

CHAPTER

# 14

---

**Medicare Advantage  
special needs plans**

---

# R E C O M M E N D A T I O N S

**14-1** The Congress should permanently reauthorize institutional special needs plans.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

.....  
**14-2** The Congress should:

- allow the authority for chronic care special needs plans (C-SNPs) to expire, with the exception of C-SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions;
- direct the Secretary, within three years, to permit Medicare Advantage plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions; and
- permit current C-SNPs to continue operating during the transition period as the Secretary develops standards. Except for the conditions noted above, impose a moratorium for all other C-SNPs as of January 1, 2014.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

.....  
**14-3** The Congress should permanently reauthorize dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

.....  
**14-4** For dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should:

- grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;
- direct the Secretary to allow these D-SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;
- direct the Secretary to allow these D-SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and
- direct the Secretary to develop a model D-SNP contract.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

.....

## Medicare Advantage special needs plans

### Chapter summary

In the Medicare Advantage (MA) program, special needs plans (SNPs) are a subcategory of coordinated care plans. What primarily distinguishes SNPs from other MA plans is that they limit their enrollment to one of the three categories of Medicare beneficiaries with special needs: dual-eligible beneficiaries, residents of a nursing home or community residents who are nursing home certifiable, and beneficiaries with certain chronic or disabling conditions. In contrast, most regular MA plans must allow all Medicare beneficiaries residing in their service area who meet MA eligibility criteria to enroll in the plan.

SNP authority expires at the end of 2014. SNPs were recently extended from 2013 to 2014 by the American Taxpayer Relief Act of 2012. In the absence of congressional action, on January 1, 2015, SNPs will not be terminated, but they will have to operate as other MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs.

We evaluate each type of SNP on how well they perform on quality-of-care measures, whether they encourage a more integrated delivery system than is currently available in traditional fee-for-service (FFS) Medicare, and how SNP reauthorization would affect Medicare program spending. We found the following:

### In this chapter

- Findings on SNPs

- Reauthorizing all SNPs would result in increased program spending. The current law Medicare baseline assumes that SNP authority will expire. If this termination occurs, some beneficiaries enrolled in SNPs will likely return to traditional FFS. If SNPs are reauthorized and beneficiaries remain enrolled in them, program spending will increase relative to baseline because spending on beneficiaries enrolled in MA is generally higher than Medicare FFS spending for similar beneficiaries.
- Institutional SNPs (I-SNPs) are plans for beneficiaries residing in nursing homes or in the community who are nursing home certifiable. They perform well on a number of quality measures. In particular, I-SNPs have much lower than expected hospital readmission rates, which suggests that I-SNPs are able to reduce hospital readmissions for beneficiaries who reside in nursing homes. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.
- Chronic condition SNPs (C-SNPs) are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures. The Commission recommended in 2008 that the list of conditions to qualify for a C-SNP be narrowed, and although the list of C-SNP conditions was reduced, we continue to believe that it is too broad. It is our judgment that regular MA plans should be able to manage most clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care for these conditions should be imported into MA plans. As a result, MA plans will move toward providing services that are more targeted to particular populations, and integration of the delivery system in regular MA plans for chronically ill enrollees will improve. There has been recent movement in the MA plan industry in the direction of importing the C-SNP model of care into regular MA plans. There may be a rationale, however, for maintaining C-SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions. These conditions dominate an individual's health and may warrant maintaining separate plans for these conditions while innovations in care delivery for these populations are still being made. However, the ability of MA plans to adequately care for beneficiaries with these three conditions should be revisited.
- SNPs for beneficiaries dually eligible for Medicare and Medicaid (dual-eligible SNPs (D-SNPs)) generally have average to below-average performance on quality measures compared with other SNPs and regular MA plans, with some exceptions. D-SNPs are required to have contracts with states. However, the contracts generally have not resulted in D-SNPs clinically or financially

integrating Medicaid benefits. We found exceptions under two D–SNP models in which an incentive exists to clinically and financially integrate with Medicaid benefits. Under one model, a single plan—the D–SNP—covers some or all Medicaid long-term care services and supports (LTSS), behavioral health services, or both through its contract with the state. Under another model, a managed care organization administers the D–SNP and the Medicaid plan that furnishes some or all of the LTSS or behavioral health services. There is overlap in the dual-eligible beneficiaries who are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans. A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits. Most of these barriers—the inability to jointly market the Medicare and Medicaid benefits that D–SNPs furnish, multiple enrollment cards, and lack of a model contract for states to use as a reference—can be alleviated by the Secretary of Health and Human Services. Aligning the Medicare and Medicaid appeals and grievances processes, however, would require a change in statute. ■



---

## Introduction

---

Special needs plans (SNPs) are a type of coordinated care plan in the Medicare Advantage (MA) program. However, unlike regular MA plans, SNPs can limit their enrollment to one of the three categories of special needs individuals recognized in statute and tailor their benefit packages to their special needs enrollees:<sup>1</sup>

- **Institutional SNPs (I-SNPs)** enroll beneficiaries residing in a nursing home or in the community who are nursing home certifiable.
- **Chronic condition SNPs (C-SNPs)** enroll beneficiaries with certain severe or disabling chronic conditions.<sup>2</sup>
- **Dual-eligible SNPs (D-SNPs)** enroll beneficiaries eligible for both Medicare and Medicaid (dual-eligible beneficiaries).

