



# *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*

## **FINAL REPORT**

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## **The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care**

There are approximately 7.5 million persons in the United States who are eligible for insurance coverage under both Medicare and Medicaid. In the health policy arena, these persons are referred to as “dual eligibles.” Dual eligibles incur disproportionately high medical and long-term care costs. According to the Congressional Research Service, in 2002, dual eligibles accounted for 16% of all Medicare beneficiaries, but 22% of all Medicare expenditures (Tritz, 2006). On the Medicaid side, in 2003, dual eligibles accounted for just 13% of all Medicaid beneficiaries, but approximately 41% of all Medicaid expenditures, primarily due to the cost of long-term care services.

Policymakers at both the federal and state levels have long recognized the high costs of insuring dual eligibles under Medicare and Medicaid, and have sought to develop innovative care models for meeting the health care needs of this population (Clark and Hulbert, 1998). Medicare is a federally-administered program, and Medicaid a state-administered program. Consequently, it has also been long recognized that because these two programs have different provider requirements, payment systems, quality assurance provisions, administrative infrastructures, and overlapping but disparate benefit packages, considerable opportunities exist to improve the effectiveness and efficiency of providing medical and supportive services to this population.

In pursuit of greater effectiveness and efficiency, policymakers have developed “integrated” care models which attempt to combine Medicare- and Medicaid-covered benefits for dual eligibles under more unified administrative structures. The Program of All-Inclusive Care for the Elderly (PACE) model, initially developed in 1982, is one example of an integrated care model for dual eligibles who have significant functional impairments. Similarly, under demonstration authority granted by the Centers for Medicare and Medicaid Services (CMS), the Wisconsin Partnership Program, the Minnesota Senior Health Options program and the Massachusetts Senior Care Options program have purchased integrated care models for dual eligibles through managed care contracts which encompass both Medicaid and Medicare services. Drawing upon the lessons learned in these demonstrations, CMS has recently taken a more proactive role in working with states to promote greater integration of Medicare and Medicaid benefits for the dually eligible population (CMS, 2006).

Nonetheless, after more than two decades of experimentation, only a small percentage of dually eligibles beneficiaries are enrolled in integrated care programs nationally; the great majority remain in the Medicare and Medicaid fee-for-service systems, with little or no care coordination between the two systems (Saucier, Burwell and Gerst, 2004). Obstacles to the development of more mainstream integrated care models include complex program design issues, consumer and provider concerns about managed care, contradictory payment incentives between Medicare and Medicaid, cumbersome regulatory requirements, and a dearth of managed care organizations with the expertise and willingness to assume risk for a broad range of Medicaid- and Medicare-covered benefits, including long-term care services.

A provision of the Medicare Modernization Act (MMA) of 2003 created new opportunities for the establishment of integrated care models for dual eligibles. Section 231 of the Act authorized the creation Medicare Special Needs Plans (SNPs) targeted to three groups of Medicare beneficiaries:

1) those receiving care in institutional settings; 2) those dually eligible for Medicare and Medicaid; and 3) those with severe or disabling conditions. The SNP legislation marks the first time that Medicare Advantage plans were given the option of limiting enrollment in their plans to specific subsets of Medicare beneficiaries. This paper examines the early impact of “dual eligibility” SNPs from the perspective of states that have developed innovative purchasing strategies for long-term care and other services for dually eligible beneficiaries.

### **Special Needs Plans Offer New Contractor Option**

SNPs offer state Medicaid programs a new potential vehicle for coordinating Medicare and Medicaid benefits for dual eligibles (Peters, 2005; Moon, Pratt, and Fiore, 2006). Because SNPs are specifically authorized under federal law, they offer states the opportunity to combine Medicare and Medicaid managed care contracting for dually eligible beneficiaries without having to secure special demonstration authority from CMS.

The early market response from health plans for SNP certification has been higher than expected. In July 2006, CMS reported that 273 SNPs had already been approved, most of which (226) were dual eligibility SNPs (Verdier, 2006). First and foremost, however, SNPs are Medicare Advantage plans, and there is nothing in the MMA that requires SNPs to also provide Medicaid services or coordinate their activities with state Medicaid programs. In fact, it is entirely possible that the majority of SNP plans will simply provide Medicare-covered benefits for dual eligibles (at the higher capitation rate that CMS pays for this group) and *not* attempt to enter into managed care contracts with state Medicaid programs for coordinated coverage of Medicaid-covered benefits.

