SNP Gold Standards Framework

A Policy Report from The SNP Alliance

February 2009

Gold Standards Framework for Special Needs Plans

Guidance for Improving Total Cost and Quality Performance in High-Risk Care

Introduction

The SNP Alliance Medical Directors Leadership Group developed the following framework for health policy and practice leaders to assess the adequacy of existing methods for financing, administering and delivering care for frail elders, adults with disabilities, and other persons with severe or disabling chronic conditions through Special Needs Plans (SNPs). Our goal is not to recommend new minimum SNP requirements, but to provide a lens for reengineering policies and practices to be more consistent with the multi-dimensional, interdependent and ongoing nature of care for persons with serious chronic conditions.

An underlying premise of the proposed ***Gold Standards Framework***, is that most Americans purchasing commercial insurance or enrolling in a traditional Medicare Advantage plan seek financial coverage for the cost of basic primary care, as well as major medical coverage for hospital and related acute-care benefits. Though some enrollees may develop a serious medical problem at some point that requires extensive, ongoing care from a broad array of providers, only a small percentage of beneficiaries will require extensive care for any significant period of time and incur catastrophic costs. Because most people are relatively healthy at the time of enrollment, traditional insurance methods provide adequate insurance coverage for most beneficiaries and adequate protection against risk for most companies.

"In some cases, usual health care policies and practices cause significant and unnecessary stress, confusion, medical complications and costs in serving persons with serious chronic conditions.

SNPs policy and practice leaders cannot afford to conduct business as usual."

In contrast, for Special Needs Plans that are required by law to enroll high-risk beneficiaries with special needs, *most, if not* all, *enrollees have a pre-existing medical condition at the time of enrollment that is complicated by other medical conditions — mental, behavioral or psychosocial problems — as well as environmental factors.* Since about three-quarters of SNPs are Dual SNPs, most enrollees also are low-income and many have language, ethnic, social and cultural challenges that complicate their care needs

To be successful, SNP payment methods, oversight structures and care arrangements must all recognize the volatile, complex and ongoing nature of conditions exhibited by the majority of SNP enrollees. The infrastructure for financing, administration and delivery of care by SNPs must offer providers the flexibility to monitor and adjust their patients' plans of care in response to an ever-changing set of circumstances, and to work with others to help manage a very complicated set of problems. Policy, plan and care network structures and procedures must embrace an "extra mile" attitude in offering a multidimensional lifetime of specialized care. The exception for traditional insurance plans must be the standard operating procedures for SNPs.

The Gold Standards Framework outlined in this report were developed by consensus in an effort by the SNP Alliance Medical Directors in seeking to identify those issues that are most important in serving frail elders, adults with disabilities and other persons with severe or disabling chronic conditions. The framework was built upon the insights and training of national leaders with extensive experience in high-risk care and currently available research and best practice material.

Some Special Needs Plans and health policy leaders already embrace many of the standards identified. However, most Federal and State policy and most core SNP operations are based on traditional Medicare and/or Medicaid structures and procedures, some of which are significantly out-of-touch and out-of-sync with the complex care requirements of SNP beneficiaries. For SNPs to succeed over the long term, it is critical for SNP stakeholders serving in leadership positions to assess the adequacy of existing practices, in light of these standards, and to work together to reengineer payment methods, oversight structures, plan administration, and care management processes to be more in keeping with the predominant specialty care needs of SNP beneficiaries.

Standards of Excellence

The standards are organized around five goals:

1. **Consumer empowerment.** To enable persons with serious chronic conditions and their family caregivers to optimize their health and well-being within the limits of their prevailing condition, with full recognition of the values and preferences of plan enrollees.
2. **Specialized care system expertise.** To ensure that benefits and services are designed, implemented and maintained according to the unique needs of the high-risk group(s) being targeted, and in accordance with *relevant* evidence-based guidelines, to the extent available.

3. **High-risk screening, assessment and care management processes.** To identify high-risk beneficiaries, assess their care needs and help them and their family caregivers access the right care, at the right time, in the right place, given the nature of their condition, the trajectory of their illness, and their care preferences, with emphasis on preventing, delaying and/or minimizing disease and disability progression as a person's care needs evolve across time, place and profession.
4. **Aligned care providers.** To ensure that provider arrangements are aligned in accordance with the multidimensional, interdependent and ongoing care needs of high-risk beneficiaries, so that care is coordinated across providers around a common treatment plan and medical errors and adverse outcomes resulting from the failure to coordinate care are avoided.
5. **System management methods.** To enable the spectrum of Medicare and Medicaid programs, disease management companies and care providers serving a common group of high-risk beneficiaries to work together to optimize total quality and cost performance for high-risk beneficiaries.

