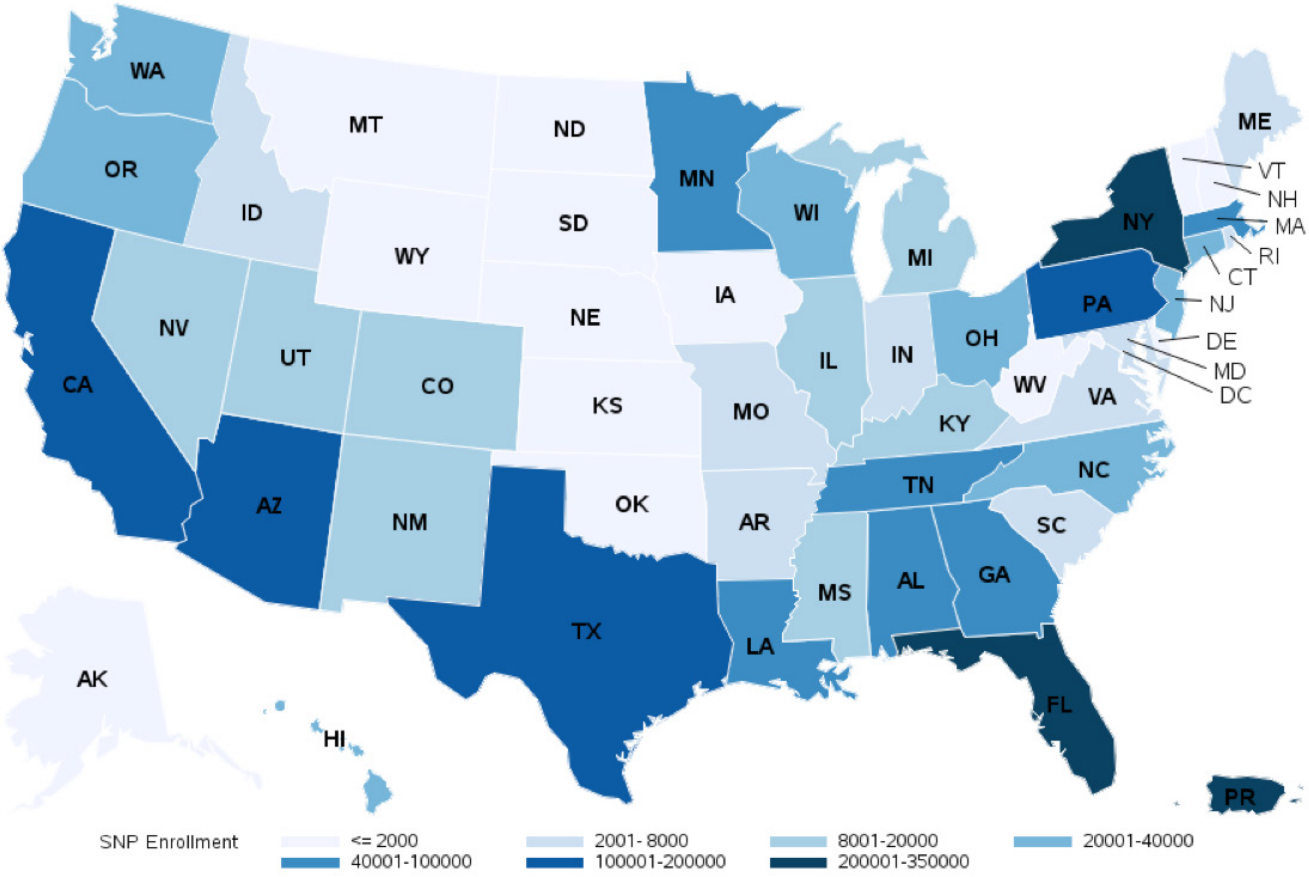
The Affordable Care Act of 2010 extended SNP authorization through December 31, 2013. The Act enabled SNPs that did not have a contract with state Medicaid programs to continue operating. The Act also formalized NCQA's role with SNPs by requiring NCQA-approval Models of Care.[8] The American Taxpayer Relief Act of 2012 extended the SNP authorization through December 31, 2014.[9] The Bipartisan Budget Act of 2013 extended the SNP authorization through December 31, 2015.[10] The Protecting Access to Medicare Act of 2014 extended SNP authorization through December 31, 2016.[11] [12]

Most recently, in April 2016, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018.[13] In April 2017, Senator Hatch re-introduced the CHRONIC Care Act, which would permanently authorize all types of SNPs. In May 2017, this bill passed unanimously out of the Senate Finance Committee.[14] In July 2017, Congressman Tiberi introduced a bill to permanently authorize I-SNPs and provide for 5-year reauthorizations for D-SNPs and C-SNPs. Congressional action is necessary to reauthorize SNPs.[15] [16]

Enrollment

Since SNPs were established in 2003, an increasing number of beneficiaries have enrolled in these specialized plans. Over the last five years, SNP enrollment has grown by over 60% and SNPs now represent about 12.5% of Medicare Advantage. In total, SNP enrollment has grown from 900,000 beneficiaries in June 2007, to over 2.4 million beneficiaries in June 2017 (*see Figure 1 and Appendix I*). Currently, beneficiaries have the choice of enrollment in nearly 600 SNPs nationwide.[17]