SNP statutory authority expires at the end of 2014. SNPs were recently extended from 2013 to 2014 by the American Taxpayer Relief Act of 2012. As of January 1, 2015, SNPs will lose their ability to limit enrollment to special needs individuals. Their contracts will not be terminated, but they will have to operate as regular MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs.

## Background on special needs plans

SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which authorized them through 2008. Subsequent legislation extended the expiration date of SNP authority on four separate occasions, and the Congress imposed a number of additional requirements on SNPs, including requiring D-SNPs to have contracts with states, narrowing the types of chronic conditions for C-SNPs, requiring all SNPs to meet model-of-care requirements, and having their models of care reviewed by the National Committee for Quality Assurance (NCQA).<sup>3</sup> SNPs benefit from their special enrollment rules, making them an attractive option for some managed care organizations. The general rule in MA is that beneficiaries may enroll in, or disenroll from, an MA plan only during the October to December coordinated open enrollment period. However, dual-eligible beneficiaries and other low-income individuals can enroll and disenroll from MA plans monthly. This provision applies to all MA plans, not just SNPs (and

will survive the expiration of SNP authority). Similarly, beneficiaries who reside in an institution have the month-to-month enrollment option, an alternative that for I-SNPs is extended to beneficiaries at risk of institutionalization. C-SNPs can enroll an individual with CMS-specified chronic or disabling conditions when the presence of the condition is certified by a physician.

As of December 2012, there were almost 1.6 million enrollees in SNPs, or about 11 percent of all MA enrollment (Table 14-1, p. 318). The largest share of SNP enrollment is in D-SNPs, followed by C-SNPs and I-SNPs. Most D-SNPs, C-SNPs, and I-SNPs are HMO plans.

D-SNPs and I-SNPs are widely available; in contrast, C-SNPs have limited availability, with enrollment concentrated in the South (see online Appendix 14-A, available at <http://www.medpac.gov>, for more information on SNPs). Although D-SNPs and I-SNPs are available to a large share of Medicare beneficiaries, residents of rural areas have relatively less access to these specialized plans compared with residents of urban areas.

Overall, the MA program has a smaller share of dual-eligible beneficiaries than fee-for-service (FFS) Medicare, including a smaller share of disabled beneficiaries under the age of 65. Within the MA program, SNP enrollees differ from other MA enrollees in their demographic characteristics (Table 14-2, p. 318). Beneficiaries under the age of 65 and African American beneficiaries are more likely to be SNP enrollees. Dual-eligible beneficiaries also make up a large proportion of C-SNP and I-SNP enrollees.

MA plans (including SNPs) and the providers they contract with are not permitted to charge dual-eligible beneficiaries deductibles or coinsurance for Medicare services. However, MA plans are permitted to charge premiums to dual-eligible beneficiaries. States have the option to pay the MA premiums on behalf of dual-eligible beneficiaries, but they are not required to do so. As of 2013, 86 percent of Medicare beneficiaries have access to at least one MA plan that charges no premium for a benefit package that includes Medicare Part A, Part B, and Part D (see Chapter 13 for information on MA plans).

African Americans enrolled in C-SNPs and I-SNPs are disproportionately dual eligible. Half of African Americans in C-SNPs are dual eligible, and 75 percent of those in I-SNPs are dual eligible. In comparison, 17 percent of African Americans in regular MA plans are dual

**TABLE  
14-1**

**Distribution of SNP enrollment, December 2012**

**Distribution of enrollment by CCP types**

Plan type	Number of contracts	Number of plans	Enrollment (in thousands)	Distribution of enrollment by CCP types		
				HMOs	Local PPOs	Regional PPOs
SNPs						
Dual eligible	214	322	1,303	95%	3%	3%
Chronic or disabling condition	44	115	233	57	5	38
Institutional	45	70	50	60	40	0
Total SNPs	303	507	1,586			
All MA plans	523	2,184	10,471	74	16	9

Note: SNP (special needs plan), CCP (coordinated care plan), PPO (preferred provider organization), MA (Medicare Advantage). CCP includes HMO, local PPO, and regional PPO categories.

Source: MedPAC analysis of CMS enrollment and landscape files.

eligible, and 36 percent of African Americans in FFS are dual eligible (data not shown in Table 14-2).

**Findings on SNPs**

In evaluating whether SNPs should be reauthorized, we considered how SNP reauthorization would affect Medicare program spending, how SNPs perform on quality-of-care measures, and whether SNPs encourage a more integrated delivery system than is currently available in FFS. Our methodology consisted of quantitative assessments of Medicare payments to SNPs, SNP quality-of-care measures (Healthcare Effectiveness Data and Information Set<sup>®</sup> (HEDIS<sup>®</sup>) measures, risk-adjusted

readmissions, and star ratings), and interviews with managed care plans that offer a variety of SNPs, other MA plans, and Medicaid managed care plans.

With respect to quality-of-care measures, we analyzed the subset of HEDIS measures that SNP plans report at the SNP benefit package level (a subset of the HEDIS measures reported at the MA contract level, discussed in Chapter 13), risk-adjusted readmission rates, and MA plan star ratings. As noted in Chapter 13 on MA plans, several HEDIS measures are reported only by SNPs, all of which are based on medical record documentation. In aggregate across all SNPs, these measures showed statistically significant improvement in average rates between 2011 and 2012: medication review, functional status assessments, pain screening (the three measures included

**TABLE  
14-2**

**Demographic characteristics of SNP enrollees, December 2011**

Characteristic	FFS Medicare	All MA plans	D-SNPs	C-SNPs	I-SNPs	Regular MA plans
Dual eligibles*	19%	16%	95%	32%	49%	8%
Under age 65	22	12	37	23	6	10
African Americans	11	11	25	32	12	9

Note: SNP (special needs plan), FFS (fee-for-service), MA (Medicare Advantage), D-SNP (dual-eligible special needs plan), C-SNP (chronic or disabling condition special needs plan), I-SNP (institutional special needs plan).