Members of The SNP Alliance believe that these goals and related standards to follow are of central importance to optimize total quality and cost performance in serving persons with multiple, complex and ongoing care needs. SNP executives and health policy leaders must assess existing administrative, financial and oversight rules that affect the way we provide care and eliminate barriers or establish new rules that will better enable SNPs to achieve these goals. Following in an outline of the key elements involved in advancing each of the five goals for the Gold Standards Framework.

Goal #1: Consumer Empowerment

1. ***Simplify and facilitate member enrollment and communications.*** Gold Standard SNPs will enable special needs individuals to:
   a. Access SNP benefits using simple enrollment procedures.
   b. Receive information about benefits and services that is accurate, easily understandable, and using materials that address language and cultural differences, as well as any limitations related to physical and visual deficits.
   c. Be fully informed, prior to enrollment, of benefits and services available to them using common, simple, integrated methods of communication regarding:
      - Medicare benefits and other supplemental benefits available under the plan.
      - Medicaid benefits for which they are entitled in the state where they reside, and which are available as well as unavailable to them under the plan.
      - Any limitations on plan benefits and services as well as differences in the cost of benefits and services, including premiums, co-pays and deductibles.

"Change is upon us, and we can neither run nor hide. The only answer is to create new — nimble — businesses capable of adroitly responding to the chaotic conditions produced by constant change. It won't be easy. Decades of deeply ingrained procedures, traditions, attitudes and cultural bias about managing change must be jettisoned. In their place, new perspectives and frameworks must be embraced."

Daryl Conners
Leading at the Edge of Chaos

- Any additional benefits available from the SNP.
- Any special requirements or exclusions affecting the receipt of benefits and services.

2. ***Enhance self-care capabilities.*** Gold Standard SNPs will enable special needs individuals to:
   a. Access medical, behavioral and social services through a simple, decentralized and standardized process.
   b. Receive the most advanced information about their condition including information about symptoms and risk factors for disease onset and illness progression, genetic predisposition, and information of importance regarding a person's medical history, dietary considerations, and environmental circumstances.
   c. Access the most current information available about best practices in caring for persons with multiple, complex care needs, and including tools for assessing quality and selecting providers.
   d. Be fully informed about the best way to access and use available benefits and services as well as information about cost, quality and satisfaction with reference to providers offering benefits and services under the SNP benefit plan.
   e. Access self-care services and technologies to optimize their health and well-being.
   f. Be fully informed of care options and be able to fully participate in making decisions about their care, with all parties appropriately accountable for decisions made.
   g. Have their family caregivers informed, trained and given emotional support in helping their loved ones deal with the complexities of their condition and care. This includes providing or arranging for respite care and assistance in making financial and legal decisions.
   h. Receive care from network providers in a way that complements, rather than supplants, their own self-directed activities.
   i. Receive care at the time and in the place that offers the greatest freedom and personal comfort to the extent that their overall condition will allow it.
   j. Be guaranteed the right to privacy, with full knowledge of and control over what information is retained and shared by the SNP and network providers.

3. ***Improve access to needed benefits and services.*** Gold Standard SNPs will enable special needs individuals to:
   a. Have access to a full array of health care services, including primary care, specialized medical care, acute care, transitional care, home health care, rehabilitation services, residential care, community-based long-term care, adult day-care, pharmacy services, palliative care, assisted housing, and supportive services at the minimum, even those all SNPs may not be able to address all beneficiary needs directly through available SNP financing.
   b. Obtain information about how to access these services from any provider in the SNP care network.

   c. Have access to specialized chronic illness care services, including specialized diagnostic and disease management services, care management services, chronic illness care technologies and adaptive devices.
   d. Receive all needed services regardless of race, age, sex, religion, nationality, sexual orientation or income.
   e. Receive all services in the least restrictive and safest environment feasible.
   f. Receive services when and where a person needs them, within the limits of available resources.
   g. Have priority access to care where they reside. All health care professionals should take into account their ability to either impede or enhance a person's ability to safely and comfortably return to that environment.
   h. Be provided information about all providers and the full array of services that help maximize personal independence and well-being, regardless of who provides the care.