On the other hand, MMA also gave Medicaid plans a one-time opportunity to seek SNP designation and “passively enroll” dually eligible members into their companion Medicare plans as part of the initial Medicare Part D enrollment process. Under passive enrollment, Medicaid plans which became certified as SNPs had the option of automatically enrolling all of their dually eligible members into their companion SNP plans. Members could voluntarily “opt out” of the Medicare SNP plan, but unless members actively disenrolled from the plan, they were automatically enrolled in the companion SNP plan. For states with mature Medicaid managed care programs that included dual eligibles, passive enrollment created an opportunity to significantly expand the number of Medicaid beneficiaries enrolled in integrated products.

### **Study Questions and Approach**

This report builds upon a previous study which focused on states that had developed managed care models for dually eligible beneficiaries needing long-term care services (Saucier, Burwell and Gerst, 2004). Some of the managed care models examined in the previous study were already fully integrated Medicare-Medicaid models (e.g. Wisconsin Partnership Program, Minnesota Senior Health Options and Massachusetts Senior Care Options). Most, however, were Medicaid-only models in which long-term care and other Medicaid-covered services were provided through capitated managed care contracts, while Medicare-covered benefits remained fee-for-service. The purpose of the current study was to investigate how states (and plans) have used the new opportunity provided under the Medicare Modernization Act to develop more fully integrated Medicare-Medicaid models for dual eligibles needing long-term care services.

The specific study questions addressed in the current study are:

- What is the current SNP status of contractors participating in State Medicaid managed care programs that include long-term care?
- Have SNPs increased the enrollment of dually eligible Medicaid managed care members into affiliated Medicare products?
- How are states addressing SNPs in current or future procurement strategies for long-term care and other services for dually eligible beneficiaries?
- What policy and program issues do SNPs present for states?

Building upon the previous study, eight states (Arizona, Maryland, Massachusetts, Minnesota, New York, Florida, Wisconsin, and Texas) were selected for the current study, most of which had substantial enrollment of dually eligible beneficiaries in Medicaid managed care prior to MMA implementation. (Maryland, the exception, was selected because the state has a dual eligibility program under development.) Telephone interviews were held with state officials in all states except Maryland, where we spoke to a state partner involved in program development. A background interview was also held with an official from a plan that has SNP products in several states. Program materials provided by the states and available on their web sites were also reviewed.

It should be noted that seven of the eight states (all except Arizona) have at least one PACE program. PACE sites have separate authority in federal statute, and although the MMA had a substantial impact on PACE sites, that is an important and distinct topic that is not the subject of this analysis. Also, this study focuses exclusively on how the new SNP designation impacted state procurement strategies for dually eligible beneficiaries receiving long-term care benefits. It does not address SNP impacts on the development of integrated products for dual eligibles not in long-term care. This larger purview will be the focus of a comprehensive evaluation of all types of Special Needs Plans currently being conducted by CMS, due to the Congress in December 2007.

## Findings

*What is the current SNP status of contractors participating in State Medicaid managed care programs that include long-term care?*

We were first interested in whether the Medicaid plans participating in each state's managed long-term care initiative had sought certification as SNPs in 2006. Our findings on this question are presented in Table 1.

At the request of CMS, the managed care contractors involved with dual eligibility demonstration programs (Minnesota Senior Health Options, Minnesota Disability Health Options, Massachusetts Senior Care Options, and Wisconsin Partnership Program) all applied for SNP certification and will formally convert to SNP status as of January 1, 2007. The plans (10 in Minnesota, 3 in Massachusetts and 4 in Wisconsin) may have had additional reasons to convert to SNP status, but clear guidance from CMS on the future of dual eligibility demonstration programs appears to have been the primary driver. In essence, all of these plans formally converted to SNP status on January 1, 2006 while their demonstration authority will end on December 31, 2007.