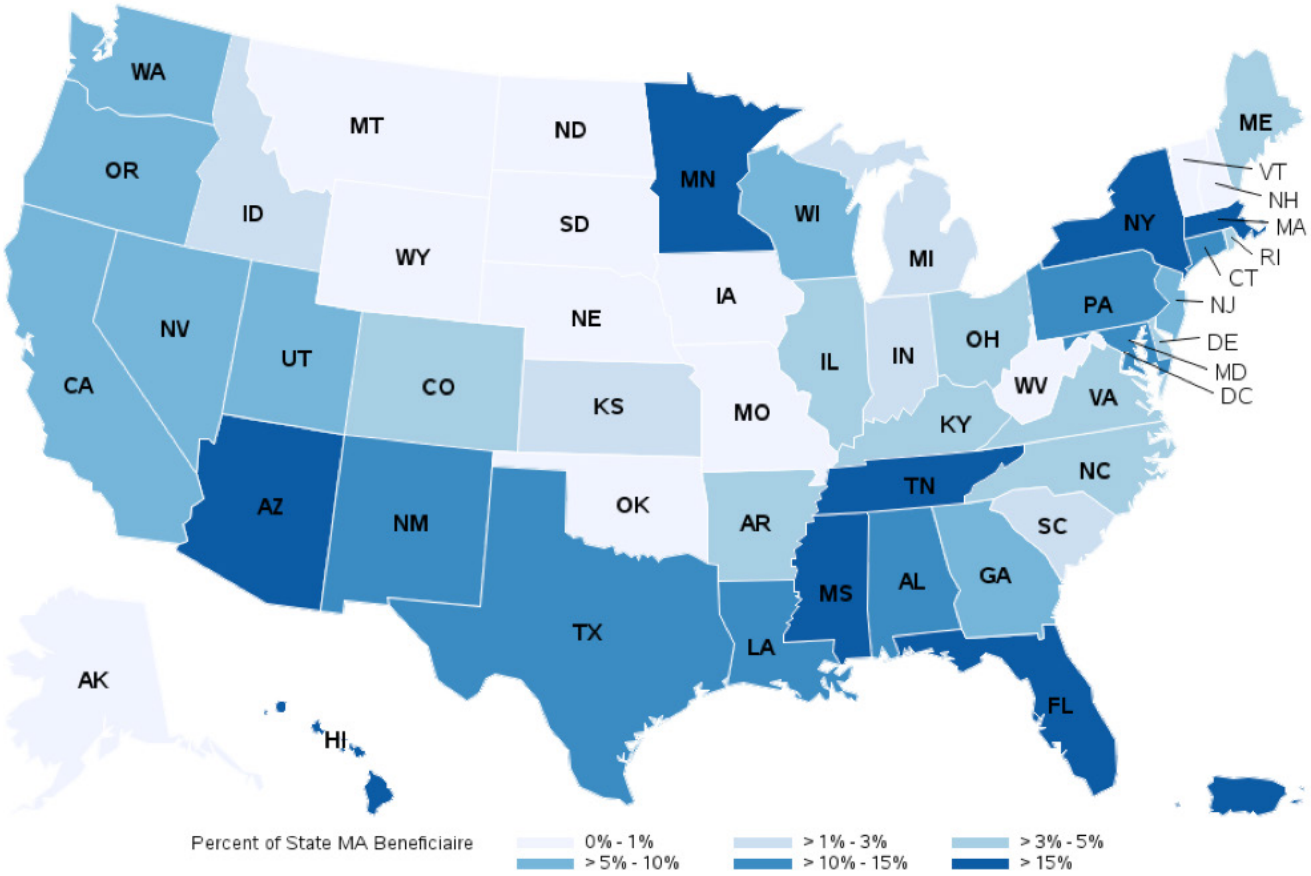
Figure 1: **Medicare Advantage Special Needs Plan (SNP) Enrollment, 2017**



Source: CMS. "Special Needs Plan Comprehensive Report." CMS.gov. June 2017. Web.

There are three types of SNPs: Dual Eligible SNPs (D-SNPs), Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs). Approximately 87% of SNP beneficiaries are in D-SNPs, 10% are in C-SNPs, and 3% are in I-SNPs.[18] SNP enrollment varies by state (*see Figure 2 and Appendix I*). Some states have 20% or more of their in-state Medicare Advantage beneficiaries enrolled in a SNP; these are Arizona, Hawaii, Minnesota, Mississippi, New York, and Tennessee.[19]

Figure 2: **Percent of State Medicare Advantage Enrollment in a Special Needs Plan (SNP), 2017**



Source: CMS. "Special Needs Plan Comprehensive Report." CMS.gov. June 2017. Web.

Payment

SNPs are paid in the same manner as other Medicare Advantage plans. The federal government pays Medicare Advantage plans a capitated monthly amount per beneficiary to provide health benefits to that individual. Medicare Advantage plans then contract with and pay practitioners, hospitals, and other providers to care for beneficiaries. To ensure capitated payments reflect the expected cost of providing medical care to each beneficiary, payments to Medicare Advantage are risk adjusted to reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status. To effectively risk adjust payment in Medicare Advantage, CMS determines a unique risk score for each beneficiary. The CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model is used to create a risk score by using the health of each patient to predict how much that patient may cost in the following year.

Dual Eligible Beneficiaries

Approximately 25% of Medicare beneficiaries are dually eligible for Medicare and Medicaid, amounting to over 11.4 beneficiaries in 2015.[20] According to the Medicare Payment Advisory Commission (MedPAC), 75% of dual eligible beneficiaries are in FFS Medicare and 20% are in Medicare Advantage (with the remaining 5% in both, likely due to changing coverage during the year).[21] In 2011, dual eligible beneficiaries' health costs were four times greater than nondual eligible Medicare beneficiaries.[22]

SNP beneficiaries are generally more expensive because they are more likely to be in poorer health than the general Medicare population.[23] In 2012, over 90% of dual eligible beneficiaries lived below 200% of the poverty line.[24] In the U.S. there is an estimated 20-year gap in life expectancy between the most and least advantaged populations.[25] Duals often have more complex care needs that require additional care and social services as well as long-term care benefits. The 27% of dual eligible enrollees who receive institutional long-term services account for 52% of total Medicare-Medicaid enrollee expenditures.[26] In 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) released a report showing dual enrollment to be a strong predictor of increased hospital readmissions and lower performance on quality measures.[27] Social determinants of health like lack of social support, food, and transportation have been shown to have a significant impact on health outcomes.