\*Medicaid status can change monthly. Beneficiaries may lose their Medicaid status and therefore their status as dual-eligible beneficiaries but remain enrolled in an MA plan.

Source: MedPAC analysis of CMS enrollment data.

## Previous Commission recommendations on special needs plans

In Chapter 3 of our March 2008 report, the Commission made a number of recommendations on special needs plans (SNPs) (Medicare Payment Advisory Commission 2008). Many, but not all, of the recommendations have been incorporated into statute or regulatory or subregulatory requirements. However, the actions taken on quality measures and dual-eligible–SNPs’ requirement to have contracts with states fall short of the Commission’s intention (Table 14-3). Recommendation 3-6—that dual-eligible and institutional beneficiaries should not be able to enroll in regular Medicare Advantage (MA) plans outside the MA

open enrollment period—has not been implemented. The recommendation left intact dual-eligible and institutional beneficiaries’ option to disenroll from MA and return to fee-for-service Medicare at any point during the year.

On net, since the Commission’s 2008 recommendations were issued, the Congress has enacted reforms to the SNP program, but more work remains to be done in developing quality measures for special needs individuals and ensuring that plans for dual-eligible beneficiaries coordinate care across the Medicare and Medicaid programs. ■

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (*continued next page*)

Recommendation	Status
<p><b>3-1.</b> The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.</p>	<p>CMS has added a number of quality measures applicable to SNPs. SNPs are evaluated on their models of care and their performance on structure and process standards. In addition, new SNP-specific process measures are a component of the CMS star system (which determines plan bonuses); these measures include organizations that have both SNP and other MA plan offerings under one contract.</p> <p>Currently, SNPs separately report on results for their specific populations using 23 of the 45 measures in the set of MA quality measures and report on several SNP-specific measures. If an organization has a contract that includes both SNP and non-SNP enrollees in the reporting unit, the organization must report performance on each of 45 measures for the overall population (which includes SNP members) as well as report separate results for the smaller set of SNP-specific measures. SNPs report on two of the eight MA outcome measures (control of blood pressure among enrollees with hypertension and hospital readmission rates). Work is under way to develop a set of measures that are appropriate for populations with special needs.</p>

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

*(continued next page)*

in the star rating system), advance care planning, and medication reconciliation postdischarge. Below, we report quality results separately for I–SNPs, C–SNPs, and D–SNPs and present results on the subset of HEDIS measures reported at the SNP level, risk-adjusted readmission rates at the SNP level, and star ratings (available only at the MA contract level).

### Effect of SNP reauthorization on Medicare spending

A reauthorization of any type of SNP will result in increased Medicare spending. Medicare generally spends more on beneficiaries who enroll in MA plans than the program would have spent had the beneficiaries remained in FFS. Consistent with higher MA spending in

## Previous Commission recommendations on special needs plans (cont.)

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (continued)

Recommendation	Status
<p><b>3-2.</b> The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.</p>	<p>It remains difficult to compare SNPs to regular MA plans. The SNP-specific measures that are currently collected are reported to the public at the medicare.gov website, with star ratings attached to each measure. However, SNP data include results for measures that are not part of the SNP-specific reporting. For those measures, the result shown for the SNP is the contract-wide result for the organization, which includes both SNP and non-SNP enrollees.</p> <p>The medicare.gov site also contains information on the benefits and other features of each plan at the SNP level.</p> <p>Currently, medicare.gov compares MA and FFS on vaccination rates for influenza and pneumonia and on patient experience measures from member surveys (measuring timeliness of access to care and members' rating of the health plan and its providers). There are no comparisons of outcomes.</p>
<p><b>3-3.</b> The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.</p>	<p>This provision was incorporated nearly verbatim in MIPPA. CMS has tightened the rules for the kinds of conditions that can qualify for special needs status.</p>
<p><b>3-4.</b> The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.</p>	<p>This provision was included in MIPPA. As of 2013, all dual-eligible SNPs must have state contracts. However, a contract alone does not ensure that SNPs have greater coordination of Medicare and Medicaid services. The minimum contract standards in the regulations require only that the contract state the financial obligations of the SNP in cost sharing and Medicaid benefits, the Medicaid benefits covered, the categories of beneficiaries covered, information sharing regarding Medicaid provider participation and verification of eligibility, and the SNP service area (42 CFR §422.107).</p>

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

(continued next page)

general, we found that, in aggregate, Medicare spending on beneficiaries enrolled in SNPs exceeds spending on comparable beneficiaries in FFS. On the basis of 2013 data, we estimate Medicare payments to SNPs to average 5 percent higher than FFS payments.

