From the Editor

A Special Opportunity

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As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in Geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as a American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages, LTC Interface, Jefferson's Health Policy Newsletter,* and *The Journal of Quality Healthcare.*

The Medicare Modernization Act (MMA) of 2003 did more than introduce Medicare Part D, the prescription drug benefit for seniors. It added life to Medicare managed care by allowing the development of programs for specific high-risk groups. These Special Needs Plans (SNPs) have the ability to develop systems and teams that can focus their expertise on unique groups of Medicare beneficiaries. Basically, an SNP is a specialized Medicare Advantage (MA) plan that exclusively or disproportionately serves special needs individuals, who are defined as persons: 1) dually eligible for Medicare and Medicaid; 2) living in an institution or the community with similar needs; or 3) with severe or disabling chronic conditions. In general, these persons reside in long-term care (LTC) facilities for at least 90 days, and include those living in skilled nursing facilities, nursing facilities, intermediate care facilities for the mentally retarded, or inpatient psychiatric facilities.

Over the years, enrollment in MA plans has varied greatly. From 1985 to 1994, the number of enrollees grew modestly from 0.4 to 2.3 million. At peak enrollment in 1999, Medicare managed care enrollments stood at 6.3 million, with 17.3% of Medicare beneficiaries enrolled in private plans. Immediately after introduction of the Balanced Budget Act (BBA) of 1997, which requires that all payments to plans be adjusted according to the health status of the enrollees by 2007, many Medicare managed care plans began experiencing problems and either left the program or curtailed benefits. As a result, Medicare managed care enrollees declined to 13% of the Medicare population by the end of 2003.

Predictions about the future of MA enrollments vary. By 2013, the Bush Administration projects that 30% of Medicare beneficiaries will be enrolled in MA plans, while the Congressional Budget Office predicts that MA enrollees will account for 16% of Medicare beneficiaries.[1] Kevin Piper and other industry watchers believe MA partici-

pation needs to reach the level of 25% to 35% to achieve a critical mass sufficient to force Congress to alter the system.[1]

Beneficiaries With Chronic Conditions

The Centers for Medicare and Medicaid Services (CMS) has left the definition of chronic conditions largely to the plans. CMS reviews each condition on a case-by-case basis. To date, SNPs' interest lies in beneficiaries suffering from cardiovascular disease, complex diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease, osteoarthritis, mental disorders, end-stage renal disease (ESRD), and HIV/AIDS. Currently, only 13 SNPs for chronic conditions have been approved.

One SNP that is developing an innovative delivery model for the special needs population is Care Improvement Plus. This SNP, dedicated to caring for Medicare beneficiaries living with complex diabetes, CHF, or ESRD, is opening assessment centers throughout its service region. The centers will provide easy access to services needed to avoid the hospitalizations and complications associated with their diseases. Obviously, SNPs will need clinical providers with expertise in managing the care of this frail population.

Institutionalized Beneficiaries

Institutionalized beneficiaries number about 3.5 million. They include residents not only of LTC facilities, but also community-dwelling residents who require an equivalent level of care. Of the 276 SNPs approved by CMS to operate in 2006, 37 are institutional SNPs.

Dual Eligible Beneficiaries

The vast majority of SNPs focus on the dually eligible population. At 7.5 million, these beneficiaries constitute the largest target group for SNPs. Comorbid conditions are common in this population, and 45% have severe mental illness. Compared with other Medicare beneficiaries, dual eligibles tend to be older, with lower incomes, and less education, leading to the need for a highly specialized care system. These high-risk beneficiaries also are disproportionately female, representative of minority groups, and highly isolated, with little or no social support. In addition to the opportunity to develop a specialized care model, SNPs have the ability to merge the funding from both Medicare and Medicaid.

CMS currently encourages States to mandate that dually eligible persons receive home- and community-based services only if they are enrolled in an integrated SNP. These demonstration projects are focused on standardizing and simplifying rate setting and risk adjustment, measuring and reporting performance standards, and managing grievance and appeal procedures, marketing guidelines, and State contracting with SNPs.

There are 5 factors that make SNPs particularly important to providers:

- *Exclusive enrollment*: The statute allows SNPs to restrict enrollment to a defined special needs population, including the possibility of limited enrollment to a specific set of care facilities.
- *Open enrollment*: Dually eligible and institutional beneficiaries have "special election periods" that allow them to enroll or disenroll from SNPs in any given month, rather than wait for the annual enrollment set for standard MA plans.
- F*oundation for serving dual eligibles*: Many LTC recipients, because of low income or after spending down their resources on LTC services, become dually eligible for Medicare and Medicaid. While most States do not offer opportunities for integration of Medicare and Medicaid, this legislation offers the potential for more extensive integration of Medicare and Medicaid outside of demonstration status. CMS currently is transitioning 3 dual eligible demonstrations to SNP status, which will establish a precedent for how, and the extent to which, dual SNPs will be able to continue integrating financing and service delivery.
- *Risk-adjusted financing*: Although SNPs are paid under the same financing structure as other MA plans, CMS is moving toward risk-adjusted payment, which will result in

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higher payments to SNPs for high-risk beneficiaries providing the incentive and means for developing specialized interventions for high-risk beneficiaries.

- *New quality measures*: CMS is beginning to explore ways to monitor quality for SNPs that appropriately assess *total* quality and cost performance in serving high-risk beneficiaries.
- *Specialized pharmacy benefit*: SNPs operate under the same regulations as other MA plans but are more likely to establish formularies and pharmacy management methods that are more appropriate for persons requiring multiple medications.
- *Umbrella for LTC innovation*: Although SNP legislation is limited in scope, it offers a vehicle for developing chronic care service innovations under mainstream financing. Virtually all the national elderly managed care demonstrations, including Evercare Choice, dually eligible demonstration sites, social HMOs, and On Lok Senior Health, are designing initiatives under the new SNP legislation.

Given the expansive growth likely for SNPs, providers and senior care facilities should explore options for tapping into this new arena by assessing the:

- Organizations that may be developing an SNP in their area
- The SNP's benefit package in relation to other financing options
- Advantages and disadvantages of SNP plans in providing drugs and supplemental Medicare and LTC benefits
- Contracting or partnering opportunities with an SNP or establishing one's own facility- or practice-related SNP

Most practices or senior care facilities are not likely to have the managed care expertise, financing resources, or large enough resident population to develop their own SNP. However, given the high level of interest in SNP development, partnership opportunities are likely. Although the benefit package and approach will vary significantly among SNPs, all are likely to offer an array of benefits and services that will be more advantageous than other MA or fee-for-service alternatives. In addition, SNPs will have the flexibility and financial incentive to help providers increase their low-cost/high-quality care offerings for high-risk beneficiaries.

Practices or senior care facilities that are interested in exploring a business partnership with an existing SNP or developing an SNP of their own should keep in mind that all SNPs must work within the context of existing MA and State regulations and laws governing Medicaid. Clearly, CMS is intent on expanding the role of coordinated models of care, of which SNPs provide the greatest promise for achieving improved outcomes in an efficient and effective manner. SNPs appear to offer special opportunities for providers ready to take advantage of them.

In this, as well as future issues of *MPM*, we intend to explore these opportunities.

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Reference

1. Piper K, ed. Medicare budget. Medicare Advantage special needs plans: understanding an untapped $250 billion market. In: *The Piper Report.* March 2, 2006. Available at: http://www.piperreport.com/archives/categories/46.html. Accessed August 15, 2006.