CMS responded to concerns that the CMS-HCC risk adjustment model was not sensitive enough to fully predict costs associated with duals by changing the model for 2017. The change sub-segmented individuals based on Medicaid status and age. Under the new methodology, CMS divides beneficiaries into six groups: 1) Full benefit dual aged; 2) Full benefit dual disabled; 3) Partial benefit dual aged; 4) Partial benefit dual disabled; 5) Non-

dual aged; and 6) Non-dual disabled.[28] CMS continues to monitor and evaluate the effect of this change in payment structure.

Interaction Between Medicare and Medicaid

"Dual eligible beneficiaries" is the general term used to describe individuals who are enrolled in both Medicare and Medicaid, but it includes multiple different categories of Medicaid eligibility. Subcategorizations include: fully Medicaid eligible and "Medicare Savings Program" (MSP) categories like Qualified Medicare Beneficiary (QMB) Program. Eligibility for these Medicaid benefit categories is based on federally-defined income and resource standards for full Medicaid and MSP categories. States have the discretion to increase the income and resource thresholds, but they cannot drop them below the federally-set minimums.

Eligibility, by type of dual eligible category, indicates the level of Medicaid services the beneficiary will receive. For example, a fully Medicaid eligible beneficiary is eligible for Medicaid to pay for premiums for Part A (if any) and Part B, cost sharing for Medicare services, as well as other Medicaid-covered services in a given state not already provided by Medicare.[29] Other duals subcategories are not eligible for the same cost sharing and other benefits as full dual eligible beneficiaries.[30]

In addition to required premium and cost sharing support, states are also required to provide nursing home coverage and certain home health services for dual eligible beneficiaries.[31] Most states go beyond these minimum required benefits to include services such as personal care services related to assistance with activities of daily living (e.g. bathing, dressing, preparing meals), more comprehensive care management, full dental coverage, and other essential services for complex, low-income beneficiaries.[32]

For dual eligible beneficiaries, Medicare is the primary payer and Medicare-covered services that are also covered by Medicaid are first paid by Medicare. This includes Part A (inpatient hospital care, Skilled Nursing Facility care, some home health services), Part B (physician services, outpatient care, some durable medical equipment, some home health services, preventive services), Part D (prescription drug coverage), and additional supplemental benefits such as dental and visions (if the dual eligible beneficiary is enrolled in Part C, Medicare Advantage). Medicaid is secondary payer for services partially covered by Medicare, such as nursing home health care, durable medical equipment, personal care, and home- and community-based services.[33] Medicaid is the primary payer for all services solely provided by Medicaid, such as nursing home care, and other home- and community-based services covered by state Medicaid program.

The federal government has several initiatives focused on integrating Medicare and Medicaid benefits for dual eligible beneficiaries. Since 2013, CMS has been testing models in states to better coordinate care for beneficiaries with Medicare and Medicaid through the alignment of financing, primary, acute, behavioral health, and long-term services

and supports. States have the option to enter into a capitated or FFS financial alignment model.[34] In June 2017, there were 12 states enrolled in the CMS-approved Financial Alignment (FA) demonstration program for dual eligible beneficiaries. A March 2017 analysis reported care coordination is one of the main components of the capitated demonstration, and it is hypothesized to be a key element of utilization reduction and quality improvement. The demonstration continues to proceed with upcoming monitoring and evaluation expected.[35]

Quality Measures

Like all Medicare Advantage plans, SNPs are held accountable for meeting quality measurements within the system. High quality plans may receive bonus payments based on a Star Rating system that rates plans from 1 to 5-Stars. Plans with a 4-Star Rating or higher are awarded a Quality Bonus Payment (QBP). The entire QBP must go to beneficiaries through reduced cost sharing or increased benefits. The Star Rating system has been effective at driving quality. In 2015, almost 70% of MA enrollees were in QBP-eligible plans, up from less than 20% in 2009.[36] SNPs and other Medicare Advantage plans are measured on nearly the same quality measures in the Star Rating system.[37] However, there are four additional measures in the 2018 Star Ratings specific to SNPs:

1. Ratings are Special Needs Plan Care Management
2. Care for Older Adults – Medication Review
3. Care for Older Adults – Functional Status Assessment
4. Care for Older Adults – Pain Assessment.[38]

There are concerns that the Star Ratings methodology disadvantages plans serving a high percentage of low income beneficiaries. A 2016 report from ASPE showed low income beneficiaries had poorer outcomes on quality metrics in Star Ratings. CMS addressed these concerns by implementing a Categorical Adjustment Index (CAI) adjustment. The adjustment is calculated based on each plan's proportion of duals, and/or enrollees receiving the low-income subsidy, and individuals with disabilities. This change is an interim adjustment to the Star Rating system while CMS continues to design more comprehensive methodological changes.[39]

Despite the actions taken by CMS, questions remain regarding the accuracy of Medicare Advantage quality payments accounting for social risk factors for low income beneficiaries. SNPs have a higher number of dual beneficiaries who have poorer outcomes on process measures.[40] The CHRONIC Care Act of 2017 would require the HHS Secretary to determine the feasibility of implementing a separate Star Rating system for SNPs.[41]

