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## MEDICARE ADVANTAGE NEWS

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### Integration With Long-Term Care Is Seen as Key for SNPs' Future

The outlook for Medicare Advantage Special Needs Plans could improve substantially if both state and federal governments take some feasible actions aimed at giving the plans more flexibility, suggests a prominent SNP executive. Several of the opportunities he outlines entail integrating SNP services with long-term care, and one of them involves carving SNPs for Medicare-Medicaid dual eligibles out of MA.

John Lovelace, a vice president of UPMC Health Plan who heads up its SNP for dual eligibles, acknowledges that there also are numerous threats and problems for SNPs and that the trend toward consolidation among them is likely to continue. But he contends there are feasible ways to demonstrate value that SNPs need to exploit.

"We're not making much progress" in some ways toward improving financial conditions for SNPs, Lovelace said in a presentation at the 2010 Medicare Advantage Congress sponsored by Global Media Dynamics in Washington, D.C., Oct. 19. He outlined a host of major issues facing SNPs, including the coming MA capitation payment cuts, which may make it harder for the plans to keep supplemental benefits they now are offering to enrollees. Other big issues, he said, include the Hierarchical Condition Category (HCC) risk-adjustment payment system and CMS's star-rating system.

### Plan Executives Say SNPs Are Underpaid

Moreover, he noted, SNPs still are under only a temporary authorization, although the reform law did extend them through 2013 except for dual-eligible SNPs without a state Medicaid contract — they got an extension just through 2012 (MAN 4/15/10, p. 1). Furthermore, chronic SNPs such as a diabetes one suffer since they don't get paid any more than does a regular MA plan that has lots of diabetic members, but yet the chronic SNPs face special requirements that the regular MA plans don't, he added.

Indeed, Ghita Worcester, senior vice president of SNP sponsor UCare, said at an AIS webinar Dec. 7 that SNPs are underpaid in multiple ways, including for new Medicare beneficiaries (who comprise many members of dual-eligible SNPs) with undocumented pre-existing conditions, and for their higher-than-average percentage of beneficiaries with sustained high costs.

There is some prospect of additional pay for chronic SNPs in the future, Lovelace said in response to a question from MAN. The reform law created a process under which the risk-adjusted portion of chronic SNPs' pay can increase, and "it will happen over time," Lovelace said, but federal regulators believe the coding system works, so changes aren't occurring yet.

Robb Cohen, chief government affairs officer of SNP operator XLHealth Corp., said at another session of the conference that regulators are working on the SNP risk-adjustment pay issue, and there "could be some improvement for 2012." And Cohen told MAN last month that the proposed MA rule for 2012 incorporated the risk-adjustment review provisions of the reform law and laid out categories of beneficiaries to examine regarding that, albeit not coupled with specific ways of doing the evaluations.

Beyond the pay issue itself, there are several other ways to improve the outlook for SNPs, Lovelace said at the conference and elaborated on in an interview. And several of his suggestions relate to long-term care.

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Dual-eligible SNPs can't do anything by themselves to "get a handle on long-term care," he asserted, but they can benefit if state Medicaid programs work with them on a more active role. Lovelace noted that the reform law specifies that all dual-eligible SNPs will need contracts with the states. And he tells MAN this could lead to expansion of what states already are doing in letting plans handle the Medicaid aspects of long-term care instead of just the Medicare aspects, as is the case for UPMC and many other SNP operators now.

**Could Duals Be Carved Out of MA?**

Further down the road, he adds, there may also be potential for carving the duals out of MA and creating a statutory structure for them similar to that for the current Program of All-inclusive Care for the Elderly (PACE). He explains that such a structure could avoid some of the "unattractive" parts of PACE such as small networks and pay focused on centralized day care.

In addition, "The ability [of SNPs] to help people corral care is big," he asserts. SNPs can become an attractive business as well as more useful to society if they create alternatives to long-term care. The best scenario, he says, would be a pooling of Medicare and Medicaid funds so that a SNP operator deals with a single payer with the right incentives and can offer flexibility in benefits. Now, on the other hand, beneficiaries wind up getting bounced to nursing homes after hospitals reach the end of government payment streams, Lovelace explains.

Worcester noted in the AIS webinar that UCare has been involved in a separate program in Minnesota, where it is based, to enroll seniors and provide early intervention and preventive care aimed at reducing the need for long-term care services. That program has shown good results because SNP-eligible beneficiaries want to live in their own communities rather than in institutions, she added.

Another change that could help all SNPs, according to Lovelace, is developing metrics that can show they are better than other plans in reducing hospital admissions, fostering medication adherence and achieving patient satisfaction.

Regardless of what happens, though, Lovelace envisions a continuation of the consolidation trend in SNPs. He notes that the number of SNPs has been going down for two years and points out the decline has occurred both because of plans exiting and because SNP operators, such as Bravo Health this year, are being acquired (MAN 9/2/10, p. 3). There is no evidence that either trend will stop, he suggests.

There also is a new fly in the ointment for SNPs. The Medicare Accountable Care Organizations that the reform law will create may perhaps be able to do what MA plans (including SNPs) can do without needing an insurance license, says Lovelace. This is not so much an issue for UPMC, he maintains, because it already has an integrated care system, but other SNPs could suffer if ACOs can achieve more patient engagement without payer involvement. Any such SNP disenfranchisement, he adds, would not happen immediately but instead would be "longer term."

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