4. ***Provide family caregiver support.*** Gold Standard SNPs will:
   a. Have structures in place that inform, train and provide emotional support to family caregivers in their efforts to help their loved ones deal with the complications of frailty, disability and or the presence of complex medical conditions.
   b. Provide access to, or help family caregivers get respite care as well as assist in making financial and legal decisions.
   c. Direct health care professionals to complement, rather than supplant, the self-directed activities of family caregivers, while being sensitive to the potential for caregiver burnout.
   d. Require health and social service staff to use protocols that ensure family caregivers are an integral part of the ongoing care team, while giving primary consideration to the needs and interests of the beneficiary.

Goal #2: Specialized Care System Expertise

1. ***Address co-morbid illnesses.*** Gold Standard SNPs will:
   a. Have medical direction provided by persons with specialized expertise in co-morbid care.
   b. Account for the presence of comorbidities during the screening and assessment processes.
   c. Contract with physicians who have special skills in adapting evidence-based guidelines and best practices for individual diseases in relation to age, co-morbid conditions, functional limitations, member goals and preferences and other variables affecting the ability and/or willingness of special needs beneficiaries to respond to traditional clinical protocols and approaches.
   d. Establish procedures that enable primary care physicians to utilize interdisciplinary care teams.
   e. Modify evidence-based guidelines to account for a higher-than-average presence of comorbidity and the need to adapt guidelines in relation to the presence of co-morbid illnesses.

"Enable beneficiaries to optimize their health and well being within the limits of their condition."

"Ensure benefits and services respond to the unique needs of the high-risk groups being served."

f. Establish record-keeping and health care planning requirements that enable the development of individual care plans that fully account for co-morbid conditions and other factors that may not be incorporated into traditional approaches.

2. ***Manage beneficiary use of multiple medications.*** Gold Standard SNPs will

a. Conduct an initial assessment of overuse, under use and inappropriate use of medications, reassess medication management at least annually, and have triggers in place for conducting reassessments at other times, as appropriate.

b. Have systems in place for defined subsets of plan enrollees for monitoring and managing multiple drug usage, maximizing coordination among multiple prescribers and dispensers of medications, and improving the continuity of drug management for patients transitioning between care settings.

c. Ensure that principal care teams, all physicians' outpatient records and hospital medical records have a *current* record of all the patient's medications and usage.

d. Have systems in place to integrate medical cost and utilization data with pharmacy data and to track and report aggregate trends in outcomes over time and across settings and to proactively intervene to prevent adverse drug events.

e. Ensure that pharmacists function as part of care teams for patients are at high-risk of medication errors resulting from multiple drug usage and involvement of multiple prescribers.

f. Ensure that patients and family caregivers are trained in the management of multiple drug usage, with emphasis on issues of compliance as well as minimizing the adverse effects of drug regimens on activities of daily living.

g. Align financial incentives related to pharmaceutical care provided by network providers serving the same person to reduce medication errors and pharmacy-related iatrogenic illnesses.

3. ***Integrate mental, behavior and physical health.*** Gold Standard SNPs will:

a. Identify persons with mental, behavioral and physical health expertise to provide leadership in advancing the integration of mental, behavioral and physical health.

b. Encourage all primary care physicians and care teams responsible for managing care for high-risk beneficiaries to work with mental and behavioral health care professionals in addressing the interdependence between mental, behavioral and physical health.

c. Ensure that every care plan for persons with multiple, complex and ongoing care needs contains information about a person's mental and behavior health.

d. Have structures in place to facilitate communication among care network providers with mental, behavioral and physical health expertise in the ongoing care of frail elders, adults with disabilities and persons with severe and disabling chronic conditions, including use of shared data while preserving patient confidentiality.

3. ***Respond to the volatile, complex and ongoing nature of frailty.*** Gold Standard SNPs will:

a. Provide for the routine diagnosis of a person's frailty as uniquely different from disability and medical complexities.

b. Provide for monitoring of real-time changes in symptoms and circumstances to reduce the probability of an acute event that could cause a person's overall condition to cascade out of control.

c. Enable health care professionals to successfully modify treatment protocols to account for reduced tolerance levels of various combinations of treatment.

d. Advance protocols that help strengthen the person's health reserves while compensating for any weaknesses.

e. Ensure for patient safety, without diminishing their ability to determine the preferred trade-offs between independence and risk.

f. Advance alignment and understanding among related primary, acute and long-term care professionals, as well as related medical and non-medical providers.