Benefits

The Medicare Advantage framework aims to align payment and care delivery to incentivize innovative ways to prevent, diagnose, and treat complex chronic conditions to achieve better outcomes and work effectively for beneficiaries. The capitated, or fixed, dollar amount per member, per month system in Medicare Advantage is designed to promote the use of the most appropriate level of care and better care management, particularly for individuals with chronic conditions. Data show that by emphasizing early intervention and better care management, Medicare Advantage can direct beneficiaries with chronic conditions, such as diabetes, to the most appropriate site of care and help prevent adverse, high cost events such as avoidable hospitalizations and emergency room visits.[42] Research also shows that the positive impact Medicare Advantage is having on care delivery is spilling over to FFS Medicare, resulting in reduced hospitalizations and costs to the system.[43] [44] [45]

Payment methodology, quality standards, and oversight for SNPs are the same as for other Medicare Advantage plans, but SNPs must meet additional regulatory and statutory requirements.[46] SNPs are administered by CMS and enrollment is limited to those beneficiaries who meet disease-specific eligibility criteria.[47] SNPs have the authority to provide specialized care to serve beneficiaries who are duals, have certain chronic conditions, or receive long-term care in an institutional setting such as a Skilled Nursing Facility.[48] A beneficiary in a SNP is still in the Medicare Advantage program with all of the same rights and protections. SNP beneficiaries get complete Medicare Part A and Part B coverage as well as Part D prescription drug coverage. Non-SNP Medicare Advantage plans are not required to include Part D coverage, and in those cases beneficiaries may consider buying separate standalone Part D coverage. However, the majority of Medicare Advantage plans include Part D and roughly 90% of Medicare Advantage enrollment is in plans that include Part D (Medicare Advantage Prescription Drug plans, MA-PDs).[49]

The main difference between a Medicare Advantage plan and a SNP are the tailored benefits and care delivery models that are provided to the specific populations SNPs serve. Because enrollment in SNPs is targeted, benefits and interventions can be customized to specific populations. For example, many D-SNPs provide programs to address the social determinants of health most impactful on the health of low-income individuals. Since SNPs have the same statutory limitations in plan design and supplemental benefits as other Medicare Advantage plans, the ability to fully tailor benefits and services to individuals with chronic conditions is limited.

Chart 1: Key Differences Between Medicare Advantage Plans and Medicare Advantage Special Need Plans

	Medicare Advantage Plans	Medicare Advantage Special Need Plans
Benefits	Must offer Medicare Parts A and B benefits. SNPs must provide Part D prescription drug coverage in the plan whereas other Medicare Advantage plans can offer a plan that does not include Part D.	
Payment Method	Capitated monthly amount per beneficiary risk adjusted to each enrolled beneficiary.	
Stars Rating System	Quality is measured through the Star Rating system which rates plans on a 1 to 5-Star scale. In addition, SNPs must report on four additional measures related to care management, medication review, functional status, and pain assessment.	
Supplemental Benefits	Supplemental benefits must be primarily health related	
Flexibility	Must have uniform benefits and plans are largely unable to customize benefit design to specific chronic conditions. *	
Eligibility	Any Medicare-eligible beneficiary residing in a plan service area.	Eligibility limited to beneficiaries who meet criteria of targeted populations in each type of SNP.
Certified Model of Care	Not required.	SNPs must meet NCQA standards and receive approval from CMS for the Model of Care. This includes a description of the SNP population, care coordination plan, a specialized provider network, and a specific, measurable quality measurement plan.

* Unless they are part of a Value-Based Insurance Design (VBID) demonstration project under the Center for Medicare & Medicaid Innovation.

Models of Care Differentiate SNPs

SNPs are required to develop evidence-based Models of Care designed to address the needs of the target population.[50] The Model of Care is designed to achieve better outcomes for beneficiaries. The NCQA is tasked with approving SNPs that have a robust model of care in place. Key elements that must be included in the Model of Care include a description of the SNP population, care coordination and care transition protocols, the provider network, and quality measurement and performance improvements.[51]

4 Key Elements in SNP Models of Care

1. **Description of SNP Population:** The description contains eligibility requirements, social, cognitive and environmental factors, living conditions, and co-morbidities associated with the population, and the ways benefits will be tailored to the highest need beneficiaries.
2. **Care Coordination:** The description contains the staff structure, the health risk assessment tool, an individualized care plan, the interdisciplinary care team, and care transition protocols.
3. **Provider Network:** The description contains the specialized expertise in the network, the use of clinical practice guidelines, and training for network providers.
4. **Quality Measurement and Performance Improvement:** The description contains a quality improvement plan that describes specific data sources and performance outcome measures, measurable goals and health outcomes, patient satisfaction measurements, and ongoing performance improvement evaluations.

SNP Models of Care provide the description of the care delivery design to be implemented to ensure beneficiary needs are identified and addressed. The elements of the Models of Care are scored by NCQA, and the score determines the number of years the Model of Care is approved. The SNP score is based on a percentage of points. SNPs with an 85% or above receive a 3-year approval, SNPs with between 84% and 75% receive a 2-year approval, SNPs with between 70% and 74% receive a 1-year approval, and SNPs with 70% or below receive an opportunity to resubmit their Models of Care.[52]

Types of Special Needs Plans

Dual Eligible SNPs (D-SNPs)

D-SNPs serve beneficiaries who are eligible for coverage under both Medicare and Medicaid, known as dual eligible beneficiaries. Dual eligible beneficiaries are also able to enroll in C-SNPs and I-SNPs. As described above, dual eligible beneficiaries receive both Medicare-covered benefits as well as Medicaid-covered benefits, such as cost sharing support, nursing home care, and varying degrees of home health, durable medical equipment, personal care, and home- and community-based services. D-SNPs are required to contract with states to cover Medicaid benefits, cost sharing, and additional services such as behavioral health.[53]