**TABLE 1**

<p><b>What is the current SNP status of contractors participating in Medicaid managed care programs that include long-term care?</b></p>	
<b>ARIZONA</b>	2 Arizona Long-term care System (ALTCS) contractors (Mercy Care and Evercare) obtained SNP status in 2006.
<b>FLORIDA</b>	2 of the state's MLTC contractors (EverCare and Vista) obtained SNP status as a dual eligible SNF. Another contractor (Amerigroup) plans to seek SNF certification in 2007.
<b>MARYLAND</b>	Not applicable. (State is expecting to implement a dual eligibility initiative in fall of 2007.)
<b>MASSACHUSETTS</b>	All 3 Senior Care Organization (SCO) contractors converted to SNP status at the request of CMS.
<b>MINNESOTA</b>	9 Minnesota Senior Health Options (MSHO) plans and 1 Minnesota Disability Health Options (MnDHO) plan converted to or became SNPs at the request of CMS. (MSHO expanded statewide in 2005, so some new plans pursued SNP status as part of becoming an MSHO contractor.)
<b>NEW YORK</b>	No MLTC contractors have SNP status as yet, though 4 plans have applications pending. 2 of the state's provider-based MLTC plans are seeking SNP status for 2007. 2 commercial plans that are expected to operate dual eligibility plans in 2007 (Evercare and Wellcare) have SNP status and are expected to affiliate with the State Medicaid program in 2007.
<b>TEXAS</b>	The 2 existing contractors in the Texas STAR+PLUS program in the Houston area (EverCare and AmeriGroup) obtained SNP status in 2006.
<b>WISCONSIN</b>	4 Wisconsin Partnership demonstration program plans converted to SNP status at the request of CMS. No Family Care contractors (which are county-based) have pursued SNP status.

The response was less consistent among contractors offering Medicaid-only plans that include long-term care benefits. Two Arizona Long-term care System contractors (Evercare and Mercy Care) obtained SNP status in 2006. Also in 2006, as part of the ALTCS re-procurement process, all of the remaining ALTCS contractors committed to obtaining SNP status directly or through partnerships by 2008. This commitment was made a state requirement in the re-procurement process. State officials reported that in at least one county-based plan, county officials were opposed to having county taxpayers underwrite Medicare risk. That county instead formed a formal partnership with a commercial plan that had SNP status. How that partnership will be executed for the benefit of members remains to be seen, but the state is looking for evidence of a tangible relationship that may include, for example, data sharing and joint care management protocols.

In Texas, the two existing Star+Plus plans in the Houston area (Amerigroup and Evercare) both obtained SNP status. (Evercare had previously operated a Medicare Advantage plan that converted to SNP status.) Both plans achieved high Medicare enrollment as part of the one-time passive enrollment process under Medicare Part D. These plans may have been particularly interested in capturing the Medicare Part D pharmacy benefit that might otherwise have been provided by an unrelated Part D plan. The passive enrollment process also gave these Texas Star+Plus plans an expanded role in managing pharmacy benefits, because under their Medicaid contracts for Texas+Plus, pharmacy benefits had been carved out to a third party manager.

In Florida's various Medicaid managed long-term care initiatives (including the Diversion Program and Frail Elder Program) and in Wisconsin's Family Care program, none of the existing Medicaid contractors have obtained SNP status. In New York, two out of twelve non-PACE Managed Long-term care plans are pursuing SNP status for 2007, but none have obtained it yet. Wisconsin's Family Care contractors are counties that have previously borne risk only for long-term care, which may explain why they haven't pursued SNP status to date. Many of Florida's and New York's Medicaid contractors are sponsored by long-term care provider organizations that have little experience with acute care risk and may be unable to meet Medicare's more comprehensive managed care requirements.

*Have SNPs increased the enrollment of Medicaid managed care members into affiliated Medicare products?*

In three of the states (Arizona, Minnesota and Texas), an estimated 47,000 Medicaid beneficiaries in managed long-term care plans became dually enrolled in affiliated SNP Medicare plans through passive enrollment (Table 2).<sup>1</sup> This represents a dramatic increase in the number of dual eligibles enrolled in integrated Medicare-Medicaid products compared to pre-MMA enrollment levels. Two conditions existed in these three states. First, each state had a large, mandatory Medicaid managed care program that included dually eligible beneficiaries. Secondly, contractors participating in those Medicaid plans obtained SNP status and worked with their state and with CMS to exercise the Medicare passive enrollment option.<sup>2</sup>

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<sup>1</sup>Arizona reported that an additional 27,000 dual eligibles in its acute care program also became enrolled in SNP plans as a result of the MMA passive enrollment process.

<sup>2</sup>An additional factor in Minnesota was that the Senior Health Options (MSHO) program was undergoing a statewide expansion that coincided with the one-time Medicare passive enrollment option, and six new MSHO contractors were able to obtain substantial membership at start-up.