The effect on Medicare spending from the expiration of SNPs is already reflected in the Medicare spending baseline. Under current law, SNP authority will end on December 31, 2014. After this date, former SNP plans can convert to regular MA plans or they may exit the market. The SNPs' enrollees can remain in the converted MA

## Previous Commission recommendations on special needs plans (cont.)

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (continued)

Recommendation	Status
<b>3-5.</b> The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.	The Congress required SNPs to enroll members only from their target population.
<b>3-6.</b> The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.	There has been no change to the current month-to-month enrollment option for dual-eligible and institutional beneficiaries in regular MA plans (a regulatory provision).
<b>3-7.</b> The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.	SNPs have been extended by statute on four occasions (through 2009 in 2007 legislation, through 2010 in 2008 legislation, through 2013 in 2010 legislation, and through 2014 in 2012 legislation). The 2007 legislation imposed a moratorium on new SNPs in 2008 and 2009, and the 2008 legislation contained the additional requirements imposed on each category of SNPs as of January 1, 2010.

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

plan, choose another MA plan, or return to FFS Medicare. Although some beneficiaries are expected to return to FFS, most are expected to remain enrolled in an MA plan, since initially, as SNP enrollees, they opted for MA over FFS.

Medicare spending on the beneficiaries who remain in MA will be similar to the spending on these beneficiaries when they were enrolled in SNPs. If beneficiaries cost a certain amount to the program when they were enrolled in a SNP, they will cost the same amount when they enroll in another MA plan because SNPs are generally paid the same as regular MA plans. Spending on the beneficiaries who return to FFS will decline because FFS spending is generally lower than MA spending. After 2014, spending on MA enrollees is expected to approximate or be slightly higher than FFS spending. The Patient Protection and Affordable Care Act of 2010 made changes to the MA benchmarks that over the next several years are designed to better align with, or in some instances be below, FFS spending. Two exceptions to this premise could continue

the trend of MA spending outpacing FFS spending. First, MA plans will receive bonuses for highly rated performance on quality measures, which will increase MA spending relative to FFS spending. Second, MA plans have an incentive that FFS providers do not to assign the most financially favorable diagnostic codes to their enrollees. For example, in 2010, payments to MA plans were \$3.9 billion to \$5.8 billion higher than they would have been if those beneficiaries were in FFS because of coding differences that were not adjusted (Government Accountability Office 2012). The American Taxpayer Relief Act of 2012 increased the coding intensity adjustment to MA plan payments. However, it is likely that coding differences will continue to result in higher payments to MA plans.

#### **I-SNPs**

Overall, I-SNPs perform better than other SNPs and other MA plans on the majority of available quality measures

**TABLE  
14-4****Readmission rates by type of SNP**

Plan type	Total admissions	Observed rates of readmission	Risk-adjusted expected rates of readmission	Ratio of observed to expected rates
HMOs*	1,032,428	14.3%	15.7%	0.91
Local PPOs*	186,490	13.2	14.8	0.90
Regional PPOs*	126,151	14.8	15.3	0.97
<b>SNP-specific results</b>				
I-SNPs				
HMOs	5,749	15.0	20.9	0.72
Local PPOs	1,623	9.9	19.2	0.52
D-SNPs				
HMOs	103,353	16.6	17.2	0.97
Local PPOs	3,141	14.5	16.9	0.86
Regional PPOs	3,803	19.3	16.6	1.17
C-SNPs				
HMOs	10,253	16.3	19.8	0.83
Regional PPOs	14,950	20.7	16.6	1.25
All SNPs				
Regional PPOs	18,758	20.4	16.6	1.23

Note: SNP (special needs plan), PPO (preferred provider organization), I-SNP (institutional special needs plan), D-SNP (dual-eligible special needs plan), C-SNP (chronic or disabling condition special needs plan).

\*Overall categories include SNP results for contracts that include both SNP and non-SNP enrollees because data cannot be disaggregated. Results exclude Puerto Rico.

Source: MedPAC analysis of CMS Healthcare Effectiveness Data and Information Set<sup>®</sup> public use files.

for SNPs. The average rates of advance care planning, medication review, functional status assessment, and pain screening are higher than the rates for all SNPs for the same measures. The I-SNP rate for medication reconciliation within 30 days of a hospital discharge (not an element of the star ratings) is about the same as the overall SNP average (31 percent).

Compared with other MA plans, I-SNPs also perform well on a number of process measures. Specifically, they have comparatively higher rates for monitoring of a group of persistently used medications and glaucoma screening in older adults. Although I-SNPs also have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions, their higher rates of monitoring of persistently used drugs suggest that drugs with potential interactions or adverse effects are also being closely monitored.

I-SNPs also perform well on risk-adjusted rates of hospital readmissions relative to other SNPs and other MA plans (Table 14-4). HMO I-SNPs have observed-to-expected readmission ratios of 0.72 and preferred provider organization (PPO) I-SNPs have observed-to-expected readmission ratios of 0.52. These ratios show that I-SNPs have fewer hospital readmissions than would be expected given the clinical severity of their enrollees.

I-SNPs' performance in hospital readmission rates is an important measure of whether they provide a more integrated delivery system. I-SNPs attempt to reduce hospital and emergency department utilization through care management and by emphasizing the provision of primary care. For example, some I-SNPs employ nurse practitioners to work with nursing home staff to provide primary care, care planning, and coordination of medical services. Achieving readmission rates that are lower than expected demonstrates that I-SNPs are meeting their goal

to reduce hospital utilization for beneficiaries who are institutionalized. Further, almost half of I-SNP enrollees are dual eligible (Table 14-2, p. 318). Reducing hospital readmission rates for these dual-eligible beneficiaries residing in nursing homes also helps prevent the churning between Medicare and Medicaid.