States have different requirements for how D-SNPs must integrate with the state Medicaid program. States that have successfully integrated services for beneficiaries in D-SNPs have done so by engaging stakeholders, achieving data sharing, developing a program design, and obtaining necessary CMS approvals.[54] Evidence shows that integrated managed care can provide beneficiaries with better care coordination and achieve better outcomes. A 2016 report published by HHS studied the delivery of Medicare and Medicaid services to dually eligible beneficiaries over age 65 in Minnesota. The study compared health care delivery between dually eligible beneficiaries in Minnesota Senior Care Plus (MSC+) and the Minnesota Senior Health Option (MSHO). MSC+ was a Medicaid-only program, and MSHO was a fully integrated Medicare-Medicaid program. The study found fully-integrated managed care plans were more effective than fragmented delivery systems. The integrated plans had higher consumer satisfaction, more service use, and lower emergency department utilization.[55]

Fully-Integrated Dual Eligible SNPs (FIDE-SNPs)

A subset of D-SNPs are known as Fully-Integrated Dual Eligible SNPs (FIDE-SNPs). FIDE-SNPs must have a risk-based Medicaid contract, coordinate care and long-term services with states, create a specialized provider network, and coordinate beneficiary communications.[56] In June 2017, there were 377 D-SNP plans serving almost 2 million beneficiaries. Of these D-SNPs, 39 were FIDE-SNP plans and they were operating in eight states serving 144,207 beneficiaries.[57] [58] Therefore, less than 8% of D-SNP beneficiaries are in FIDE-SNPs nationwide. About 75% of FIDE-SNP enrollment is in Massachusetts, New Jersey, and Minnesota.[59] States have the discretion to decide whether or not they want to engage in FIDE-SNP arrangements, and many have not yet decided to do so.

Some states have decided to create capitated arrangements to provide Managed Long-Term Services and Supports (LTSS) through Medicaid. These programs vary widely state to state. As of June 2017, 19 states had a Managed LTSS program.[60] Some states require a

Medicare Advantage plan to also have a Managed LTSS contract in the state and varying degrees of integration to be able to operate a SNP.[61]

Chronic Condition SNPs (C-SNPs)

C-SNPs serve beneficiaries with a disabling chronic condition, as specified by CMS. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum.[62] For example, a C-SNP for a beneficiary with congestive heart failure (CHF) would include a network of providers who specialize in treating this chronic condition, care management programs with expertise in serving people with the chronic condition, and a drug formulary designed around treating congestive heart failure. In June 2017, there were 123 C-SNPs serving over 339,000 beneficiaries.[63]

Eligibility for C-SNPs:

In the fall of 2008, CMS convened the SNP Chronic Condition Panel. The panel included six clinical experts on chronic condition management from the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and CMS. Public comment was solicited on the chronic conditions meeting. After discussing public comments, the panel recommended, and CMS approved, 15 SNP-specific chronic conditions.[64]

Beneficiaries may be eligible for a C-SNP with one or more of the following severe chronic conditions:

- Chronic alcohol and other drug dependence
- Autoimmune disorders
- Cancer (excluding pre-cancer conditions)
- Cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes mellitus
- End-stage liver disease
- End-Stage Renal Disease (ESRD) requiring any mode of dialysis
- Severe hematologic disorders
- HIV/AIDS
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Neurologic disorders
- Stroke [65]

Evidence shows C-SNPs are providing high-value care. A 2017 study authored by the RAND Corporation found home visits for beneficiaries in C-SNPs to be a promising avenue to meet beneficiaries' needs.[66] A 2012 study found beneficiaries in a C-SNP had lower rates of hospitalizations and readmissions than their peers in FFS Medicare. Risk-adjusted hospital days per beneficiary were 19% lower than FFS Medicare and per beneficiary readmission rates were nearly 30% lower than FFS Medicare.[67] A 2015 Commonwealth Fund case study found that the Medicare Advantage Plan CareMore, which includes SNPs, had 20% fewer hospitalizations than FFS Medicare, while delivering Medicare benefits more efficiently.[68]

Institutional SNPs (I-SNPs)

Institutional SNPs (I–SNPs) serve institutionalized beneficiaries who, for 90 days or longer, have resided or expect to reside in a long-term care facility, such as a Skilled Nursing Facility. A subset of I-SNPs are IE-SNPs for institutional equivalent beneficiaries living in their own homes, but requiring an institutional level of care. I-SNPs contract with nursing facilities to care for beneficiaries.[69] In June 2017, there were 83 I-SNPs serving over 65,000 beneficiaries.[70]

Evidence shows I-SNPs have higher rates of advance care planning, medication review, functional status assessment, and pain screening.[71] UnitedHealthcare's Nursing Home Plan I-SNP is the largest in the country and delivers coordinated, individualized, and carefully monitored care to roughly 50,000 Medicare Advantage beneficiaries. The UnitedHealthcare Nursing Home Plan has been highlighted by MedPAC as a model for reducing unnecessary hospitalizations. The UnitedHealthcare Nursing Home Plan provides nurse-practitioners (NPs) on site care at Skilled Nursing Facilities to manage the beneficiary's care. The use of NPs onsite support was noted by MedPAC as an important component of the model to provide support and education to residents and facility staff, which improves communication, training, and care. The model was also highlighted for engagement in palliative care and advanced care planning with beneficiaries.[72]

Policy Recommendations

To build on the successes of SNPs across the country and ensure the continuity of this specialized care for Medicare Advantage beneficiaries, the following recommendations aim to continue and strengthen the program:

1. Permanent Authorization of SNP Program

Without Congressional action, SNP authority will expire in 2018. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery option for high risk beneficiaries. Congress should ensure SNP authority does not expire in 2018. Permanent authorization will provide certainty for states and plans to invest in the program, improve integration, and foster long-term partnerships in SNPs. It will also provide stability, and improve continuity of care for Medicare beneficiaries.

