



Policy Considerations for Special Needs Health Plans Submitted by CareMore

CareMore is pleased to provide these thoughts and recommendations regarding Special Needs Health Plans (SNPs) to the Obama Transition Team. CareMore is a health care delivery system which excels in the delivery of health care services for the chronically ill and frail. As such, CareMore operates a Chronic Care SNP and an Institutional SNP in Southern California. Our comments emanate from the perspective of an organization whose roots are in health care services, not insurance. As such, we see a singular objective for the SNP Program – to provide Medicare programs with alternative, proven models of health care delivery which produce superior clinical outcomes and dramatically reduced cost compared to the clearly traditional modes of health care delivery and payment. In order to achieve that goal, we believe several dimensions of the SNP program could be improved, and we have made several policy recommendations to that end.

DIFFERENTIATE SNPs BY TYPE AND CREATE POLICY AND RULES SPECIFIC TO EACH TYPE

Frequently, policy considerations regarding SNPs lump all three into one discussion and fail to recognize that the three are very distinct programs. It is our belief that the best policy and programs for the populations to be served by SNPs will be achieved by clearly separating them from one another, and developing policies, rules, and measurements distinct to each one. This would provide the best opportunity for each program to thrive and to meet its intended goals on behalf of the Medicare program. Congress made a move in this direction in 2008 by separating out a subset of specific requirements for each SNP. This is directionally correct, but additional strategic thinking about the specific needs of and requirements for each type of SNP will enable each program to achieve its maximal success on behalf of the Medicare Program. Further, policy regarding other components of the Medicare program should be aligned with SNP objectives. For example, nursing homes who have a financial incentive to hospitalize residents because of higher post-discharge revenues for that same patient are not likely to be cooperative with I-SNP programs designed to increase patient stability and thereby reduce hospitalization.

ACTUALIZE THE INTENTION OF DUAL SNPS BY REQUIRING STATES TO COORDINATE BENEFITS

The intent of the Dual SNP program has not been realized because, with few exceptions, States have not worked with SNPs to integrate payment and care for the dually eligible. Congress passed law in 2008 which required any Dual SNP to have a contract with the State, but did not require States to have contracts with Dual SNPs. So, SNPs will work to try to get their States to contract with them, but will largely be unsuccessful. If such coordination of benefits and care has merit, and we believe it does, policy needs to focus on Medicaid granting policy to the States. We believe significant savings of Federal and State Medicaid funds can be realized through such integration.



RECOGNIZE THAT CHRONIC CARE AND INSTITUTIONAL SNPs ARE PRIMARILY ABOUT HEALTH DELIVERY AND NOT PRIMARILY ABOUT INSURANCE COVERAGE.

Because they are currently a derivative of the Medicare Advantage Program, C-SNPs and I-SNPs are bound by the same regulations and measurements as all MA Programs. This reinforces to the beneficiaries that they are primarily buying insurance, when, in fact, it is Congressional intent that these programs be about changing health delivery practices. This misfit manifests itself in two primary ways: marketing rules and quality measurement.