**TABLE 2**

<p><b>Have SNPs increased enrollment of Medicaid managed long-term care members into affiliated Medicare products?</b></p>	
<p><b>ARIZONA</b></p>	<p>Yes, by about 8,000 persons. The two Arizona Long-term Care System (ALTCS) contractors with SNP certification that participated in passive enrollment were the largest in the System (Mercy Care and EverCare), accounting for about 1/3 of the estimated 24,000 ALTCS members.</p>
<p><b>FLORIDA</b></p>	<p>No.</p>
<p><b>MARYLAND</b></p>	<p>Not applicable. (State is expecting to implement a dual eligibility initiative in fall of 2007.)</p>
<p><b>MASSACHUSETTS</b></p>	<p>No. Approximately 3,000 Senior Care Options (SCO) members were already enrolled in combined Medicare-Medicaid products, and were carried over with the SNP conversion. SCO enrollment has increased by approximately 50% since January 2006, but enrollment growth was not due to the conversion of SCO plans to SNPs.</p>
<p><b>MINNESOTA</b></p>	<p>Yes, by about 23,000 persons. Minnesota Senior Care Options (MSHO) statewide expansion coincided with the one-time Medicare passive enrollment process, allowing thousands of former Medicaid-only members to convert to combined Medicare-Medicaid MSHO products offered by the same organizations. The result was an increase in MSHO enrollment from about 12,000 in November 2005 to 35,000 in January 2006.</p>
<p><b>NEW YORK</b></p>	<p>No.</p>
<p><b>TEXAS</b></p>	<p>Yes, by about 16,000 persons. Passive enrollment into Medicare of dually eligible STAR+PLUS members increased the number of people in Medicare-Medicaid products from 4,000 to 20,000. (One of the contractors had some pre-existing dual enrollment in a companion Medicare Advantage plan that pre-dated SNP certification.)</p>
<p><b>WISCONSIN</b></p>	<p>No. Partnership Program members were already enrolled in combined Medicare-Medicaid products. Family Care contractors did not become SNPs.</p>



Medicaid managed care contractors in Florida, New York and Wisconsin Family Care had not obtained SNP certification, so there was no passive enrollment in 2005-2006 in those states. Massachusetts enrolls dually eligible persons only into its Senior Care Options program, a demonstration that already included Medicare enrollment.

*How are states addressing SNPs in their Medicaid purchasing strategies for managed long-term care and other services for dually eligible beneficiaries?*

The emergence of SNPs has introduced an important new consideration in state purchasing strategies for dual eligibles in long-term care. State responses to this new opportunity, however, are varied. As discussed above, previously existing dual eligibility demonstration programs (Minnesota Senior Health Options and Disability Health Options, Massachusetts Senior Care Options and Wisconsin Partnership) will now require SNP status as a condition of participation, in response to CMS guidance. Future expansion or re-procurement of these programs will include a requirement that all contractors achieve SNP status, unless the SNP option is allowed to sunset, or some other unanticipated policy change occurs.

Arizona moved toward requiring SNP status as part of its ALTCS re-procurement process in 2006. However, in response to the concerns of some county-based plans that were concerned about taking on Medicare risk, Arizona developed an interesting compromise, which requires ALTCS contractors to either become SNPs or develop formal partnerships with SNPs by 2008. A partnership must be more than a cross-referral system, though the state has not yet specifically defined what a "partnership" means. Envisioned, for example, is a partnership where data would be shared across plans for purposes of improving care coordination. These plans could also entertain risk sharing arrangements, but again, Arizona has not yet dictated the precise requirements of a partnership.

New York has incorporated the SNP option into the design of a new dual eligible initiative that goes beyond its existing managed long-term care pilots. The new program has two components, one called Medicaid Advantage and one called Medicaid Advantage Plus. Medicaid Advantage is geared towards dual eligibles that are not receiving long-term care benefits. Under Medicaid Advantage, dual eligibles receive all of their Medicare benefits and some Medicaid wrap-around coverage (including Medicare cost sharing) by enrolling in a SNP. In 2006, seven plans participated in Medicaid Advantage, and that number is expected to double in 2007.

New York's Medicaid Advantage Plus program, on the other hand, is geared towards dual eligibles in need of long-term care services. Members must be eligible for nursing home level of care in order to enroll. The Medicaid benefit package includes the full array of Medicaid benefits, including all long-term care benefits. Medicaid Advantage Plus will begin in 2007 with two plans that have already achieved SNF certification. A number of plans participating in New York's managed long-term care demonstrations have also expressed interest in joining the Medicaid Advantage Plus program.