There is broad consensus in Congress, MedPAC, and among stakeholders that SNPs should be permanently authorized. The Senate Finance Committee Chronic Care Working Group recommended permanently authorizing SNPs.[73] In 2016, MedPAC recommended Congress permanently authorizing all I-SNPs, certain D-SNPs and certain C-SNPs.[74] Greater certainty will unlock the potential of these innovative, successful models that are meeting the needs of high cost, high need beneficiaries under Medicare Advantage across the country.[75]

2. Provide SNPs with More Flexibility in Benefits

Increasing flexibility in benefit design and supplemental benefits would help SNPs tailor care and services to specific populations to improve health outcomes for beneficiaries. Currently, Medicare Advantage supplemental benefits are limited to health-related services, which can prevent investments in services such as home delivered healthy meals and transportation to medical appointments. These restrictions limit plans' ability to target benefits, lower cost-sharing, and forge innovative partnerships with community-based organizations. Broadening the definition of health-related services to include all benefits that have a reasonable expectation of improving or maintaining health or overall function would give Medicare Advantage plans more flexibility to offer additional benefits to chronically ill beneficiaries and would better enable plans to address social determinants of health.

Certain high performing D-SNPs receive additional flexibility from CMS to design benefits such as in-home food delivery, support for caregivers, and home modifications. Plans must get approval from CMS to offer the benefit and the benefit must come at zero cost to the beneficiary, must not be duplicative, and must be offered to all beneficiaries uniformly.[76] CMS has acknowledged the need for flexibility by removing regulatory barriers that could help ensure beneficiaries have access to the most high-value care.

In the Medicare Advantage Final 2018 Rate Notice and Call Letter, CMS decided to develop

SNP-specific network adequacy evaluations. Currently, SNP network adequacy is evaluated based on Medicare Advantage network adequacy standards. More flexibility in networks could enable SNPs to more appropriately tailor care to beneficiaries with special needs.[77]

3. Provide Beneficiaries with More Information About SNPs

According to MedPAC, D-SNPs are limited in their ability to describe to beneficiaries the combination of Medicare and Medicaid benefits available in SNPs in marketing materials.[78] States have different requirements associated with D-SNP marketing materials, further complicating the information a beneficiary is provided to help determine whether a SNP is a good option.[79] CMS should provide more information to beneficiaries by more clearly identifying SNPs as an option in the "Medicare & You 2018 Handbook." State-specific handbooks should also be available for download on the Medicare.gov site so people who choose to receive the Medicare & You Handbook online will also have access to the SNP information that is available in the printed books.

The Medicare.gov Plan Finder is currently not an effective resource for beneficiaries to identify SNP options. The Plan Finder should be improved by including more comparison tools and sorting functionalities. In a BMA survey of Medicare Advantage beneficiaries, over 60% of beneficiaries said Medicare.gov's Plan Finder was not helpful in finding the right Medicare Advantage plan.[80] CMS should invest the necessary resources to make effective updates to the Plan Finder. Improvements should include incorporating better comparison tools, especially related to out-of-pocket costs, comparison of Medicare Advantage plan options to FFS Medicare and the additional cost of supplemental, private policies such as Medigap, as well as user-friendly sorting capabilities. Plan Finder should better enable beneficiaries to make informed decisions about cost and quality.[81]

4. Ensure Effective Implementation of the Model of Care

The SNP Model of Care process is based on Structure & Process measures previously developed by NCQA.[82] The Structure & Process measures were developed to ensure SNP beneficiaries received comprehensive, coordinated care in the design. NCQA developed the Structure & Process measures through field testing, public comment and the NCQA Geriatric Measurement Advisory Panel.[83] The 2012 Structure & Process measures included requirements around complex case management, member satisfaction, clinical quality improvement, and care transitions. While the Healthcare Effectiveness Data and Information Set (HEDIS) measures included in the Medicare Advantage Star Rating system focus on performance on specific clinical issues, Structure & Process measures were designed to assess the systems SNPs had in place.[84]

However, according to the SNP Alliance, the Structure & Process measures and Model of Care domains were developed independently, and failed to align.[85] Policymakers should consider putting in place mechanisms to ensure the Models of Care are being implemented in a manner consistent with the approved plan.

5. Strengthen the CMS Medicare-Medicaid Coordination Office (MMCO)

The MMCO should act as the point of contact for states and plans in regards to SNPs to help establish best practices for contract information, questions, and integration of services for dual eligible beneficiaries.[86] The MMCO currently helps facilitate alignment between Medicare and Medicaid in SNPs.[87] The office was established by the Affordable Care Act in 2010 to integrate the Medicare and Medicaid programs more effectively for duals and work with states to test integration models.[88] The Integrated Care Resource Center reported a key component of successful D-SNP contracts is federal agency leadership and staff knowledgeable about Medicaid and Medicare Managed Care.[89]

SNP integration requirements should include definitions that appropriately capture all variations of delivery models achieving improved integration. Specific consideration should be given to ensuring states and plans have multiple pathways to tailor integration. The goal of more integrated care can be accomplished through better data sharing, aligned incentives, and more fully integrated services.[90] The integration and alignment of services financed by Medicare and Medicaid is important to achieving effective care for dual eligible beneficiaries.

6. Ensure Accurate Payment and Quality Measurement for SNPs

Despite the CMS move to a Risk Adjustment system sub-segmented by dual status to improve accuracy, analyses indicate inaccuracies remain for beneficiaries with multiple chronic conditions.[91] Duals have more complex health care needs and a higher prevalence of multiple chronic conditions such as diabetes, Alzheimer's disease and mental illness.[92] CMS should conduct a transparent evaluation of the Risk Adjustment system and the Star Rating system to ensure payment accuracy and effective quality measurement for all beneficiaries, including those with the compounding impact of multiple chronic conditions, as well as the effect of social factors and cognitive impairments on risk and cost.