## RECOMMENDATION 14-1

**The Congress should permanently reauthorize institutional special needs plans.**

## RATIONALE 14-1

This recommendation makes I-SNPs a permanent plan offering under the MA program. I-SNPs serve a distinct population—beneficiaries who are institutionalized or who live in the community and require a nursing home level of care. I-SNPs on average perform better than SNPs and other MA plans on certain quality measures, including risk-adjusted hospital readmission rates. Reducing hospital readmissions suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in FFS Medicare.

## IMPLICATIONS 14-1

### Spending

- This recommendation will not change Medicare spending in 2014 because I-SNPs are reauthorized through the end of that year. This recommendation will increase spending relative to current law by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. Under current law, the Medicare baseline assumes that I-SNP authority will expire at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in I-SNPs will likely return to FFS. If I-SNPs are reauthorized and beneficiaries remain enrolled in them, Medicare spending will increase relative to baseline because spending on beneficiaries enrolled in MA plans (including I-SNPs) is generally higher than FFS spending.

### Beneficiary and plan

- Beneficiaries currently enrolled in I-SNPs can remain in those plans and new beneficiaries can join I-SNPs.
- Managed care organizations that offer I-SNPs will be permitted to continue to offer these plans. New managed care organizations may enter the I-SNP market once the plans are made permanent.

## C-SNPs

In general, C-SNPs tend to perform no better, and often worse, than other SNPs and other MA plans on most quality measures. Among C-SNPs, regional PPOs (almost 40 percent of the C-SNP population) tend to perform worse than HMOs. For example, for medication reconciliation after discharge, regional PPO C-SNPs scored 18 percent and HMO C-SNPs scored 25 percent, compared with the 31 percent average across all SNPs. The C-SNP rate for glaucoma screening in older adults is about the same as the rate for other MA plans, but C-SNPs perform worse on this measure compared with I-SNPs. However, C-SNPs and I-SNPs have similar performance on measures of monitoring of a specific group of persistently used medications.

There are a few measures for which regional PPO C-SNPs perform worse than HMO C-SNPs. On risk-adjusted hospital readmissions, regional PPO C-SNPs have higher than expected rates (ratio of 1.25, see Table 14-4), which means that enrollees in regional PPOs have more hospital readmissions than would be expected given their clinical severity. Most other SNPs, including HMO C-SNPs, have lower than expected hospital readmission rates. Regional PPO C-SNPs also perform poorly on the advance care planning measure (10 percent) compared with HMO C-SNPs (43 percent) and the average across all SNPs (39 percent). The measures on which regional PPO C-SNPs perform relatively well are the SNP-only measures of medication review, functional status assessment, and pain screening.

The Commission recommended in 2008 that the list of health conditions that qualify for a C-SNP be narrowed (Table 14-3, pp. 319–321). Although the list was later narrowed, we believe the current list continues to be too broad. It is our judgment that regular MA plans should be able to manage most clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care—that is, their ability to tailor benefits to chronically ill beneficiaries—should be imported into MA plans for these conditions. This change will enable Medicare beneficiaries with chronic conditions such as diabetes, congestive heart failure, and cardiovascular disorders to receive a care management approach and services that are more tailored to their needs through an MA plan. It will also move MA plans in the direction of providing services that are more targeted to particular populations and providing a more integrated delivery system.

There has been recent movement in the MA plan industry in the direction of importing the C–SNP model of care into regular MA plans. Some managed care organizations that primarily operate regular MA plans have recently purchased C–SNPs, consistent with the intention to import the C–SNP model of care into regular MA plans.

MA plans will need flexibility to offer a separate benefit package for chronically ill beneficiaries in order for the C–SNP model of care to be imported into MA plans. Currently, MA plans must offer the same benefit package to all their enrollees. However, under this flexibility, MA plans would be permitted to offer multiple benefit packages. The benefit packages for chronically ill beneficiaries would be permitted to vary from the benefit package for other beneficiaries. For example, under this new flexibility, MA plans could vary the supplemental benefits, cost sharing for services and drugs, and provider networks for chronically ill enrollees. The separate benefit packages for chronically ill beneficiaries would need to differ by type of chronic condition and be designed for the needs of the targeted population.

Importing the C–SNP model of care into MA plans could reduce the potential for MA plans to select relatively healthier beneficiaries (i.e., “favorable selection”). As noted in the MA chapter of this report, the degree of favorable selection in MA is not as great as it has been in the past (Newhouse et al. 2012). Researchers attribute this fact to several factors, one of which is the policy change in the MA plan enrollment period. Previously, all beneficiaries could enroll in or disenroll from MA plans monthly, which created a greater opportunity for favorable selection. Now, most beneficiaries may enroll or disenroll yearly only during the open enrollment period. In contrast, C–SNPs can elect to enroll beneficiaries with only certain chronic conditions and can enroll those beneficiaries throughout the year, which provides greater opportunity for favorable selection. Importing the C–SNP model of care into MA plans would reduce this opportunity, as formerly eligible C–SNP beneficiaries would be subject to the rules of the yearly open enrollment period, which has already shown success in reducing favorable selection.

We recognize that some of the conditions that currently qualify for a C–SNP may warrant maintaining separate plans for these conditions while innovations in the care delivery for these populations are still being made. These conditions include end-stage renal disease (ESRD), HIV/AIDS, and chronic and disabling mental health conditions (currently defined for C–SNP eligibility as bipolar

disorder, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder).

