

Medicare Special Needs Plans

A Consumer Advocate's Guide to
Opportunities, Risks, and Promising
Practices

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COMMUNITY CATALYST

Community Catalyst, based in Boston, Massachusetts, is a national nonprofit advocacy organization dedicated to achieving quality, affordable health care for all.

Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

Medicare Special Needs Plans: A Consumer Advocate's Guide to Opportunities, Risks, and Promising Practices was produced as part of Community Catalyst's Special Needs Plan Consumer Education Project (hereinafter "the SNP Project"). The SNP Project seeks to educate state and federal payers, advocates, health care providers, and the public on the opportunities and risks that accompany Special Needs Plans. Other Community Catalyst projects include Consumer Voices for Coverage, the State Consumer Health Advocacy Program, the Prescription Project, the Hospital Accountability Project, the New England Alliance for Children's Health, Prescription Access Litigation, and RealBenefits[®].

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INTRODUCTION & PURPOSE

What is the goal of this guide?

This guide has three purposes:

- To provide basic background on the Special Needs Plan (hereinafter “SNP”), a relatively new type of Medicare Advantage plan;
- To provide information to consumer advocates on what it means to integrate Medicare and Medicaid benefits for individuals who are dually eligible in preparation for discussions with other stakeholders, should integration be proposed in their state; and
- To provide an overview of the potential risks and benefits SNPs hold for individuals who are dually eligible for Medicare and Medicaid, the population early trends suggest to be the principal target for SNP enrollment.

In addition to these goals, the guide identifies a set of promising practices that have emerged from several health plans, some of which began as Medicare/Medicaid demonstration projects and have now transitioned to SNP status. Finally, because this primer is not an exhaustive treatment of issues related to Medicare, Medicaid, SNPs, or to Medicare/Medicaid integration, it includes a list of resources for more in-depth information.

Who is the guide for?

The principal audience for this guide is state-based consumer health access advocates who are working to preserve, strengthen, and expand coverage to health care. It may also have utility for policymakers and the general public who are engaged in the same effort. In most cases, Medicaid advocacy is the core of their work, whether it involves maintaining the program as an entitlement in places like Florida or using it as a vehicle to expand coverage in states like Massachusetts. Although the guide focuses on SNPs, which are a relatively new type of *Medicare* managed care option, there is a link back to Medicaid. When integrated with state Medicaid benefits, SNPs offer the potential to improve the quality of care for one of the most vulnerable segments of the Medicaid population: individuals who are also eligible for Medicare. And because better quality care is also more cost-effective care, SNPs may have longer-term potential to contribute to the financial sustainability of both Medicaid and Medicare. However, there are also potential risks to beneficiaries including insufficient quality oversight that could disrupt care coordination efforts for those that are dually eligible.

What challenges are advocates and consumers facing?

Our health care financing and delivery system is confusing, difficult to navigate and expensive. And, too often the quality of care is not good. While these challenges are present regardless of health or coverage status, the individuals who are at greatest risk are frail elders and people with complex or serious chronic care needs. A significant number of these individuals—about 14 million—are enrolled in Medicaid, and half of those are also Medicare beneficiaries.

Although these dually eligible individuals have some of the most comprehensive coverage in the United States, the care they receive is frequently fragmented, impersonal, unresponsive, and ineffective.¹ There is no “point person” to help them navigate the health care system or to assume accountability for care outcomes. They typically need to see multiple providers and take multiple prescription drugs. Their physicians may not always communicate with one another, and often there is not a common medical record. Many in this population could benefit from home visits and social or behavioral support, but some or all of these services may not be covered under state Medicaid programs. Additionally, because medical care and behavioral health services are rarely integrated, physical or mental deterioration is not always caught. The consequences of this fragmentation can be dire: individual health status may decline, resulting in a preventable hospitalization or placement in a nursing home.