For example, when CMS recently updated the Medicare Advantage risk adjustment model it resulted in a 10% drop in I-SNP payment rates due to a recalibration of the institutional segment of the model.[93] CMS stated the update was to improve the predictive power of the model and the cut reflected utilization decreases, but specifics were unclear and there were no impact assessments for the large reduction in payment.[94] Greater transparency with stakeholders regarding rationale for proposed changes and impact analyses would improve feedback and input from stakeholders and capacity to comply with changes. It would also mitigate adverse impacts on beneficiaries, especially vulnerable individuals like those enrolled in I-SNPs.

7. Utilize Demonstration Authority to Test Community-Based Institutional SNPs (I-SNPs)

In February 2017, Senator Grassley (R-IA) introduced S. 309, the Community-Based Independence for Seniors Act.[95] The bill would establish a Community-Based I-SNP demonstration program to target home and community-based services to eligible Medicare beneficiaries. The bill would enable HHS to enter into agreements with Medicare Advantage plans to enroll low-income Medicare beneficiaries in a plan to provide long-term care services and supports and benefits such as home delivered meals, transportation services, and respite care. In 2013, the Senate Finance Committee passed legislation to create a Community-Based I-SNPs as a demonstration in five states for three years to target community-based long-term services and supports for low-income beneficiaries who are functionally impaired, however, the bill was never enacted into law.[96] Action to implement such a demonstration would provide valuable services and evaluation of the impact of these services.

8. Update Report to Congress Evaluating SNPs Impact on Cost and Quality of Beneficiary Care

When SNPs were created in 2003, a report to Congress was required from HHS to assess the impact of SNPs on the cost and quality of services to beneficiaries. CMS contracted with Mathematica Policy Research to evaluate SNPs. The analysis found SNPs had grown steadily and reported that the majority of state Medicaid officials appeared to feel other issues took priority over Medicare/Medicaid integration.[97] The report concluded that not enough time had passed to do an analysis of quality, and found no evidence that Medicare payments to SNPs differed as compared to other Medicare Advantage plans. Since the last report was released in 2008, an update should be conducted to evaluate SNP impact on quality and cost.

9. Utilize Demonstration Authority to Simplify Criteria for Institutional Equivalent SNPs (IE-SNPs)

IE-SNPs provide care for beneficiaries who need institutional-level care and are living at home. In order to determine eligibility for an IE-SNP, beneficiaries must undergo a state assessment, which varies state to state. State variation creates complexity for plans attempting to administer IE-SNPs across the country. This burden could limit access to IE-SNPs for Medicare beneficiaries at a time when an increasing number of Medicare beneficiaries are choosing to age in place. For example, in Oregon the state criteria for an institutional level of care is any person in an assisted living community. In Arizona, the state criteria include many medical, functional, and emotional criteria, resulting in fewer beneficiaries qualifying for the program. A demonstration could help develop appropriate criteria that is consistent across states.

10. Reinstate Seamless Conversion with Appropriate Protections

CMS has put a hold on any new plans in the seamless conversion program due to concerns about consumer protections. Through seamless conversion, health plans apply to CMS and CMS grants approval to enroll their commercial beneficiaries, including Medicaid Managed Care beneficiaries, in a comparable Medicare Advantage plan when they become eligible for Medicare. Beneficiaries must be informed, and can opt-out if they decide to choose a different Medicare Advantage plan or to enroll in FFS Medicare. In 2006, 46 D-SNPs were allowed to enroll dually eligible beneficiaries from their Medicaid Managed Care plans. Beneficiaries were notified in advance and able to opt-out. Seamless conversion has the potential to ensure that high risk beneficiaries, such as Medicaid beneficiaries who are newly eligible for Medicare, maintain continuity of care and stay in a managed care plan that is tailored to their needs.

In August 2016, BMA polled 68,258 BMA advocates to gain an understanding of their attitudes on seamless conversion. A total of 749 beneficiaries completed the survey. Less than 4% of respondents found the auto-enrollment process in seamless conversion to be negative (3.65%).[98] Through follow-up phone conversations, BMA staff found that many seniors feel that seamless conversion alleviates the complexity of researching many options. CMS should work with consumer advocates and health plans to reinstate and update the seamless conversion program to ensure it is available to beneficiaries and has appropriate protections for consumers.

CONCLUSION

SNPs embody the goals of innovation, choice, and flexibility inherent in Medicare Advantage. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery model for high risk beneficiaries. Congress should act on permanent authorization this year to ensure SNP authority does not expire in 2018.

There is broad consensus in Congress, MedPAC, and among stakeholders that SNPs should be permanently authorized. The Senate Finance Committee Chronic Care Working Group recommended permanent authorization of SNPs.[99] MedPAC has recommended Congress permanently authorize I-SNPs, and certain D-SNPs and C-SNPs.[100] Greater certainty will unlock the potential of these innovative, successful models that are meeting the needs of high risk, high need beneficiaries in Medicare Advantage across the country.[101]

In addition to permanent authorization, several policy changes would strengthen the effectiveness of SNPs. Increasing flexibility for SNP benefit design and supplemental benefits would allow services to be tailored more effectively to improve health outcomes for vulnerable beneficiaries. Providing beneficiaries with more information about SNPs would enable beneficiaries to better understand their options. Ensuring the effective implementation of the SNP Models of Care and better integration between Medicare and Medicaid will also strengthen the program. SNPs need accurate payment and flexibility to effectively adapt to the needs of each beneficiary.[102]

SNPs are providing some of the highest need Medicare beneficiaries with comprehensive, coordinated, and personalized health care to manage chronic conditions and avoid preventable hospitalizations. Providing SNPs with greater certainty will help unlock the potential of these models across the country. Increased flexibility around benefit design will enable plans and providers to address beneficiaries' needs in the community through preventive care, effective care management, and tailored care driven by the consumer. Permanent authorization of SNPs will allow the program to continue operating effectively and enable CMS and states continue to improve the program into the future.

