November 19, 2013

The Honorable Fred Upton
Chairman
Committee on Energy & Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy & Commerce
United States House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

We are writing to urge swift congressional action this year to extend Medicare Chronic Care Special Needs Plans (C-SNPs) for the hundreds of thousands of chronically-ill beneficiaries who depend upon them. Our organizations represent patients suffering from heart disease, diabetes, kidney disease, depression, and dementia. We support programs targeted to the special needs of our patient populations, and believe that extending current C-SNP authority is the best way to ensure stable and predictable coverage for the most vulnerable beneficiaries.

C-SNPs focus on one chronic disease or condition that CMS has identified as being particularly prevalent and high-cost for the Medicare population. This targeted approach to disease has served as the incubator for innovation and advanced specialty care across the spectrum of targeted chronic conditions, including diabetes, congestive heart failure (CHF), end-stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), severe and persistent mental illness (SPMI), and HIV/AIDS. Recent data suggest that C-SNPs serve vulnerable populations that have historically been underserved – and can help reduce health disparities.[1] These beneficiaries are more likely to belong to minority populations and to be single or widowed than individuals enrolled in standard Medicare Advantage plans.

In addition to the conditions targeted by C-SNPs today, the C-SNP model can be expanded to concentrate on other high-cost, high-prevalence conditions for the Medicare population. For example, C-SNPs offer the possibility of care coordination interventions that take into account the needs of patients with dementia and their caregivers. Individuals with Alzheimer's Disease and related dementias confront unique challenges, both in executing activities of daily living and in treating other co-morbidities. C-SNPs can make comprehensive, patient-centered care available to such populations, ideally reducing the high costs of institutionalization that otherwise so often occurs.

More than 276,000 seniors and disabled beneficiaries have voluntarily enrolled in a Medicare C-SNP, where they receive specialized, highly-personalized care with customized benefits not available

[1] Cohen, R., Lemieux, J., Schoenborn, J., Mulligan, T. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients." *Health Affairs*. January 2012 31:1110-119.

anywhere else in Medicare. These benefits include expanded access to specialty providers, free transportation to doctors' appointments, zero co-payments for specific treatments and medications, more generous coverage of high-cost specialty drugs, and intensive case-management services. If authority for C-SNPs is allowed to expire, hundreds of thousands of vulnerable beneficiaries will have their care disrupted, and opportunities for new classes of beneficiaries to benefit from this model will be lost – with no guarantee that standard Medicare Advantage plans will offer the same level of benefits, unique interventions, or specialized care. Unfortunately, it would be financially impossible to provide such specialized benefit packages in a regular Medicare Advantage plan, since under current law, these plans would be required to extend these benefits to each and every beneficiary – regardless of their health status.

Compared to traditional Medicare, many disease management programs offered by specialized C-SNPs have demonstrated superior results for patients. According to the 2012 SNP Alliance Profile Summary, C-SNPs that focus on diabetes have reduced inpatient hospitalizations by nine percent, while C-SNPs targeting CHF reduced these incidents by more than 30 percent.[2] Other examples include:

- One C-SNP achieved a 50 percent reduction in inpatient admissions in five months, the result of designating a case manager and nurse practitioner to receive referrals from persons with diabetes in lieu of emergency room visits.[3]
- Another plan achieved a 56 percent reduction in hospital admissions in three months for CHF patients by equipping each with a wireless scale that alerted clinicians of excessive weight gain and triggered same-day visits.[4]
- A C-SNP targeting mental illness achieved a 60 percent reduction in inpatient admissions for beneficiaries with SPMI through unlimited access to psychiatrists with an SPMI subspecialty, and assignment of other providers with no cost-sharing.[5]

Our organizations recognize that some improvements to C-SNPs may be helpful to improve Medicare beneficiaries' access to high-quality C-SNPs. However, we don't believe that ending the program is the answer. It is imperative that this model be allowed to continue to fuel the innovations in care and disease management that ultimately benefit the entire system until authority is available to managed care plans to provide enhance benefit designs to cater to specific populations. We urge Congress to extend the authorization of C-SNPs so that our most vulnerable Medicare beneficiaries retain access to high-quality plans that are so effectively managing their care.

Sincerely,

Alzheimer's Association
American Heart Association
National Kidney Foundation

[2] "SNP Alliance Survey Continues to Show High Performance: Highlights of the 2012 Survey." SNP Alliance. April 2013.
[3] "SNP Alliance Position on MedPAC Reauthorization Recommendations." SNP Alliance. December 2012.
[4] *Ibid.*
[5] *Ibid.*