There is also a financial dimension to this type of substandard care: it is expensive. This is why Medicare is moving to a so-called “pay for performance” system and why it recently announced it will not be paying hospitals for care that is needed as a result of hospital errors. In the Medicaid context, the costs associated with hospitalizations and long-term care placements resulting from substandard care are a significant driver of state and federal Medicaid budgets.² And as state health access advocates and others know all too well, efforts to control Medicaid expenditures often take the form of program cuts—in eligibility, in benefits, and in provider payments.

What are common consumer and advocate concerns about Medicare and Medicaid managed care?

Many consumer health advocates and their constituencies have concerns about Medicare and Medicaid managed care in general and SNPs in particular. Those general concerns include the following:

- A federal and state policy direction that favors “privatizing” Medicare and Medicaid;³
- A related shift from a system that guarantees a certain level of benefits to one that guarantees only a fixed amount of money with which the beneficiary will have to purchase coverage in the marketplace;
- Insufficient quality standards and oversight, particularly where mandatory managed care enrollment is concerned; and
- In the case of those beneficiaries who are frail, chronically ill, or disabled, an inability to access the amount and kinds of services they require to remain independent.

In the context of Medicare managed care, concern that private-sector health plans are being paid more to take care of beneficiaries than those beneficiaries would cost in traditional fee-for-service Medicare has been substantiated. This overspending means fewer resources are available for other important purposes, such as improving the Medicare prescription drug benefit or creating a coordinated care benefit in traditional Medicare.

¹ Berenson, R., and Horvath, J., “Confronting the Barriers to Chronic Care Management in Medicare,” *Health Affairs*, January 2003.

² See, e.g., Miller, M., Quigley, K., Seiffert, R., and Sullivan, J., “The Outlook for Medicaid in Massachusetts,” Massachusetts Medicaid Policy Institute, March 2007. Available at http://www.massmedicaid.org/briefs_11.html.

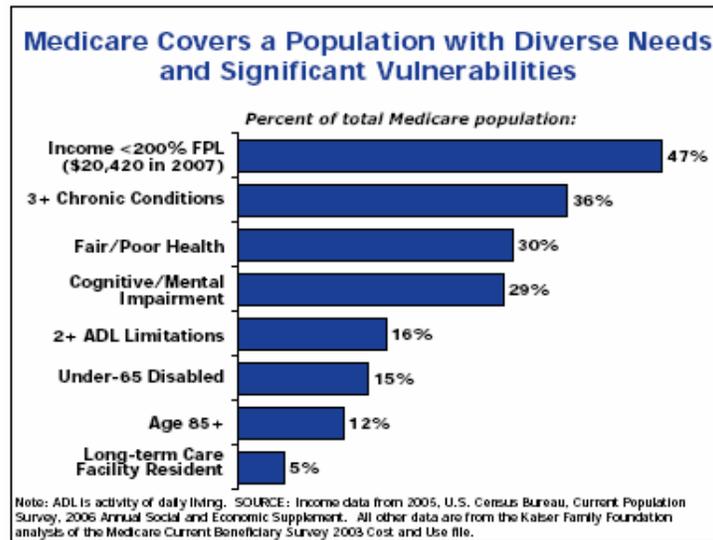
³ This same policy direction is evident in the Medicaid program at both the federal and state levels.

Are SNPs a potential solution?

For the time being, it seems unlikely that there will be a fundamental shift away from a privately administered Medicare managed care option. So long as SNPs continue to be an option for Medicare beneficiaries, it makes sense to ensure that they “be all that they can be”: well-designed, well-administered, closely monitored plans that deliver high-quality care to the sickest, frailest, and most disabled Medicare beneficiaries. If SNPs can also serve as a vehicle for Medicare and Medicaid integration, preserving entitlement to the full benefits of both programs but mandated to tailor benefits and services to the unique needs of their voluntarily enrolled members, then the SNP experiment will be worth the commitment of scarce advocacy resources.

WHAT IS MEDICARE?