5. ***Manage illnesses within the context of disability.*** Gold Standard SNPs will ensure that:

a. Every care facility is fully accessible to persons with disabilities, with technological assistance provided, as appropriate.

b. Disability factors are integral to all comprehensive assessment and care planning instruments.

c. Disability is addressed within the context of a person's total care needs and interests.

d. All care network providers can effectively address the spectrum of disability concerns.

e. Clinical interventions empower disabled patients to manage their own affairs as much as possible.

6. ***Address the unique needs at the end of life.*** Gold Standard SNPs will:

a. Modify their end-of-life care approach according to whether a person:

- Has a condition, such as cancer, where their prognosis is reliably fewer than six months and thus can readily qualify for hospice enrollment;
- Has a condition with organ system failure, such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), cirrhosis, or kidney failure, where most die suddenly from an unpredictable complication in the course of their chronic disease; and
- Has a condition where the person is likely to lose their ability to take care of themselves long before death, and thus require intensive personal care throughout their period of dependency.

b. Regularly evaluate beneficiaries with serious illness at the end of life for pain, dyspnea and depression and treat accordingly using proven efficacy appropriate evidence-based guidelines.
c. Encourage all beneficiaries diagnosed with serious chronic conditions to complete advance care planning, including making decisions about advance directives as soon as possible after their diagnosis, with information updated, through to death. This information is retained in the patient's medical record and made available to all care providers at the time of admissions. All health care professionals are informed of the patient's wishes and treated accordingly.
d. Provide support services to keep patients and caregivers fully informed of symptoms, with support provided to minimize undue burden and maximize the potential for a comfortable and meaningful death.

"Enable beneficiaries to access the right care, at the right time, in the right place, given the nature of their condition, the trajectory of their illness, and their care preferences."

Goal #3: High-Risk Screening, Assessment and Care Management Processes

1. ***Identify high-risk beneficiaries for specialized care.*** Gold Standard SNPs will:
   a. Establish methods to identify persons at risk of:
      - Disease progression;
      - Functional decline;
      - Adverse drug events;
      - Potential for treatment failure;
      - Acute events that may trigger hospitalization or re-hospitalization;
      - Sustained use of long-term nursing home care;
      - High-cost or sustained high-costs; and
      - Death.
   b. Establish methods to triage beneficiaries into primary, secondary and/or tertiary interventions designed to prevent, delay or minimize chronic disease and disability progression, as well as to reduce overall costs for the define risk group.
   c. Ensure that beneficiaries monitor their own risk factors and adopt risk-reducing strategies in an appropriate and timely manner.
   d. Establish risk identification, triage and risk-reduction interventions as standard operating procedures throughout its care network.

2. ***Advance interdisciplinary care teams.*** Gold Standard SNPs will advance interdisciplinary teams to provide periodic assessment and care planning support as well as, in some cases, ongoing management of care for persons with:
   a. Co-morbid and/or medically complex conditions, such as beneficiaries with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and complex diabetes.
   b. Advanced or late-stage chronic conditions, such as end-stage renal disease (ESRD).

   c. Chronic conditions associated with physical or mental impairment that creates difficulty in carrying out activities of daily living.
   d. Disabling chronic conditions, such as Multiple Sclerosis, or conditions associated with cognitive impairment, such as Alzheimer's disease.
   e. Frailty that includes a critical mass of conditions such as generalized weakness, poor endurance, weight loss, low physician activity, and slow gait speed.
   f. Conditions that qualify for institutional level of care.

3. ***Provide comprehensive assessment and reassessment.*** Gold standard SNPs:
   a. Establish procedures to regularly — at least on an annual basis — assess and reassess the medical, mental, psycho-social, functional, environmental and financial circumstances involved for every high-risk beneficiary served.
   b. Develop and/or update a care plan in accordance with the person's assessment or reassessment that addresses the spectrum of medical and non-medical needs.
   c. Share assessment findings and plan information with all relevant care providers.

