

WHITE PAPER

Special Needs Plans and Model of Care After HR 6331 (MIPPA)

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Background

The Medicare Modernization Act of 2003 (MMA) created the concept of Chronic Disease and special status health plans with federal regulations to allow Special Needs Plans, (SNPs).

The MMA allowed for Medicare SNP members who meet the following conditions:

- A Medicare Advantage (MA) individual who is institutionalized,
- A Dual Eligible (Medicare and Medicaid), entitled to medical assistance under a State plan, or
- One who has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized plan.

CMS further defined a Specialized MAPD plan for Special Needs individuals who meet the above requirements and allows the SNP to limit enrollment to those individuals who meet the CMS and MAPD requirements. This is a major change in the Medicare Managed Care environment, prior to the enactment of the MMA, a Medicare health plan of any type was required to enroll anyone who qualified for Medicare Parts A and B, regardless of health, age, or any other denominator with a few small exceptions such as having ESRD. **The SNP is still an MA insurance plan, funded with a risk adjusted capitated arrangement by CMS.**

CMS:

- Did not set forth detailed definitions of a chronic care MAPD plan in the regulation in order to provide the industry as much flexibility as the law allows and as such,
- Will evaluate plan proposals on a case-by-case basis
- Will consider in its evaluation the appropriateness of the target population, clinical programs, and special expertise and how the MAPD SNP will cover the full spectrum of the target population without discrimination against “sicker” individuals.
- Has seen interest from plans for chronic disease SNPs for: cardiovascular disease, diabetes,

congestive heart failure, osteoarthritis, mental disorders, ESRD, HIV/AIDs.

Issues inherent in a Chronic Disease SNP

Type of Chronic Disease SNP

While CMS has left the question of type of Chronic Disease SNP open, there are practical issues to consider in determining the type of SNP a plan may choose to adopt. CMS does not limit the creation of the Chronic Disease SNP to one type of disease category. So the first decision management may need to address is a plan for “simple sick” or “chronic sick,” meaning to focus on one disease category or several. The size of the universe of members and the health plan’s ability to care for their members are the limiting factors in this determination. The Medicare population includes significant numbers of individuals who are financially and medically vulnerable. Twenty-eight percent of all Medicare beneficiaries report being in only fair or poor health.¹ In African-American and Hispanic groups, this percentage is higher with more Medicare beneficiaries report having two or more diagnoses.

These categories break down further by age group but CMS will not allow for discrimination by age or sex.

Identification of the member

Once a health plan has determined the type of chronic disease SNP, CMS wants to know how the plan will identify potential members. This can be as simple as using a diagnosis code or requesting a referral from a network physician, obviously in conjunction with HIPAA rules and regulations.

CMS Payment Structure for Chronic Disease SNPs

There are no extra payments for Chronic Disease SNPs. The CMS payment methodology is the same as it is for a non-SNP MAPD. This being said, the

advantage to having a chronic disease SNP is that a health plan can focus its efforts and benefits in one major direction as opposed to spreading its resources over the entire gamut of the Medicare population.

Disease-specific benefit plans designed to lower health care costs can be instituted and membership restricted to those who qualify (Chronic Disease SNP) or to everyone (Disproportionate Share SNP) depending on if they find the benefits attractive enough to join.

Payments to a Chronic Disease SNP are focused around the HCC diagnostic classification system implemented by CMS. This system first classifies over 15,000 ICD-9-CM codes into 804 diagnostic (Dx) groups. Each ICD-9 code maps to exactly one DxGroup. DxGroups are further aggregated into 189 Condition Categories, or CCs. Hierarchies are imposed among related CCs so that a member is coded for only one related category. However, a member can be coded into more than one non related CC. Based on these codes, a risk score is assigned to each member and this factor is considered into the base payment received by the health plan. Additional payments may be added to the plans premium if the members are further classified as ESRD, Institutional, or Medicaid eligible. But these are the same payments a health plan would receive regardless of its SNP status.

Management of Chronic Disease SNPs

The 2008 MIPPA legislation required strong Model of Care programs for Special Needs Plans. This ties to valid Quality Improvement Plans (QI), Care Management Programs (CMP), and strong reporting requirements.

The new Model of Care Plan requires:

- Evidence based measurements
- Specialized network
- Comprehensive Health Risk Assessment and annual reassessment
- Individualized Care Plan
- A Managed care team

Care teams are built around the following functions.

Customer Service – To successfully operate a Chronic Disease SNP, the Customer Service department must be the first line of attack. From a vigorous health care assessment, to assisting the member in accessing care, (both covered, and through related social programs), and should include the ability to refer the member to case management or disease management as needed. This would include prospective calls reminding members of medical appointments or just following up with a member who has not been heard from in over 3 months to see how they are doing.

Case Management – Vigorous case management will be required to assure that this population is receiving the appropriate care at the appropriate time in the appropriate manner. This includes:

- Coordinate activities of medical professionals, community agents, funding sources, client and family for the goal of achieving maximum functional outcomes.
- Facilitate inpatient, outpatient, and home services as well as medical evaluations and environmental modifications as needed.
- Assist the member in securing funding or donations for medical equipment, supplies, medications and services in a cost effective manner.
- Provide disease and care specific information to the client to help facilitate timely and appropriate treatment.
- Guide member to self-directed care, self-advocacy and decision making to the degree possible.
- Maintain open communication with all members of the health plan team so that the care plan can be discussed, problems identified, and adjustments made as needed.
- Make adjustments in the care plan to promote better outcomes, if the plan is not showing the outcomes expected.
- Support the stability of the client and family environment

Disease Management – This is the foundation of a successful Chronic Disease SNP.