Medicare is the federal social insurance program that provides health coverage to people who are 65 and older and to those under 65 who have significant long-term disabilities. In contrast to most other publicly financed health coverage programs, Medicare beneficiaries do not need to satisfy an income or asset test. Moreover, as a federal entitlement program, Medicare guarantees a certain level of benefits to people who meet its eligibility requirements. Medicare currently provides benefits to about 44 million people.⁴ Of those, about 6 million are under age 65.⁵



Source: Kaiser Family Foundation

Medicare covers a range of basic health services. They include the following:

- Inpatient hospital care, short-term stays in skilled nursing facilities, skilled home health care, and hospice care are covered under what is called **Medicare Part A**;
- Outpatient hospital care, physician services, laboratory services, ambulance services, diagnostic tests, durable medical equipment, outpatient mental health services, and some preventive services are covered under what is called **Medicare Part B**;
- Outpatient prescription drugs are covered under what is called **Medicare Part D**.

Eligibility requirements for Medicare benefits differ under Parts A, B, and D. All individuals who are eligible for Social Security and have paid the Medicare payroll tax are automatically eligible for Part A benefits at age 65 (or, in the case of eligibility based on disability, after receiving

⁴ "Medicare: A Primer," Kaiser Family Foundation, Publication No. 7615, March 2007. Available at www.kff.org.

⁵ Ibid.

Social Security disability payments for 24 months).⁶ To obtain Part B benefits, beneficiaries must enroll at the point they become eligible for Medicare Part A *and* then pay a monthly premium.⁷ In 2008, that premium is \$96.40 for beneficiaries with incomes under \$82,000.⁸ Beneficiaries who want prescription drug coverage under Medicare Part D must enroll in a private prescription drug plan. Depending on the plan, they may have to pay an additional premium for this coverage.

Medicare benefits are *not* comprehensive. Medicare does not cover some care that is important to the beneficiary population. For example, it does not cover hearing exams or hearing aids, routine dental care or dentures, or routine vision care and eyeglasses. In addition, Medicare coverage of long-term care and related services is limited: it covers only 100 days of care in a skilled nursing facility during a so-called “spell of illness,” and coverage is available only when *skilled* nursing is required on a daily basis.

Most Medicare beneficiaries have to pay deductibles and co-insurance for their Medicare benefits in addition to all applicable premiums. In 2008, the Part A deductible is \$1024. There is a substantial co-insurance payment after a certain number of inpatient days in a hospital or skilled nursing facility.⁹ Part B benefits include an annual deductible of \$135 and co-insurance of 20% for all costs incurred thereafter. For prescription drug coverage under Part D, most beneficiaries are subject to a deductible and co-payments for each prescription drug, the amounts of which vary depending on the plan. Additionally, most beneficiaries are liable for prescription drug costs once they have reached the benefit’s coverage gap (the so-called “donut hole”), which is triggered when a beneficiary has incurred \$2,400 in drug expenses.

Supplemental coverage is available to cover some of these out-of-pocket expenses and fill in some of the benefit gaps. Medicare beneficiaries can purchase “Medigap” policies, which typically cover some or all of the deductibles and co-insurance amounts. State Medicaid programs cover some or all of these expenses, including those related to prescription drug coverage, for beneficiaries who are eligible for both Medicare and Medicaid. Medicare managed care plans, described in more detail below, may also cover some out-of-pocket expenses and provide some of the benefits not covered by Medicare.

Medicare beneficiaries can choose to receive their Part A and Part B benefits through one of two mechanisms. Traditional (also known as “fee-for-service”) Medicare is similar to traditional insurance coverage. A beneficiary obtains covered services from any provider that agrees to accept Medicare reimbursement, and Medicare reimburses the provider directly once the provider files a claim. Alternatively, a beneficiary can choose to enroll in a private-sector health plan. This latter

⁶ Individuals qualifying for Medicare based on age must have paid the Medicare payroll tax for at least 10 years. Their spouses are also eligible upon turning 65. Individuals who qualify for Medicare by virtue of disability must be eligible for Social Security but need not meet the 10-year payroll tax requirement.