Few C–SNPs currently operate to serve beneficiaries with ESRD, HIV/AIDS, or chronic and disabling mental health conditions, but some offer models of care that are tailored to beneficiaries with these conditions. For example, one chronic and disabling mental health C–SNP serves beneficiaries with high medical, behavioral, and social needs. Some enrollees are homeless and, although they may be on a medication regimen, they may appear or act mentally unstable. This C–SNP recruits primary care physicians, specialists, and psychiatrists who are willing to treat their enrollees. Beneficiaries are assigned to a primary care physician, a psychiatrist, and a behavioral health case manager upon enrollment, and there is no copay to see the primary care physician. This model of care focuses on coordination between enrollees’ behavioral health and medical care, particularly because many enrollees take behavioral health medications that have medical side effects. The model of care also emphasizes teaching enrollees how to accomplish daily routine tasks and become more independent and social under the premise that such activities may make individuals less vulnerable to their underlying mental health condition. The behavioral health case managers are responsible for knowing enrollees’ whereabouts, helping enrollees comply with their treatment regimen, and helping homeless enrollees find permanent housing. The C–SNP also employs a mobile nurse team that visits enrollees who are homebound or homeless.

## RECOMMENDATION 14-2

### The Congress should:

- **allow the authority for chronic care special needs plans (C–SNPs) to expire, with the exception of C–SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions;**
- **direct the Secretary, within three years, to permit Medicare Advantage plans to enhance benefit designs so that benefits can vary based on the medical needs of individuals with specific chronic or disabling conditions; and**
- **permit current C–SNPs to continue operating during the transition period as the Secretary develops standards. Except for the conditions noted above, impose a moratorium for all other C–SNPs as of January 1, 2014.**

This recommendation is consistent with the Commission's 2008 recommendation to limit the number of conditions that qualify for a C-SNP. It also moves MA plans in the direction of providing more tailored services and offering a more integrated delivery system to chronically ill beneficiaries by importing the C-SNP model of care into MA plans. Under this recommendation, C-SNP authority would expire for most conditions that are currently eligible for a C-SNP. The C-SNP model of care for these conditions would be imported into MA plans, which would be given the flexibility to offer specialized benefit packages within the MA plan to beneficiaries with these conditions. The Secretary would have three years to develop the regulations that permit benefit design flexibility. Our intention is for benefit design flexibility to be fully implemented and for the transition period to end no later than December 31, 2016. During the transition period, current C-SNPs would continue operating, but no new C-SNPs would be permitted to operate for the conditions with expiring authority. For the separate benefit packages for the chronically ill, we anticipate that MA plans would be held to some or all of the existing C-SNP model-of-care requirements, such as having a specialized provider network, developing an individualized care plan for each enrollee, and providing care management. We are not recommending, however, that MA plans' compliance with the model-of-care requirements be measured through the existing SNP model-of-care reporting process. Beneficiaries with conditions for whom the C-SNP model of care is imported into MA plans would follow MA's yearly open enrollment process.

This recommendation gives C-SNP authority to continue for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions, making the recommendation consistent with our 2008 recommendation to narrow the conditions eligible for a C-SNP. It also reflects our understanding that there may be a rationale for maintaining a separate plan option for these conditions to permit innovations in the care delivery for these populations to continue. However, we encourage the Secretary to assess how MA plans respond to the increased flexibility to offer separate benefit packages and to revisit whether MA plans can adequately care for beneficiaries with these three conditions under new benefit flexibility authority.

### Spending

- This recommendation decreases Medicare spending by less than \$50 million in 2014. C-SNPs are reauthorized through the end of that year under current law, and this recommendation places a moratorium on new C-SNPs in 2014. This recommendation increases spending by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. Under current law, the Medicare baseline assumes that C-SNP authority expires at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in those C-SNPs will likely return to FFS Medicare, thus lowering spending compared with what spending would have been for them in MA. However, under this recommendation, current C-SNPs could continue to operate during the transitional period. Medicare spending would increase relative to the baseline if beneficiaries who otherwise would have returned to FFS remain enrolled in C-SNPs during the transitional period.

### Beneficiary and plan

- This recommendation is not expected to have adverse impacts on Medicare beneficiaries because chronically ill beneficiaries would be able to receive a specialized benefit package that is tailored to their needs through new benefit flexibility. Benefit flexibility could result in more MA plans offering specialized benefit packages than are currently available through C-SNPs. Beneficiaries with ESRD, HIV/AIDS, and chronic and disabling mental health conditions would still have access to any C-SNPs offered in their service area.
- MA plans can continue to serve beneficiaries with chronic conditions through flexible benefit designs and as appropriate through the C-SNP model. The recommendation also gives plans a three-year period to transition their benefit structures from the C-SNP. C-SNPs for beneficiaries with ESRD, HIV/AIDS, or chronic disabling mental health conditions would be able to continue.

### D-SNPs

Overall, D-SNPs tend to have average to below-average performance on quality measures compared with other SNPs and regular MA plans, but some of the D-SNPs that are the most highly integrated with Medicaid perform well on the star ratings. D-SNPs have the lowest rates of performance by 5 percent to 12 percent on all but one

of the quality measures that only SNPs report. Similar to other SNPs, D-SNPs have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions. D-SNPs perform similarly to regular MA plans on the rates of monitoring of persistently used drugs, but they perform better than regular MA plans on monitoring anticonvulsants. D-SNPs also have high rates of glaucoma screening, persistence of beta blocker use after a heart attack, and bronchodilator use in managing chronic obstructive pulmonary disease. For most other measures that can be compared with regular MA plans, D-SNPs generally have below average rates. Exceptions to this level of performance include eight D-SNPs that have a star rating of 4 or 4.5. In addition, among the fewer than 25 D-SNPs that furnish some or all Medicaid benefits, 8 have star ratings of 4 or 4.5 (10 of these 25 plans do not have sufficient enrollment or have not been in operation long enough for a star rating to be calculated for them).