4. ***Establish principal care management leadership and support.*** Gold Standard SNPs:
   a. Establish procedures for a principal care physician and/or care team to assume overall responsibility for the ongoing management of care for persons with complex and ongoing care needs.
   b. Enable the principal care management physician and/or care team to be kept informed of all admissions, treatments and changes in condition, medication, care or living arrangements.
   c. Enable the principal physician or care team to assume a leadership role in working with the patient and family in negotiating the system and making care decisions.

"Align provider arrangement according to the multi-dimensional, interdependent and ongoing care needs of high-risk beneficiaries."

Goal #4: Aligned Care Providers

1. ***Establish and maintain advanced medical homes.*** Gold Standard SNPs:
   a. Designate advanced medical home(s) for SNP enrollees in defined service areas where providers are aligned to provide specialty care across the continuum.
   b. Develop arrangements that enable the medical home to assume a central role in the ongoing, real-time monitoring of patient conditions and coordinating care among related network providers.
   c. Enable the medical home to create an ongoing partnership with patients and their families to serve as a coach and support in addressing the volatile, complex and ongoing care needs of high-risk beneficiaries.
   d. Work with the medical home in monitoring key quality indicators for continuous quality improvement for special needs populations.

2. ***Establish and maintain integrated care networks.*** Gold Standard SNPs will:
   a. Identify networks of primary, acute and long-term care providers who serve many of the same high-risk beneficiaries.
   b. Work with these care network providers to enable them to establish safe and effective care transitions and common care practices to optimize care continuity in serving people with common, interrelated care needs.
   c. Provide incentives for care network providers to work together around a common care plan and optimize total quality and cost performance as an aligned group of providers working with the medical home in managing an array of complex care.

3. ***Partner with community programs.*** Gold Standard SNPs will:
   a. Identify community service organizations of importance to the high-risk beneficiaries enrolled in their health plan.
   b. Develop relationships with these community service organizations to simplify referral and enhance collaboration.
   c. Develop coordinated care arrangements wherever it holds the potential for improving total quality and cost performance and is of interest to those served.

4. ***Employ specialty care protocols and advance practice methods.*** Gold standard SNPs contract and/or employ health care professionals who have special skills in:
   a. Working as part of an interdisciplinary care team.
   b. Empowering the self-care capabilities of their patients and in strengthening the health reserves of the frail, disabled and/or chronically-ill persons.
   c. Using comprehensive assessment and care planning methods, supported by a more multidimensional team of health care professionals.

   d. Working within the context of a condition's history and trajectory of conditions that are likely to evolve after the person leaves their care setting.
   e. Balancing medical and non-medical concerns, with the overall concern for a person's functional capabilities and personal interests and values, rather than simply seeking to kill an infection, repair an injury, or mask or nullify symptoms of pain and disease.
   f. Using relevant evidence-based guidelines, where available, and knowing how to modify them to accommodate diminished tolerance levels, co-morbid conditions, coexisting treatment plans for co-morbid conditions, etc.

5. ***Ensure safe and effective transitions.*** Gold Standard SNPs will:
   a. Establish compatible approaches to intake and assessment.
   b. Improve communication among providers involved in care transitions.
   c. Improve care team follow-up with patients following transitions to another care setting or home.
   d. Empower patients to help minimize errors in transitioning between care settings by educating them about their conditions, what to expect and their roles in self-care.
   e. Reduce rates of iatrogenic illness and medical errors caused by a failure to provide for safe and effective transitioning between care settings.

6. ***Increase care continuity.*** Gold standard SNPs will:
   a. Work with the leadership from the medical home and care network providers who serve many of the same persons to develop consensus expectations of what will be done, by whom, in what setting, along what specific time scale, in relation to a defined set of circumstances. The care team seeks to work together to achieve a mutually-agreed upon set of care and cost outcomes for enrollees with certain high-risk conditions, as their conditions evolves over time and across care settings.
   b. Monitor continuity of care for targeted groups and intervening when inconsistencies appear to produce adverse clinical or cost outcomes.
   c. Insure continuity of clinical management in all needed settings, including home, primary care, hospital, outpatient clinics, pharmacy, skilled nursing facility, home health care, day health care, etc.

