Advising the Congress on Medicare issues

Medicare Advantage special needs plans

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MEDPAC

SNP authority expiring

- Medicare Advantage special needs plans (SNPs) limit their enrollment to certain classes of beneficiaries
- Authority for exclusive enrollment expires at end of 2013 (current law status)
- Plans can continue as non-SNP MA plans (general MA plans that must accept all eligible enrollees)

Outline of presentation

- Background on special needs plans (SNPs)
- Features and current landscape
- Issues to consider in deciding on policy options
- Policy options

Basis of analysis

- SNP requirements and performance standards established in law and policy
- Review of literature
- Discussions with SNPs
- Analysis of data on enrollment patterns, quality measures

SNP types, enrollment and prevalence

- **D-SNPs**: For Medicare-beneficiaries dually eligible for Medicare and Medicaid
  - Largest, at 1.26 million enrollees (Sept. 2012). As of 2013, D-SNPs will be available to about ¾ of all Medicare beneficiaries.
- **C-SNPs:** For specified chronic or disabling conditions
  - 223,000 enrollees; as of 2013, C-SNP of at least one disease type available to slightly over half of all Medicare beneficiaries
- **I-SNPs:** For beneficiaries in institutions (e.g., nursing homes) or in community at institutional level of care
  - 48,000 enrollees; as of 2013, available to slightly less than half of all Medicare beneficiaries
- Composition of enrollment different from general MA

Evolution of SNP requirements

- SNPs originally authorized through 2008 in Medicare Modernization Act of 2003
- Re-authorized several times with moratorium on new SNPs in 2008-2009
- New requirements as of 2010
  - New requirements on D-SNPs (state contracts), C-SNPs (only certain conditions), I-SNPs (method of certifying need for institutional care)
  - For all: Model of care requirements, structure and process standards, certification by National Committee for Quality Assurance

Do SNPs perform better than non-SNP MA plans on quality indicators?

- Evidence is mixed: As with general MA, variation across SNPs in current quality indicators; geographic variation
- Most process and intermediate outcome measures (HEDIS®) lower for SNPs than general MA averages, but C-SNPs that are HMOs better on several measures
- I-SNPs perform well on hospital readmission rates, as do some D-SNPs
- On average, CMS star ratings lower for SNPs
  - But SNPs in CA, MA, MN and WI perform well on star ratings

Note: HEDIS is the Health Plan Employer Data and Information Set that MA plans report.

Should SNPs be judged using different quality measures?

- Industry concern that current measures and star system not appropriate for SNP plans:
  - Socio-economic differences should be taken into account
    - But how and to what extent?
  - Compare like populations within sectors (MA-SNP, general MA, FFS)
    - Difficult to do with currently available data, particularly for outcomes
  - Use measures more appropriate to the population served
    - Work still underway on developing new measures
    - Not a SNP-only issue; also applies to general MA plans

I-SNP policy options

Option 1: Re-authorize I-SNPs

- Serve a distinct population, with distinct model of care and benefit package
- Critical mass may be needed to put model in place (contracting with nursing homes, using nurse practitioners for defined population)
- Plans show good results on certain quality measures (e.g., readmissions)

Option 2: Allow authority to expire (current law)

- Consequence would be that current enrollees could continue in MA plan but would not have a specialized benefit package and may not have same types of services

Option 3: Facilitate offering I-SNP benefits in general MA plans

- Allow benefit package flexibility and enrollment rules that would facilitate I-SNP model within MA

C-SNP policy options

Option 1: Re-authorize C-SNPs

- Some HMO C-SNPs perform well on quality indicators

Option 2: Allow authority to expire (current law)

- Consequence is that beneficiaries could continue in current MA organization, but benefit package/provider network may be different

Option 3: Re-authorize C-SNPs but narrow range of diseases

- Needs of beneficiaries with diseases such as end-stage renal disease, and HIV/AIDS, are sufficiently different to warrant special needs plans

Option 4: Give general MA plans flexibility to develop disease-specific benefit designs

- Can be included as part of option 2 or option 3

Do D-SNPs improve beneficiaries' access to supplemental benefits?