APPENDIX I

Table 1:
Medicare Advantage and Special Needs Plan (SNP) Enrollment and Percent of SNP Beneficiaries by State, 2017

State	Total Medicare Advantage Enrollment*	SNP Enrollment**	Percent of Medicare Advantage Beneficiaries enrolled in a SNP
National Total	17,970,289	1,902,513	
AK	702	0	0.0%
AL	361,953	51,959	14.4%
AR	133,434	6,203	4.6%
AZ	467,198	101,900	21.8%
CA	2,363,061	184,689	7.8%
CO	286,914	13,755	4.8%
CT	182,958	25,639	14.0%
DC	8,174	5,592	68.4%
DE	21,177	950	4.5%
FL	1,813,115	347,123	19.1%
GA	564,565	41,207	7.3%
HI	117,089	21,462	18.3%
IA	96,272	0	0.0%
ID	93,642	2,316	2.5%
IL	456,920	14,772	3.2%
IN	315,957	7,235	2.3%
KS	76,795	1,513	2.0%
KY	250,777	10,329	4.1%
LA	274,919	40,973	14.9%
MA	265,983	44,510	16.7%
MD	65,371	7,219	11.0%
ME	89,719	4,082	4.5%
MI	677,860	11,803	1.7%
MN	164,889	40,363	24.5%
MO	374,252	3,677	1.0%
MS	96,313	17,461	18.1%
MT	43,477	249	0.6%
NC	592,882	26,430	4.5%
ND	2,158	0	0.0%
NE	40,319	73	0.2%
NH	28,836	0	0.0%
NJ	331,911	27,128	8.2%
NM	132,408	19,765	14.9%
NV	170,900	11,118	6.5%
NY	1,336,902	257,946	19.3%
OH	793,765	24,413	3.1%
OK	125,556	202	0.2%
OR	357,727	27,815	7.8%
PA	1,065,044	129,371	12.1%
RI	77,481	2,906	3.8%
SC	246,810	5,396	2.2%
SD	7,973	0	0.0%
TN	472,000	92,851	19.7%
TX	1,274,955	191,009	15.0%
UT	129,211	8,347	6.5%
VA	222,135	6,754	3.0%
VT	12,164	0	0.0%
WA	387,374	32,934	8.5%
WI	386,578	30,597	7.9%
WV	109,010	477	0.4%
WY	2,704	0	0.0%

Source: CMS. Medicare Advantage Enrollment Data. June 2017. Web.

Notes: Puerto Rico has 578,405 Medicare Advantage enrollees and 297,068 SNP enrollees.

* Cost, Demo, PACE removed.

** Includes only publicly available data for SNPs with over 10 enrollees with state data.

Table 2:
Medicare Advantage Special Needs Plan (SNP) Enrollment by State and Type of SNP, 2017

Source: CMS. "Special Needs Plan Comprehensive Report." CMS.gov. June 2017. Web.

Notes: Puerto Rico has 297,068 SNP enrollees: 283,527 in D-SNPs; 13,541 in C-SNPs; 0 in I-SNPs.

Includes only publicly available data for SNPs with over 10 enrollees with state data.

	Special Needs Plan Type			
State	D-SNP Enrollment	C-SNP Enrollment	I-SNP Enrollment	SNP Enrollment Grand Total
National Totals	1,924,543	215,944	59,094	**2,199,581**
AK	0	0	0	**0**
AL	51,959	0	0	**51,959**
AR	6,203	0	0	**6,203**
AZ	87,769	11,528	2,603	**101,900**
CA	134,707	47,364	2,618	**184,689**
CO	10,635	46	3,074	**13,755**
CT	22,576	0	3,063	**25,639**
DC	5,499	93	0	**5,592**
DE	950	0	0	**950**
FL	273,240	69,466	4,417	**347,123**
GA	37,826	79	3,302	**41,207**
HI	21,462	0	0	**21,462**
IA	0	0	0	**0**
ID	2,316	0	0	**2,316**
IL	10,140	3,900	732	**14,772**
IN	6,144	0	1,091	**7,235**
KS	1,513	0	0	**1,513**
KY	9,641	497	191	**10,329**
LA	39,418	1,555	0	**40,973**
MA	44,409	0	101	**44,510**
MD	3,438	3,541	240	**7,219**
ME	3,933	149	0	**4,082**
MI	11,803	0	0	**11,803**
MN	40,363	0	0	**40,363**
MO	3,389	0	288	**3,677**
MS	17,461	0	0	**17,461**
MT	249	0	0	**249**
NC	23,433	125	2,872	**26,430**
ND	0	0	0	**0**
NE	73	0	0	**73**
NH	0	0	0	**0**
NJ	24,993	101	2,034	**27,128**
NM	19,765	0	0	**19,765**
NV	0	10,478	640	**11,118**
NY	239,109	804	18,033	**257,946**
OH	22,987	0	1,426	**24,413**
OK	0	0	202	**202**
OR	22,616	4,006	1,193	**27,815**
PA	122,162	2,960	4,249	**129,371**
PR	283,527	13,541	0	**297,068**
RI	1,240	0	1,666	**2,906**
SC	4,975	421	0	**5,396**
SD	0	0	0	**0**
TN	92,851	0	0	**92,851**
TX	150,619	40,105	285	**191,009**
UT	8,347	0	0	**8,347**
VA	2,687	3,315	752	**6,754**
VT	0	0	0	**0**
WA	31,553	0	1,381	**32,934**
WI	26,563	1,870	2,164	**30,597**
WV	0	0	477	**477**
WY	0	0	0	**0**

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