An important feature of both the Medicaid Advantage and Medicaid Advantage Plus programs is that New York is proactively defining the value-added benefits it will look for on the Medicare side as a condition of awarding a Medicaid contract. In other words, New York is using its Medicaid purchasing power to influence the design specifications of SNPs. New York is looking for some uniformity in the characteristics of SNP plans it intends to do business with, and wants to avoid a situation where it has to negotiate with multiple SNP plans serving dual eligibles, each with its own unique Medicare benefit package that in turn requires an individually-tailored Medicaid wrap-around benefit package.

Texas is currently in the midst of a significant expansion of its Star+Plus program. The state did not require contractors bidding in expansion counties to achieve SNP status, but reports that some of the expansion area contractors have achieved SNP status on their own. These plans will be able to offer Star+Plus members the opportunity to enroll in a companion SNP, but the state is not taking an active role in promoting fully integrated products, in part because state officials see little financial benefit to the state, unless states and the federal government arrive at some method to share whatever savings might accrue from more closely coordinated benefits.

**TABLE 3**

<b>How are states addressing SNPs in their purchasing strategies for long-term care and other services for dually eligible beneficiaries?</b>	
<b>ARIZONA</b>	In its 2006 procurement, the state required Arizona Long-term care System (ALTCS) bidders to seek SNP certification or have a formal partnership with a SNP by 2008.
<b>FLORIDA</b>	In the proposed Florida Senior Care pilot program (the State's most recent MLTC initiative), the state will solicit proposals from a variety of eligible provider types that may or may not have SNP certification.
<b>MARYLAND</b>	The State expects to require SNP status as a condition of participation in its future Community Choices program. (It will set standards of participation rather than use a selective procurement process.)
<b>MASSACHUSETTS</b>	Reprocurement for Senior Care Options (SCO) program is planned for 2008 or 2009. SNP status will be required (absent any policy change from Congress or CMS).
<b>MINNESOTA</b>	Minnesota Senior Health Options (MSHO) plans must maintain SNP status as a condition of participation. The state is developing a new Medicaid-Medicare product for persons with disabilities under the age of 65, which will also require SNP certification.
<b>NEW YORK</b>	The state is rolling out a new managed long term care initiative (Medicaid Advantage Plus) in 2007 that goes beyond its current MLTC demonstrations. SNP certification is required for the new program, and New York is establishing state-specific standards for dual SNPs that will affect the Medicare portion of the benefit package to ensure that it is complementary to the State's Medicaid benefits.
<b>TEXAS</b>	Texas has not required SNP status for the upcoming STAR+PLUS expansion (January 2007).
<b>WISCONSIN</b>	SNP status will continue to be a condition of participating in the Partnership Program. The State issued an RFP in August, 2006 to expand MLTC to two additional counties (Kenosha and Racine) in 2007. Bidders have the option to offer a limited (Family Care) or expanded (Partnership) benefit package. Those offering Partnership must have SNP status, but the expanded benefit package is not given preference in the selection process.

Florida, Maryland and Wisconsin are also looking at SNPs as they plan new or expanded programs. Maryland has decided that SNP status will be required for all contractors participating in its future Community Choices program. Wisconsin is weighing the pros and cons of including Medicare through SNPs as part of the Governor's desire to expand managed long-term care programs statewide, but no final decisions have yet been made, and an extensive stakeholder planning process is currently under way. Similarly, Florida is planning a new legislatively authorized Senior Care pilot program in two parts of the state, but has made no decisions about Medicare coordination generally or SNPs in particular.

## **State Policy Perspectives on Special Needs Plans**

*What policy and program issues do SNPs present for states?*

The early response from state Medicaid programs and their Medicaid contractors suggests that the SNP option offers an exciting new opportunity for the development of fully integrated Medicare-Medicaid products for dual eligibles. State officials cited several issues, however, that they believe should be addressed to make the SNP option even more attractive to state Medicaid programs.