- Disease Management (DM) represents a significant challenge for the health plan and offers real opportunities for improvements in member outcomes and reduction of costs. Obviously, DM programs should be tied back to the determination of the type of Chronic Disease SNP that is being operated and the quality and quantity of a health plan's provider contracts and network.

The following are the foremost goals in a SNP DM program:

Primary care interventions

- Reduction of hospital admissions
- Reduction in "length of stay" of members when hospitalized
- Facilitate open communications between providers, health plan, and community agencies to utilize services available through social service networks
- Reduction in medications with improved health outcomes
- Reduction in urgent care visits

This would be accomplished by emphasizing the prevention of exacerbations and complications using cost-effective interventions, assisting the member to buy into patient self-management and behavior modification, and should show empirically, the effectiveness of the DM interventions.

In conjunction with the DM program, a Medication Therapy Management Program (MTMP) must be established. The MTMP needs to integrate with the DM program and have measurable outcomes showing improved quality of life using evidence-based practices and interventions. Outcomes for these programs can be measured through HEDIS as well as member financial, clinical, and humanistic evaluations. SNPs have to report HEDIS measurements to CMS as they provide empirical data to measure improvements in outcomes to compare against health care costs and allow CMS to publicly rate Special Needs Plans.

The success of managing a Chronic Disease SNP will

depend on several factors including:

- Adequate reporting support from I/T
- Ability to construct a data warehouse dedicated to these programs
- Dedicated professionals (including pharmacist) to the program
- Standardized reporting
- Standard and custom queries into the data warehouse

Marketing of Chronic Disease SNPs

Marketing for a Chronic Disease SNP will have many differences from a non-SNP MAPD. HR6331 detailed many changes in the marketing regulations. The marketing will be four fold:

1. Internal marketing to current non-SNP MAPD members who fit the profile for the SNP
2. Provider marketing through the selected providers in the plan's SNP network,
3. Grass roots marketing through community service providers and health delivery partners.
4. Targeted direct mail to those with the specific disease state.

This involves investing time and effort to work with providers and community-based organizations, creating opportunities to work together for better outcomes for your members.

All of the usually required MAPD materials must be created as a SNP still has to abide by all CMS marketing and communication rules. In addition, materials that can clearly delineate better clinical outcomes and improved quality of life will be needed. These materials will need to reach directly to the prospect, and the prospect's family members, especially the primary care enabler in the family. This can require a different approach based on your target market. For example, in the Hispanic community, the eldest daughter is more often the primary care enabler and decision maker.

Benefit Management

Benefits should be designed with the ideas of treating the SNP member and assisting your QI and Model of Care program. The Part A and B premium can be used to enhance the Part D benefit; additional benefits can be added to the standard MAPD benefit package but must relate to a health outcome or the CMS 25% premium withhold kicks in.

The benefits should be designed with other community services and State programs in mind to ensure that the health plan is not duplicating already available care. The formulary can be designed in such a way as to make the specific chronic disease medications inexpensive and easier to obtain to assist with DM and MTMP outcomes.

Chronic Disease SNP Operations

The operations and reporting platform for a Chronic Disease SNP will be much the same as for a non-SNP MAPD health plan. This will include:

- Fulfillment of Part D CMS reporting requirements
- Member monthly EOB
- Rebate aggregation and reporting to CMS
- PBM claims cost reporting and re-insurance threshold capture
- Drug utilization review program data capture and reporting
- MTM program reporting
- Grievance, appeals and exceptions reporting
- PBM validation of data and testing
- Supply of information to Medicare.gov
- TrOOP Reporting

In addition, policies and procedures can be adopted to support the specific objectives required by the Chronic Disease SNP, such as requiring member cooperation in DM programs or the member is subject to disenrollment. However, all the member rights and all CMS rules for involuntary disenrollment must be observed.

CMS does want to see evidence of how specific aspects of the Chronic Disease SNP work, including:

- How the DM management and protocols enhances care and care outcomes
- How the provider network configuration and intervention strategies benefit the members
- How the benefit structure serves the need to the target population
- What distinguishes the Chronic Disease SNP from a non-SNP MAPD
- What clinical interventions have been developed specifically for the target population

Summary

The passing of MIPPA and CMS's rules allowing for the continuation of Chronic Disease SNPs is a significant change in the traditional way CMS allows health plans to serve the Medicare population. It is significant that CMS did not dictate how this population was to be served but allows health plans to build their own model, based ideally on the health plans strengths. This in conjunction with premiums being risk- based allows a Chronic Disease SNP to identify and closely manage a heretofore largely unmanaged population. This will require a significant investment in time and resources by the SNP health plan but the rewards for a job well done will be manifest in managing a higher margin member at lower costs. This also allows for creativity in helping and treating the more vulnerable members of the Medicare population, improving quality of life of your member, and developing your health plan as the standard for Medicare care.

The future of coordinated care plans will be directed by the successes of the SNP health plans. SNPs will offer more diversity in benefits and costs, resulting in greater services to a sicker, less healthy population. The non SNP health plans will be faced with a smaller premium based on lower risk scores from a healthier population, and less opportunity to manage a larger margin. and less opportunity to manage to a larger margin.

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