⁷ Beneficiaries can enroll up to 3 months before or 3 months after turning 65 or, in the case of eligibility based on disability, up to 3 months before or after receiving Social Security disability benefits for 25 months. Enrolling *more* than 3 months after the qualifying date will result in a monetary penalty unless the beneficiary had other qualifying coverage up to the time of enrollment.

⁸ Beginning in 2007, that premium is higher for higher-income beneficiaries.

⁹ See “HHS Frequently Asked Questions: What are the Medicare premiums and coinsurance rates for 2008?,” U.S. Department of Health and Human Services. Available at www.hhs.gov/faq/medicaremedicaid/650.html.

mechanism is officially called Medicare Part C, but it is more commonly referred to as the Medicare Advantage program.

Medicare Part D – the prescription drug benefit – is delivered solely through private-sector plans. Beneficiaries who opt to receive coverage through traditional Medicare can enroll in a prescription drug plan. Most Medicare Advantage plans also include prescription drug coverage.

In general, Medicare law guarantees Medicare beneficiaries participating in traditional Medicare the freedom to choose providers (doctors, hospitals, other providers of services/benefits), subject only to the provider's willingness to participate in the Medicare program. By contrast, “freedom of choice” in the context of the Medicare Advantage program is considered to be exercised when a beneficiary voluntarily elects to enroll in a Medicare Advantage plan. Once enrolled, the beneficiary is subject to the health plan's requirements, which may include such things as obtaining non-emergency care only from the plan's provider network and obtaining a referral prior to seeing a specialist.

WHAT IS MEDICAID?

Medicaid is the nation's public health insurance program for low-income people. Enacted in 1965 by Title 19 of the Social Security Act as a companion piece to Medicare, it replaced a range of state-funded medical assistance programs targeted to specific groups (*e.g.*, disabled children) with a more uniform, federal approach. States can choose whether they wish to participate in Medicaid. To date, all have opted to do so.

Medicaid is funded jointly by the states and the federal government. State expenditures on Medicaid are matched by federal funds. While the typical matching rate is 50%, some states with significantly lower per capita income receive matching percentages as high as 77%.

The federal government establishes the basic framework for program eligibility and benefits, but states have considerable latitude to cover additional populations or cover additional services. In most cases, states receive matching funds for these additional populations and services. Every state spells out the details of its program in a state Medicaid plan that is approved by the federal government. Since each state's program is shaped by its unique economic and political environment, some states venture far beyond the minimum federal requirements while others are less expansive.

To qualify for Medicaid, individuals must meet certain income and asset tests, and they must also meet categorical eligibility requirements. Categories of individuals that *all* state Medicaid programs must cover include the following:

- Pregnant women and children under age 6 up to 133% of the Federal Poverty Level (hereinafter "FPL");
- School-age children with family incomes below 100% FPL, parents with incomes below states' July 1996 welfare eligibility levels (often below 50% FPL);
- Most elderly and people with disabilities receiving Supplemental Security Income (hereinafter "SSI").¹⁰ Additionally, elderly and disabled individuals who qualify for Medicaid must have very few assets (\$2,000 for an individual and \$3,000 for a couple, in most states); and
- Some categories of legal permanent resident immigrants.

Federally recognized optional populations include individuals in the mandatory categories but with higher income levels; low-income individuals who are elderly or disabled; and individuals who have high recurring health expenses.

Federal law requires all participating states to cover a minimum set of benefits in order to receive matching funds. Required services include physician, hospital, laboratory and x-ray services; family planning; early and periodic screening, diagnostic, and treatment services (EPSDT)

¹⁰ Income eligibility for SSI is less than 75% FPL.

for persons under 21; nursing facility services for individuals 21 and older; and home health care for individuals who are eligible for nursing facility services.