Goal #5: System Management Methods

1. ***Align Medicare and Medicaid.*** Gold Standard SNPs will:
   a. Work with county (and, if appropriate, state) government, other managed care companies and other persons responsible for helping beneficiaries access needed benefits and services to enable any dually-eligible person to access and receive all their Medicare and Medicaid benefits and services through a single entity using:
      - A single enrollment process and form.
      - A single set of marketing materials and standardized member communications.
      - Standardized or coordinated grievance and appeals procedures.

   b. Work with state, regional and CMS policy staff to align regulations and oversight functions to support the alignment of care for individual enrollees. This includes:
      - Aligned SNP application and Medicaid contracting provisions.
      - Aligned payment methods.
      - Aligned program requirements.
      - Aligned auditing and performance evaluation methods.

2. ***Align financial incentives.*** Gold Standard SNPs will:
   a. Use compatible financing and accounting methods.
   b. Recognize the interdependence of Medicare and Medicaid expenditures in contracting for services and establishing payment methodologies.
   c. Create financial incentives for related administrators, plans and providers to collaborate around common goals and objectives.
   d. Create financial incentives to avoid inappropriate cost shifting between programs and providers without regard to the cumulative effects.

3. ***Advance inter-provider communication.*** Gold Standard SNPs will:
   a. Structure the composition of boards and senior executive teams to assure adequate representation from the full spectrum of a care continuum.
   b. Identify network-wide goals and objectives for improving care for complex care beneficiaries, in addition to general business and program specific objectives.
   c. Revisit options to strengthen the role of primary care physicians with special expertise in high-risk care.
   d. Designate and advance the alignment of care planning activity for programs serving the same person, either at the same time or in sequence to one another.
   e. Revisit contracting options where there are incentives for providers within designated care networks to work together around common goals and objectives.
   f. Facilitate improved communication among programs and clinicians serving a common group of high-risk beneficiaries but working in different provider settings.

   g. Train health care professionals from different professions and care settings in team management and interdisciplinary and inter-program communication.
   h. Develop and share collective performance reports on high-risk beneficiaries served by network providers.

4. ***Align medical records and informatics.*** Gold Standard SNPs will:
   a. Expand the concept of medical records to include the full spectrum of psycho/social, functional, environmental and medical considerations.
   b. Extend routine information sharing across the spectrum of primary, acute and long-term care providers.
   c. Increase the timeliness of communication upon referral and discharge.
   d. Ensure that all pharmacy information is included and updated in one central medical record that is accessible to all prescribers.

5. ***Provide ongoing training and support.*** Gold Standard SNPs will:
   a. Develop training programs that enable all seemingly independent and related programs and health care professionals in high-risk care to see themselves as members of a common, interdisciplinary care team.
   b. Create training opportunities for nurses, social workers, rehab specialists and other health care professionals who serve many of the same persons, but work in different care settings, to become more acutely aware of their interdependence and adopt new usual care practices that are more fully aligned.
   c. Develop opportunities for program executives from different parts of the care continuum to become more fully aware of their interdependence and develop new usual care practices that are more fully aligned with the nature of complex care.

6. ***Monitor total quality and cost performance.*** Gold Standard SNPs will:
   a. Develop new measures and methods to monitor:
      - Continuity of care;
      - Safe and effective care transitions;
      - End-of-life care;
      - Maintenance of functional independence;
      - Member choice and satisfaction;
      - Medication management, particularly for complex care patients;
      - Management of multiple and/or co-morbid conditions;
      - Use of specialized medical care in treating targeted high-risks conditions;
      - Treatment of mental illness and behavioral health, including integration of treatment with medical care and social support; and
      - Self-care and family caregiver support.

   b. Develop new measures and methods to monitor the effectiveness of care network strategies to:
      - Reduce hospitalization rates, nursing home stays and emergency room usage in relation to usual care practices for targeted beneficiaries.

“Enable Medicare and Medicaid programs, plans and care providers to work together to optimize total quality and cost performance.”

- Reduce the incidence rates for adverse drug events and medical errors.
- Delay morbidity and/or mortality.
- Improve beneficiary and caregiver satisfaction.

Conclusion

One of the greatest fallacies about improving health care services is that the main road to quality and cost improvement is through specialization, where specialization means digging deeper in our understanding of physiology and fine-tuning our methods for treating specific symptoms without regard to their multidimensional nature and interdependence with other aspects of life.

> **"Serious chronic conditions are systemic in nature; any one symptom is simply one facet of an overall illness trajectory and mosaic of life.**
>
> **We will not solve their problems without fixing the fractures in financing, administration and care."**

About 66 percent of Medicare costs are for persons with five or more chronic conditions. Seventy percent of Medicaid costs are for caring for elderly persons and adults with disabilities. More than $200 billion are spent each year in care of persons dually eligible for Medicare and Medicaid, many of whom have multiple, complex and ongoing care needs.