D-SNPs have the potential to integrate Medicare and Medicaid benefits for dual-eligible beneficiaries—that is, assume clinical and financial responsibility for Medicare benefits and some or all of Medicaid’s long-term care services and supports (LTSS), behavioral health services, or both. Through integrating Medicaid benefits, D-SNPs can offer a more cohesive delivery system than FFS by eliminating the incentives that exist in both Medicare and Medicaid to shift costs to one another (Medicare Payment Advisory Commission 2010), improving quality of care, and possibly reducing costs.

The Commission’s 2008 recommendation for D-SNPs to contract with states reflected the Commission’s concern that D-SNPs were not clinically or financially integrating Medicaid benefits. D-SNPs were subsequently required by the Medicare Improvements for Patients and Providers Act of 2008 to contract with states. However, generally, the contracts have not resulted in the desired integration of Medicaid benefits. Most D-SNP contracts do not cover some or all of Medicaid’s LTSS or behavioral health services. Instead, the contracts call for D-SNPs to coordinate, but not furnish, Medicaid benefits; furnish Medicaid payments of dual eligibles’ cost sharing for Medicare services; or furnish some of the Medicaid acute care benefits not covered under Medicare, such as transportation, vision, and dental services. Some states have been reluctant to contract with D-SNPs to cover some or all of Medicaid’s LTSS and behavioral health services for several reasons. Legislation prohibits some states from moving LTSS or behavioral health services

into managed care programs. Other states without such legislative prohibitions are nevertheless adverse to providing Medicaid benefits through managed care. Still other states lack the staff resources or technical capabilities to develop, for D-SNPs, contracts that cover LTSS or behavioral health services.

We found exceptions under two D-SNP models in which an incentive exists for D-SNPs to clinically and financially integrate Medicaid benefits. Under one model, a single plan—the D-SNP—covers some or all of Medicaid’s LTSS or behavioral health services through its contract with the state. We estimate that fewer than 25 plans, or about 8 percent of D-SNPs, currently follow this model. Collectively, these D-SNPs enroll approximately 65,000 dual-eligible beneficiaries, or about 5 percent of all dual-eligible beneficiaries enrolled in D-SNPs.

Under the other model, one managed care organization administers a Medicaid plan that furnishes some or all LTSS or behavioral health services and a D-SNP; the same dual-eligible beneficiaries are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans. The D-SNP in this scenario does not need to have a state contract to furnish some or all of Medicaid LTSS or behavioral health benefits. The managed care organization is financially responsible for providing these benefits through the Medicaid plan. Approximately 35 D-SNPs, or 11 percent of D-SNPs, currently are administered under this model.<sup>4</sup> These D-SNPs enroll an estimated 235,000 dual-eligible beneficiaries, or about 19 percent of all dual-eligible beneficiaries enrolled in D-SNPs. Under both models, one managed care organization has a financial incentive to manage and coordinate the Medicare and Medicaid services because they are financially at risk for those services. It also has an advantage in managing and coordinating services. For example, when D-SNP staff are notified of a hospitalization, they can begin discharge planning and the transition to post-acute care settings or to the home. If the D-SNP or its companion Medicaid plan covers some LTSS, staff can coordinate and ensure that necessary services, such as home modifications or personal care attendant hours, are in place when the beneficiary returns home.

#### RECOMMENDATION 14-3

**The Congress should permanently reauthorize dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.**

## RATIONALE 14-3

Consistent with the Commission's 2008 recommendation on D-SNPs, the intention of this recommendation is to move D-SNPs toward clinical and financial integration of Medicare and Medicaid benefits for dual-eligible beneficiaries. Under this recommendation, the D-SNPs that would become permanent MA offerings would be those that clinically and financially integrate Medicare with Medicaid's LTSS, behavioral health services, or both. This recommendation includes D-SNPs that fall under the two models discussed above where we observe that incentives exist for the clinical and financial integration of Medicare and Medicaid benefits.

D-SNPs that do not currently meet the clinical and financial criteria for integrating with Medicaid benefits will not be reauthorized under this recommendation. However, they can work with states now or at a later time to become integrated. Alternatively, they can convert to regular MA plans.

## IMPLICATIONS 14-3

### Spending

- This recommendation will not change Medicare spending in 2014 because D-SNPs are reauthorized through the end of that year. This recommendation will increase spending relative to current law by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. The current Medicare baseline assumes that authority for integrated D-SNPs will expire at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in D-SNPs would likely return to FFS Medicare, which would lower Medicare spending relative to MA spending for these beneficiaries. However, if the integrated D-SNPs were made permanent, beneficiaries who otherwise would have returned to FFS would remain enrolled in those plans, raising Medicare spending relative to FFS Medicare spending.

### Beneficiary and plan

- Dual-eligible beneficiaries enrolled in D-SNPs that clinically and financially integrate Medicaid benefits will benefit by continuing to remain enrolled in those programs. Beneficiaries currently enrolled in D-SNPs that will not be reauthorized can remain in the MA program (either in the same plan, if it continues as a regular plan, or in another MA organization) or can enroll in FFS Medicare.