States may choose to offer—and receive matching funds for—a range of optional services.

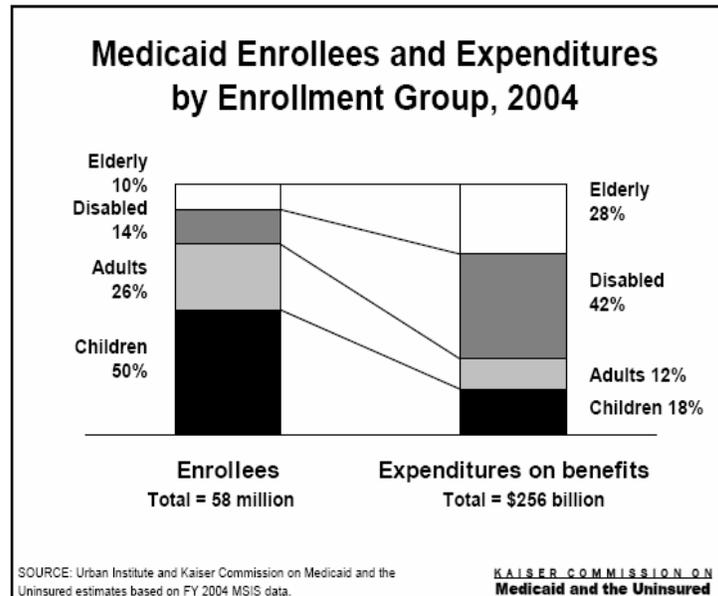
Services falling into this category include coverage for prescription drugs, dental and vision services and supplies, home- and community-based care services, and personal care services. Many of these optional services are particularly important for frail elders and people living with disabilities.

States typically purchase and deliver Medicaid services in one of two ways: through fee-for-service payment, for which they have considerable discretion in setting provider payment rates, or by purchasing coverage through managed care plans.

Many states have adopted mandatory managed care enrollment for large segments of their recipient populations, although such requirements are less common for recipients who are elderly and/or disabled. States may also obtain federal waivers that permit them to operate their programs outside of the broad federal requirements so they can experiment with new models of care delivery and coverage.

Recent data indicate that Medicaid provides health insurance coverage to 58 million people in the United States.

This population includes roughly 29 million children and 15 million adults in low-income families as well as 14 million individuals who are elderly and/or have disabilities and who rely on Medicaid to fill Medicare's gaps.¹¹ Dually eligible beneficiaries rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical services Medicare does not cover, such as long-term care. As the graph below illustrates, expenditure by enrollment group demonstrates an inverse relationship to enrollment categories: though they comprise only 24% of the entire Medicaid population, the elderly and the disabled—arguably the most vulnerable members of our society—account for 70% of Medicaid spending.



¹¹ “As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: A 50-State Medicaid Budget Survey for State Fiscal Years 2006 and 2007,” The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, Publication No. 7699, December 2007. Available at www.kff.org/medicaid/7699.cfm.

HOW DOES MEDICARE ADVANTAGE WORK?

Under Medicare Advantage, private-sector health plans contract with the federal Centers for Medicare & Medicaid Services (hereinafter “CMS”) to provide all Medicare-covered services to enrollees in exchange for a monthly payment for each enrolled beneficiary. The types of plans that can participate in Medicare Advantage include health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and health plans that incorporate medical savings accounts (MSAs) with high-deductible insurance coverage. As of June 2007, about 18% of Medicare beneficiaries are enrolled in Medicare Advantage plans.¹²

A subset of Medicare Advantage plans are referred to as Medicare “coordinated care plans.” These plans, which are managed care plans, include HMOs, PSOs, local PPOs, and other network plans. Special Needs Plans are a type of coordinated care plan. Medicare Advantage PFFS and MSA plans are *not* coordinated care plans.