- 1) *Marketing Rules:* When C-SNP and I-SNP programs were inaugurated, policy-makers rightly considered the needs of the future beneficiaries and waived the annual open enrollment restrictions for these beneficiaries. It was recognized that when a chronically ill or institutionalized individual was identified, it would be imprudent to say “wait until January” in order to meet their needs. And, in 2007, CMS recognized that physicians – who otherwise are strictly instructed not to recommend health plans – were in the best position to discuss health care programs to the chronically ill, and gave physicians freedom to recommend C-SNPs to their qualifying patients. Both of these provisions recognize that it is health care, not insurance, that is being communicated to the beneficiary. The new marketing rules instituted by Congress and CMS in 2008 attempted to address the abuses by some insurance brokers and put strict regulations on all MA Plans, including C-SNPs and I-SNPs. While the year-round enrollment provision remains, the physician’s ability to recommend a program has been eliminated. Added to the rules are restrictions on communicating with members in health care settings, waiting 24 hours between initial contact with a member and discussing a plan, and inability to discuss an MA product at a health care event. While these restrictions may serve to modify inappropriate insurance-related activity, they are highly impractical in the marketing of C-SNP and I-SNP Programs. For example, to attend a diabetes fair, as a Diabetes SNP and not be able to talk about the Diabetes program is unproductive. Similarly, to be restricted from reaching out to ESRD patients in their dialysis setting – where they spend literally ½ of their time – severely limits access to appropriate patients for a narrowly categorized program.
- 2) *Quality Measures* We strongly believe that quality and outcomes measures must be a fundamental element of the SNP Programs and that SNPs must prove that they are significantly more effective than standard modes of care. However, those measures must recognize that the populations served in those programs are very unique – and will be all the more specialized given CMS direction for single-condition SNPs. However, CMS has looked to NCQA for measurement of effectiveness, and this has resulted in many existing HEDIS measures being applied to C-SNP programs. This results in measurement of non-relevant factors as well as missing the opportunity for relevant measures. For example, I-SNPs should not be measured based on traditional HEDIS metrics – i.e. % of members receiving colonoscopies or mammograms. When measured on such metrics, an I-SNP will look very poor in quality, showing very low compliance with HEDIS measures, and possibly leading some to question the quality of care delivered. But the reality is that these populations are no longer receiving such health services, and to include them as measure of effectiveness misses the point. The right measures for an I-SNP include metrics such as falls, wounds and mental health support. A similar case can be made for every C-SNP condition recently approved by CMS. Each should have measures specific to that condition, and “quality” should not be judged based upon the health care services delivered to the average of the population.



RECOGNIZE THE HIGH RISK NATURE OF THE POPULATION SERVED AND MATCH THE TIMING OF PAYMENTS TO ELIGIBILITY FOR SERVICES

C-SNP and I-SNP programs would literally be impossible without the risk-adjusted payment provisions initiated by Congress four years ago. However, a mis-match in timing remains, whereby a plan receives revenue reflective of the patient's condition one year from the time the condition is identified. This delay in compensation makes growth of SNPs very risky. In addition to the obvious issue of health care costs exceeding revenue, it is the case that because the beneficiaries of these programs are the most frail individuals, they often die within the year, resulting in additional financial burden to the SNP. Payment rules should remove this risk.

ELIMINATE NEED FOR ANNUAL RE-AUTHORIZATION OF THE PROGRAM.

At their inception, SNPs were authorized for three years, and recently have been re-authorized for one year. To require annual Congressional action makes the existence of the program uncertain, resulting in restrained investments in development of care programs and geographic expansion of proven models.

CONSIDER RECATEGORIZING CHRONIC CARE AND INSTITUTIONAL SNPs OUT OF THE MA PROGRAM AND INTO A CHRONIC/FRAIL INITIATIVE

Perhaps a way to make the clear delineation between health system objectives and the standards of the MA Insurance-type programs is to free SNPs from MA – as the Pace Program is – and have them operate as their own unique category of Medicare Program. Such a distinction would under gird the unique nature of the SNP programs, insure that they weren't one more "angle" for the large insurers, and encourage health care systems to enter the market, free from the encumbrances of being an MA Plan. Policy makers and legislators seem dissatisfied with the lack of creative health delivery models emerging, as was hoped with the introduction of SNPs. If SNPs were freed from the general body of regulation governing the "insurance" aspects of Medicare Advantage, perhaps more health delivery systems would be attracted to the program and the kinds of models desperately needed in the Medicare program would emerge. As noted above, the program would achieve the most vibrancy if it was considered a new, permanent part of the Medicare Program, rather than a program requiring annual re-authorization. It would free CMS to think specifically about Chronic and Frail care delivery and payment methods, and permit it to craft federal policy regarding the clear inter-relationships of health delivery models and the cost to the Federal system for managing these high-need individuals. Key elements of the current program would need to remain in place, like prepayment for all health services, proven systems of care and documented quality outcomes. But perhaps thinking of the management of the Chronically Ill and Frail as its own body of focus within the Medicare program would expedite the introduction and maturity of badly needed care programs.

Respectfully Submitted

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