*State role in dual SNP certification.*

The most common issue cited by state officials was the absence of any role for states in the certification of dual eligible SNPs. The majority of dual SNPs certified to date have no affiliation whatsoever with state Medicaid programs. That is, they enter the market to provide Medicare services to dually eligible beneficiaries, with no intention or at least no commitment from the state to execute a companion Medicaid contract. This makes it difficult to incorporate SNPs into a state's purchasing strategy for long-term care and other services for dually eligible beneficiaries. In active SNP markets like Arizona, Florida and Texas, officials note that dual eligibles in Medicaid managed care plans are sometimes being actively marketed by "unaffiliated" SNPs. In Florida, enrollment in an unaffiliated SNP, by state policy, results in disenrollment from the Medicaid product. In Arizona, beneficiaries who switch to an unaffiliated SNP are not disenrolled from ALTCS, but end up in two unrelated and uncoordinated plans. A few states also reported that some unaffiliated SNP plans were approaching the state asking for Medicaid wrap-around contracts, as if they were somehow automatically entitled to those contracts.

Some State officials cited the PACE state option as one approach that gives the state an effective mechanism for coordinating with CMS on programs for dually eligible beneficiaries. In that model, states must elect PACE as a state Medicaid option in order for a PACE site to operate. It may be that something short of the PACE model would be more appropriate, since not all SNPs desire partnerships with states.

*Marketing.*

Marketing strategies of SNPs are governed by federal Medicare Advantage marketing provisions. Cognizant of marketing scandals in some early Medicaid managed care programs, most states have adopted Medicaid marketing controls that are more restrictive than Medicare Advantage provisions. This may give unaffiliated SNPs somewhat of a marketing edge over state-affiliated SNPs that have agreed to more restrictive marketing provisions in their Medicaid contracts.

It may cause disruptions in the memberships of fully integrated plans, because unaffiliated SNPs can market directly to their dually eligible beneficiaries enrolled in affiliated state plans.

#### *Open Enrollment.*

Dually eligible beneficiaries are free to disenroll from Medicare Advantage products (including SNPs) on a month-to-month basis, whereas Medicare-only beneficiaries may switch plans only during an annual open enrollment or special enrollment period. In theory, the monthly option protects dually eligible beneficiaries and allows those in integrated products to switch easily if Medicaid eligibility cycles on and off. In practice, however, states are already noting a churning among dually eligible beneficiaries that is not related to changing Medicaid status, but rather results from marketing by unaffiliated SNPs.

Some state officials suggested that dually eligible beneficiaries should have the same enrollment options as Medicare-only beneficiaries, and that a more targeted exception should be crafted specifically for duals who experience a change in their Medicaid eligibility status.

#### *Consistency of Medicare benefits and cost sharing.*

SNPs' ability to vary their benefit packages and cost sharing requirements could potentially result in a lack of uniformity across state integrated products. Some state officials would like to be able to influence the value-added benefits offered by SNPs, in order to ensure consistency and to complement state Medicaid wrap-around benefits. States also expressed interest in ensuring access to SNPs by keeping cost sharing requirements low.

New York State has asserted itself on this issue by issuing requirements that SNPs must meet as a condition of doing business with the State Medicaid program. The requirements specify what value-added benefits the SNP must offer, and ensure low cost-sharing requirements. New York has two commercial SNPs lined up to offer combined Medicare-Medicaid products that meet the state's requirements, but it remains to be seen whether such an approach would work in less populous states with less market clout.

#### *Data sharing.*

In order for SNPs to be viable partners on integrated products, states believe they need data to which they currently are not assured access. One important set of data are the bids that SNPs make to CMS. In order for both Medicaid and Medicare to get the best value from SNPs, some states would like to have access to information on Medicare capitation rates to SNPs. However, SNPs (and CMS) consider payment rates to be proprietary. The other area is quality improvement. Massachusetts, for example, uses linked Medicare-Medicaid data to conduct clinical studies in the SCO program that would not be possible under existing Medicare data requirements. (The SCO program has special contract provisions that require data reporting by participating plans.)

One possible approach is for states to define the Medicare data it wants from SNPs as a condition of doing business with Medicaid. While this approach may be effective in large states, less populous states may find they do not have adequate market leverage. Also, some state officials believe they will encounter political obstacles if they move to require data that is resisted by SNPs.

Federal SNP policy has made it a private matter between the SNP and the state as to whether bid data may be shared with the state. States need to discuss with SNPs if plans would be willing to share the data, but it is most unlikely that they would. Alternatively, CMS could require SNPs to furnish data determined by states as necessary to conduct quality improvement activities.