As part of the application process for CMS approval to operate a Medicare Advantage plan, plan sponsors must specify how they will ensure continuity and coordination of care for their enrollees.¹³ They are also required to describe how they will coordinate care with community and social services available within the plan's service area. In addition, they are required to have procedures in place for ensuring that clinical information is shared among providers.¹⁴ It is not clear what criteria CMS uses to evaluate the adequacy of these processes and procedures.

Many Medicare Advantage plans offer benefits in addition to those covered under Medicare Part A and B. These typically include coverage for some or all of the deductible and co-insurance amounts described above as well as coverage for services that are not included in Medicare (such as vision care, hearing care, or preventive dental care). Some Medicare Advantage plans charge their enrollees a supplemental premium for the additional benefits, but many do not. These services and premium support are provided for dually eligible beneficiaries by Medicaid.

Payments to Medicare Advantage plans are based on a two-step process. First, Medicare Advantage plans submit annual bids to Medicare to be compared to a federally set benchmark for the geographic area in which the plans operate. If a plan's bid is higher than the area benchmark, the enrollee pays the difference as a beneficiary premium. If the bid is at or below the benchmark, the difference between the benchmark and the bid is shared by the Medicare Advantage plan (75%) and the federal government (25%). The Medicare Advantage plan is required to use its share to expand

¹² “Medicare Advantage: Private Health Plans in Medicare,” Congressional Budget Office Issue Brief, June 28, 2007.

¹³ “Draft 2009 Medicare Advantage (MA), Medicare Advantage-Prescription Drug (MA-PD), Cost-Based Plan, and Prescription Drug Plan (PDP) Sponsors Call Letter,” Centers for Medicare & Medicaid Services, January 16, 2008 (hereinafter “Draft 2009 Call Letter”). Available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>.

¹⁴ Applications to operate as a Medicare Advantage plan may be found on CMS's website at <http://www.cms.hhs.gov/MedicareAdvantageApps>.

benefits or reduce enrollee cost-sharing.¹⁵ Second, the plan's bid is risk-adjusted based on the enrolled beneficiary's health status.¹⁶ Individual health status is determined by diagnoses that appeared on the individual's Medicare claims in the prior year.¹⁷ The resulting rate is further adjusted based on whether the beneficiary is in an institution, is dually eligible for Medicaid, or was originally eligible for Medicare based on disability.

The risk adjustment system for calculating payments to Medicare Advantage plans was put in place because it predicts a beneficiary's health care costs more accurately than the prior method. Phase-in of the risk adjustment approach began in 2004 and was completed on January 1, 2007. Under the prior system, reimbursement rates to private plans were based primarily on demographic factors (*e.g.*, age, gender) and geographic location. This method failed to adequately cover costs associated with many of the most disabled and chronically ill beneficiaries.¹⁸ As a result, some Medicare Advantage plans engaged in "cherry picking": either deliberately enrolling only healthy beneficiaries or encouraging sicker enrollees to return to traditional Medicare. Although risk adjustment represents a significant improvement in the development of appropriate payments, the current method may not account fully for all health problems that might affect a person's need for health care services.¹⁹ As a result, it may not sufficiently differentiate among beneficiaries who have the same diagnoses but use vastly different amounts of health services. Similarly, it may not account sufficiently for plan differences in the scope and nature of the services they provide to meet their enrollees' needs.

Recent research has shown that, on average, Medicare is paying Medicare Advantage plans substantially more on behalf of enrolled beneficiaries than it would cost to cover those same beneficiaries in traditional fee-for-service Medicare.²⁰ This is primarily attributable to payment system changes contained in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (hereinafter "MMA") that resulted in artificially high benchmarks which, in turn, serve as the basis of Medicare Advantage plan rate-setting. In the years prior to 2003, many Medicare managed care plans withdrew from the market, claiming that the reimbursement was insufficient to cover their enrollees' costs. Hundreds of thousands of Medicare beneficiaries lost private health

¹⁵ In July 2007, the Government Accountability Office issued a report faulting the auditing process that is supposed to ensure that the funds are actually being used to benefit consumers. It noted that, where Medicare officials had found errors—which amounted to millions of dollars—they had taken no action to recoup the funds or mandate they be used to benefit consumers. "Medicare Advantage: Required Audits of Limited Value," United States Government Accountability Office, July 2007.