- Clinically and financially integrated D-SNPs will benefit from this recommendation because those plans will convert to a permanent status. Nonintegrated D-SNPs have the option to convert to regular MA plans, in which case they could keep some or most of their enrollees, exit the MA program, or work with states to become integrated D-SNPs.

### Several administrative policies are barriers to D-SNP integration

Several administrative policies act as barriers to integrating Medicare and Medicaid benefits (Medicare Payment Advisory Commission 2010). One barrier is how D-SNPs are allowed to market their benefits to beneficiaries. D-SNPs that furnish Medicaid benefits are not currently able to describe the combination of Medicare and Medicaid benefits they cover in their marketing materials. This situation can lead to confusion for beneficiaries and make the advantages of joining an integrated D-SNP less clear. The Secretary has the authority to address this problem. Specifically, the Secretary could permit D-SNPs to describe—in the same section of the plan's marketing materials—the Medicaid and Medicare benefits they cover.

Multiple enrollment cards are another administrative barrier to the coordination of benefits. Dual-eligible beneficiaries are sometimes given two enrollment cards—one to cover their Medicare benefits and a second to cover their Medicaid benefits—even though they are enrolled in one plan or with one organization that covers both sets of benefits. The Secretary also has the authority to address this misalignment by helping D-SNPs overcome some of the barriers to using a single enrollment card. For example, Medicare and a state Medicaid program may have different effective dates of enrollment, out-of-pocket costs, contact numbers for authorization or member services, and claims submission processes. A single enrollment card could be less burdensome and confusing to beneficiaries; however, it may be difficult to place all the necessary and relevant Medicare and Medicaid information on one enrollment card if the information between the two programs is not coordinated. Another barrier—the state's lack of resources and expertise to include its Medicaid benefits in contracts with D-SNPs—could also be addressed under the Secretary's authority by providing states with a model Medicaid contract with D-SNPs. The model contract would serve as a form of technical assistance and states would have the option to refer to the model contract as a resource guide when developing Medicaid contracts with D-SNPs.

Separate appeals and grievances processes for Medicare and Medicaid services are another barrier to integration. The current appeals and grievances processes for Medicare Part A and Part B have different rules and timelines from the appeals and grievances processes for Medicaid. It can be confusing and time-consuming for beneficiaries to navigate these separate processes. An aligned appeals and grievances process would alleviate this barrier, but the Secretary does not have the authority to do so, as it would require a change in law by the Congress. The current MA standards for appeals and grievances should represent a minimum standard. An alignment with the Medicaid process should result in an appeals and grievances standard that is an improvement over what is currently available through MA.<sup>5</sup>

#### RECOMMENDATION 14-4

**For dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should:**

- **grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;**
- **direct the Secretary to allow these D-SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;**
- **direct the Secretary to allow these D-SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and**
- **direct the Secretary to develop a model D-SNP contract.**

#### RATIONALE 14-4

This recommendation would alleviate misalignments between the Medicare and Medicaid programs that are barriers to an integration of program benefits. Under this recommendation, D-SNPs that are clinically and financially integrated would have aligned appeals and grievances processes for Medicare and Medicaid benefits. They would also be able to market all the benefits they cover as a combined benefit package, and it would be easier for them to give enrollees a single enrollment card to access their Medicare and Medicaid services. Under this recommendation, the Secretary would develop an example of a model Medicaid contract with a D-SNP for states to use as a resource.

#### IMPLICATIONS 14-4

##### Spending

- This recommendation would not affect program spending but would alleviate administrative barriers between the Medicare and Medicaid programs.

##### Beneficiary and plan

- We expect this recommendation to have a positive effect on beneficiaries and plans by fostering the coordination of Medicare's and Medicaid's separate benefits for the beneficiaries who are dually eligible for both sets of benefits. ■

## Endnotes

---

- 1 Employer plans are another type of MA plan that can limit enrollment. They are not included in the analysis in this chapter.
- 2 Fifteen conditions are currently approved by CMS for C-SNPs: chronic alcohol and other drug dependence; autoimmune disorders; cancer, excluding precancer conditions or in situ status; cardiovascular disorders; chronic heart failure; dementia; diabetes mellitus; end-stage liver disease; end-stage renal disease requiring dialysis; severe hematologic disorders; HIV/AIDS; chronic lung disorders; chronic and disabling mental health conditions; neurologic disorders; and stroke.
- 3 The NCQA approval process, required as of 2012, evaluates the extent to which plans adhere to these “model of care” requirements. A separate NCQA process evaluates the structure and processes of SNPs.
- 4 MedPAC analysis of plan participation of Medicaid managed long-term care programs and SNP enrollment files from CMS.
- 5 CMS is currently working with a number of states on demonstrations for integrated care programs for dual-eligible beneficiaries and will likely alleviate many of these misalignments for the plans that participate in the demonstrations.

## References

---

Government Accountability Office. 2012. *Medicare Advantage: CMS should improve the accuracy of risk score adjustments for diagnostic coding practices*. Washington, DC: GAO.

Medicare Payment Advisory Commission. 2010. *Report to the Congress: Aligning incentives in Medicare*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Newhouse, Joseph P., Mary Price, Jie Huang, et al. 2012. Steps to reduce favorable risk selection in Medicare Advantage largely succeeded, boding well for health insurance exchanges. *Health Affairs* 31 (December): 2618–2628.