*Alignment of administrative, operational and regulatory processes.*

States that have operated demonstration programs for dually eligible beneficiaries (Minnesota, Massachusetts, Wisconsin) see the potential of SNPs to take integrated care into the mainstream, but also express concerns about what might be lost in terms of aligning the multiple administrative processes required by both Medicaid and Medicare. These include enrollment, grievance and appeal, bidding on integrated products, quality assurance and improvement, etc. Through waivers and variances, demonstration programs have streamlined and made consistent many of these processes, and do not want to go back to a less coordinated and efficient approach.

CMS could be given authority to refine Medicare Advantage processes for dual SNPs when necessary to streamline integrated Medicare-Medicaid products in partnership with States.

*Alignment of incentives.*

States believe that combined Medicare and Medicaid products are beneficial for dually eligible consumers and their families, but they note that state incentives for partnering with SNPs are unclear at best. To the extent that well-coordinated care results in decreased Medicare hospital costs, CMS and SNPs share in those savings, but states do not, directly.

States would like to see a three-way incentive that allows state Medicaid programs, SNPs and CMS to share any savings that result from combined Medicare and Medicaid products.

*Provider and county-based plans.*

The early evidence suggests that small provider organizations or counties may not be well-suited or inclined to become SNPs. Issues include administrative burden, financial reserves to meet HMO solvency requirements, inexperience with acute care risk and, for counties, the political hazard of passing financial risk onto county tax payers.

In its recent re-procurement of ALTCS, Arizona required bidders to either have SNP status or have an affiliation with a SNP. This allowed Pima County to bid on ALTCS with a partner, avoiding direct Medicare risk itself. Similarly, in its public dialogue regarding future expansion of managed long-term care options, Wisconsin is encouraging stakeholders to discuss possible partnerships among public and private entities.

*Medicare payments.*

States with dual eligibility demonstrations negotiated special Medicare payments that they believe better account for the cost of dually eligible beneficiaries than Medicare Advantage's mainstream risk adjustment system. What remains to be seen is whether mainstream Medicare payments are adequate.

A natural experiment is occurring, now that some states without special Medicare payment demonstrations have large numbers of dually eligible people enrolled in SNPs (Texas and Arizona).

## Conclusions

The early response of states and health plans, while not uniform, suggests that SNPs are considered an important new policy tool for providing the Medicare portion of coordinated Medicare-Medicaid managed care products.

The one-time passive enrollment process that was made available during the initial enrollment period for Medicare Part D led to a huge percentage increase in the number of dually eligible beneficiaries enrolled in combined Medicare-Medicaid products. However, since passive enrollment was a one-time opportunity, future enrollment in integrated Medicare-Medicaid products will proceed more slowly, regardless of new state purchasing strategies for dually eligible beneficiaries.

A policy issue of concern to states—how states and the federal government can share in any savings that stem from the better coordination of Medicare and Medicaid benefits—is not addressed by the SNP legislation, and may limit the energy that states apply to the future development of integrated products.

The actual cost-effectiveness of SNP-based Medicare-Medicaid plans remains speculative at this point in time, from the perspective of both quality and cost. How the actual coordination of benefits occurs has not been examined, nor have cost or quality outcomes been measured.

The vast majority of dual eligibility SNPs are not providing Medicaid services and have no relationship with a State Medicaid agency. The SNPs described in this report are unique in that they started as Medicaid or demonstration plans and acquired SNP status specifically to offer a combination of Medicaid and Medicare benefits. In the majority of the states we contacted, most dual SNPs were *not* interested in pursuing state contracts for Medicaid wrap-around benefits.

Ultimately, the greatest obstacle to using SNPs for combined Medicare-Medicaid products may be fundamental differences between federal and state policies for managed care. First and foremost, SNPs are Medicare Advantage plans. Medicare Advantage policy in general is based on consumer choice, and values variation across plans as a positive outcome of competition. Offering value-added benefits are a way for plans to differentiate themselves in the market. In their Medicaid purchasing strategies, many states use competitive procurement processes, but seek to make long term investments in a limited number of partners, and value uniformity of benefits to promote equity in a publicly-funded program.

Special Needs Plans targeted to dual eligibles have clearly had a dramatic impact on increasing opportunities for states to enroll dually eligible beneficiaries in health plans that integrate Medicare and Medicaid-covered benefits, hopefully leading to improved clinical outcomes. However, states with some initial experience in using the SNP option to develop integrated Medicare-Medicaid products for dual eligibles have also suggested a number of improvements to the SNP model that could lead to improved integrated products for the dually eligible population.

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