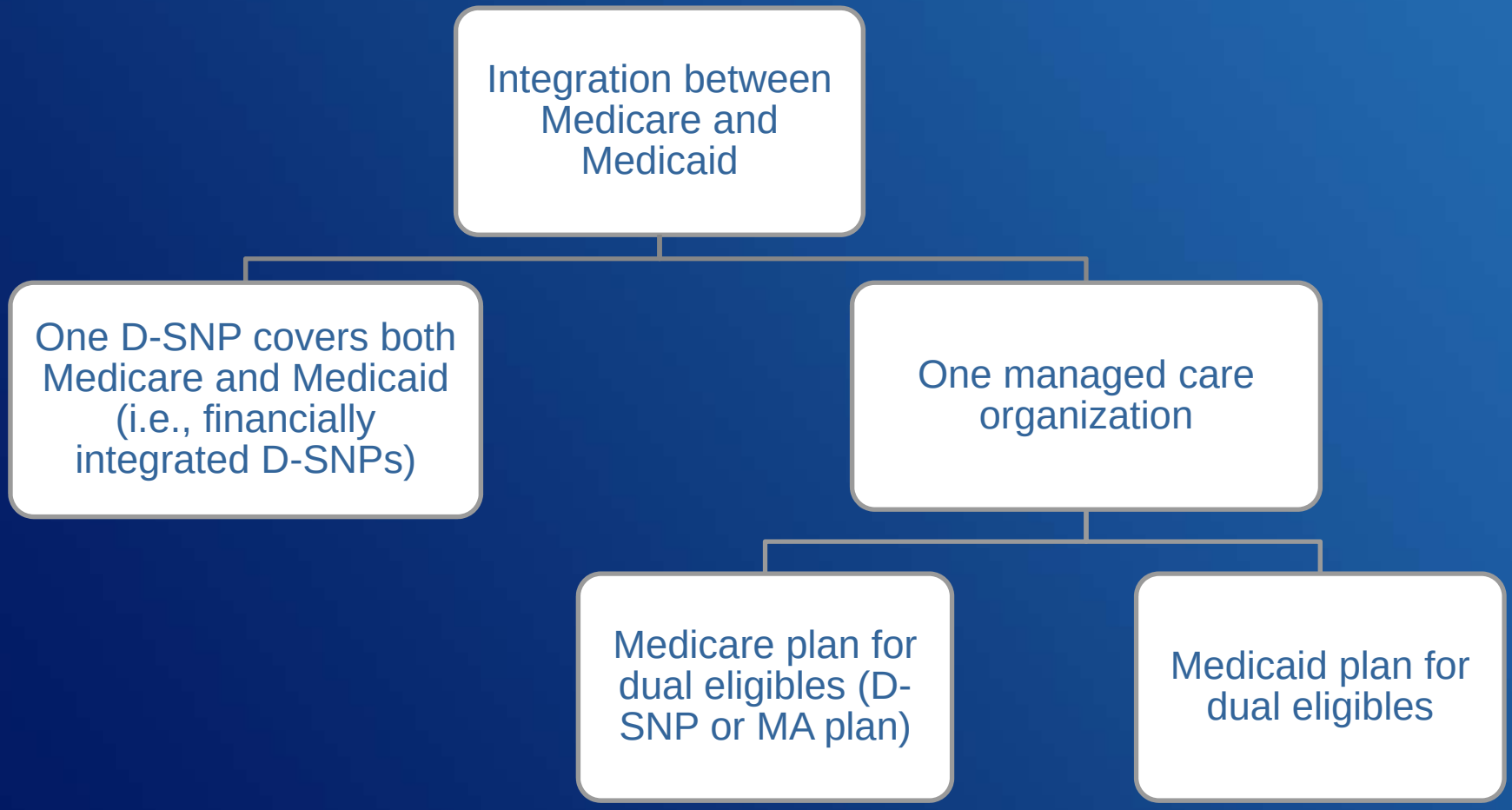
- Analysis of D-SNPs' supplemental benefits as a proxy for access
- Compared to general MA plans, D-SNPs tend to offer fewer supplemental benefits, but some of the supplemental benefits they offer are more comprehensive (GAO 2012)
- D-SNP supplemental benefits (e.g., dental, vision) can be more comprehensive than those same services offered by Medicaid
  - Can improve access to care
  - Can result in cost-shifting from Medicaid to Medicare