Prevention strategies can halt or delay a growing prevalence of certain illnesses and reduce their impact on individuals and society. Research focused on specific organ functions and advancing technologies for treating specific disease symptoms is important. However, problems of chronic disease and disability are systemic in nature; any one symptom is simply one facet of an overall illness trajectory and mosaic of life.

Most health care costs and quality problems are related to caring for persons with serious chronic conditions. These conditions involve a whole series of interconnected symptoms and behaviors that require the *collaborative* involvement of multiple providers over an extended period of time. We will not solve our current health care crisis without greater attention to fixing the fractures in our "system" for financing, administering and delivering care for persons with multiple, complex, ongoing care needs.

In 2008, Congress passed legislation extending Special Needs Plan authority through 2010. It sharpened its expectations of SNPs to target care for persons with advanced care needs and to develop interventions that are truly special in relation to what is currently available under fee-for-service financing and from traditional Medicare Advantage plans. This is the first time in history that Congress authorized, outside of demonstration authority, the development and implementation of care systems exclusively focused on caring for frail elders, adults with disabilities and other Medicare beneficiaries with severe and disabling chronic conditions.
In response to this Congressional mandate, national leaders cannot maintain business as usual and expect SNPs to succeed. National leaders cannot assume that the weight of responsibility for transforming care is entirely on the shoulders of Special Needs Plans. All those involved in the financing, administration and delivery of Medicare and Medicaid benefits and services

must look across the spectrum of health policy and practice to identify changes needed to promote effective specialty care models. National leaders must look across the domains of care and along the trajectories of chronic illnesses and develop a systems approach to health care. They must fix the fractures of our component-based financing, policy and practices that reinforce care fragmentation and cause significant and unnecessary confusion, medical complications and waste.

The Congressional mandate for specialized managed care can only be realized with a tenacious, collaborative and focused agenda to transform current operating methods, policy and practice. Government, plan, provider and consumer leadership must all see themselves as part of the same team in common pursuit of improving total quality and cost performance for all Medicare and Medicaid beneficiaries with special care needs.

Members of The SNP Alliance offer the standards outlined in this policy report as a starting point for this discussion. We offer this as a framework for advancing a systemic approach to transforming our health care systems to be more in keeping with the multidimensional, interdependent and ongoing care needs of persons with serious chronic conditions. We look forward to a continuing dialog in our common quest for establishing a better care system for Medicare's most vulnerable and costly care segment.

Notes

The Gold Standards outlined in this paper were developed through a collaborative effort of those participating in the Medical Directors Leadership Group of The SNP Alliance. Rich Bringewatt and Valerie Wilbur, of the National Health Policy Group, developed draft material based upon review of the literature and best practice experience and facilitated a consensus decision-making process with group participants. Following is a list of persons who participated in this developmental effort.

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The Medical Directors Leadership Group of The SNP Alliance also drew upon work of the following national associations, demonstration initiatives and national leaders in crafting the Gold Standards outlined in this report.

National Associations and Related Initiatives

- American College of Physicians, The Advanced Medical Home concept.
- American Health Insurance Plans, HMO Study Group on Case Management
- Institute of Medicine, Crossing the Quality Chasm and The Future of Disability in America reports.
- National Alliance on Mental Illness, various guidelines and material
- National Chronic Care Consortium, Self-Assessment for System Integration tool and other tools and relevant materials.
- National PACE Association, various guidelines and material
- National Registry of Evidence-based Programs and Practices

Research and Demonstration Initiatives

- Evercare
- MassHealth Senior Care Options (SCO)
- Minnesota Senior Health Options
- Partnership for Solutions, Johns Hopkins.
- Social HMOs
- Wisconsin Partnership Program

National Research Leaders, Published Reports

- Chad Boult, Johns Hopkins, health systems research
- Linda P. Fried, Johns Hopkins, research of frail elderly, co-morbidity and disability
- Joanne Lynn, MD, end-of-life care
- Steve M. Shortell, University of California, Berkley, health systems research
- Barbara Starfield, Johns Hopkins, primary care research
- Ed Wagner, Group Health Cooperative of Puget Sound, Chronic Care Model

The SNP Alliance is an initiative of the National Health Policy Group.
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