Do D-SNPs encourage a more integrated delivery system?

- Contracts cover capitation of Medicaid services or only provide for coordination. Services included in contracts range from:
  - Medicaid payments of dual eligibles' cost sharing
  - Wrap around benefits (i.e., vision, dental, transportation)
  - Behavioral health services
  - Long-term care services (e.g., home health, personal care, home modifications, nursing facility care)

- D-SNPs with capitated contracts to cover some or all long-term care are "financially integrated"
  - Less than 25 financially integrated D-SNPs
  - Cover about 65,000 dual eligibles (<1 percent of all dual eligibles)

Integration with Medicaid occurs under two types of D-SNPs



Two administrative barriers to D-SNPs' integration with Medicaid

- Marketing requirements
  - D-SNPs cannot describe the Medicare and Medicaid benefits they cover in the same place on marketing materials
  - Precludes clear description of the advantages of the plan and can be confusing to beneficiaries
- Separate Medicare and Medicaid processes for appeals and grievances
  - Can be confusing and burdensome for beneficiaries and plans

Source: MedPAC June 2010 Report to Congress

D-SNP policy options

Option 1: Reauthorize all D-SNPs

- There would continue to be a vehicle in Medicare for managed-care based integrated care programs for dual eligibles
- However, D-SNPs that are not providing value would continue

Option 2: Reauthorize integrated D-SNPs

- Applies to financially-integrated D-SNPs and those with a companion Medicaid plan
- Consistent with Commission's interest in encouraging integration
- Authority still expires for D-SNPs that only coordinate Medicaid benefits

Option 3: Allow D-SNP authority to expire (current law)

- D-SNPs could continue as MA plans, but would have to enroll non-dual eligibles and could no longer tailor benefit package
- There would no longer be a vehicle in Medicare for managed-care based integrated care programs for dual eligibles

D-SNP policy options (continued)

Option 4: Alleviate administrative barriers to integration for integrated D-SNPs

- Option available if all or only integrated D-SNPs are reauthorized
- Reduce barriers in marketing requirements and use a combined process for appeals and grievances

Policy options – financial and beneficiary impacts

Spending implications:

- A reauthorization of SNPs will result in a small increase in program spending relative to current law

Beneficiary implications:

- The beneficiary impacts of an expiration of SNP authority will vary. Some beneficiaries will remain in MA and others will enroll in FFS

Additional SNP policy options

- Time-limited reauthorization
  - If reauthorized, could be for a limited time (e.g., 3 to 5 years)
  - Continue to develop new quality measures; require further study to compare SNPs to general MA and FFS Medicare
- Moratorium on new SNPs
  - Continue to develop new quality measures; require further study

Summary of policy options for Commissioner discussion

	D-SNPs	C-SNPs	I-SNPs
Current law	• *SNP authority expires on December 31, 2013*		
Reauthorization	• Reauthorize all • Reauthorize integrated • Alleviate administrative barriers	• Reauthorize all • Reauthorize C-SNPs for a narrow range of diseases	• Reauthorize all
If all or some SNPs are reauthorized	• Reauthorize for a limited time (e.g., 3 to 5 years) and require an evaluation • Place a moratorium on new SNPs and require an evaluation		
If all SNPs not reauthorized	• N/A	• Give general MA plans greater flexibility on benefit design	• Facilitate offering under general MA