¹⁶ In the case of a Medicare Advantage plan whose bid was at or above the benchmark, the health status adjustment is made using the benchmark amount. While individual health status is the most significant factor, other factors taken into account are the beneficiary's age, sex, whether or not the beneficiary is also enrolled in Medicaid, whether or not the beneficiary is disabled, and whether or not the beneficiary is in a long-term care facility or other type of institution.

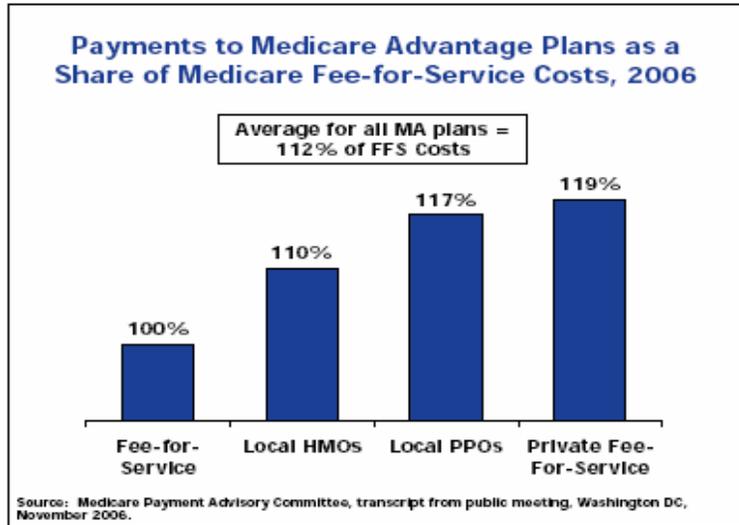
¹⁷ Rates for individuals who are newly eligible for Medicare are based on the same demographic factors, but because those individuals have not yet incurred any Medicare claims, the rate is adjusted by the basis for Medicare eligibility, *i.e.*, age or disability.

¹⁸ Field, M.J., and Jette, A., eds., *The Future of Disability in America*, Institute of Medicine of the National Academies, The National Academies Press. Washington, D.C., April 2007.

¹⁹ *Ibid.*

²⁰ "Medicare Advantage Benchmarks and Payments Compared with Average Fee-for-Service Spending," Medicare Payment Advisory Commission, June 2006. See also Biles, B., Nicholas, L.H., Cooper, B.S., Adrion, E., and Guterman, S., "The Cost of Privatization: Extra Payments to Medicare Advantage Plans – Updated and Revised," The Commonwealth Fund, November 2006.

plan coverage, and enrollment in Medicare managed care dropped significantly. The MMA's reimbursement provisions were intended to encourage health plans to enter—or remain in—the Medicare market. Congress currently is examining the payment methodology and considering whether these payments should be reduced.²¹



Source: Kaiser Family Foundation

²¹ The Children's Health and Medicare Protection (CHAMP) Act of 2007, passed by the House of Representatives in July 2007, sought in part to reduce payments to Medicare Advantage plans over a period of four years. However, this provision, as well as others relating to Medicare, was deleted from the final version passed by the full Congress. As of the publication date of this Guide, Congress has not introduced new legislation related to Medicare Advantage payments.

WHAT ARE MEDICARE SPECIAL NEEDS PLANS?

Special Needs Plans are a type of Medicare Advantage coordinated care plan. They are subject to the same requirements that apply to all Medicare Advantage plans, with the following exceptions:

- They are required to limit their enrollment to one of the following three categories of Medicare beneficiaries:
 - People who qualify to live in **institutions**;²²
 - People who receive *both* Medicare and Medicaid (individuals who are “**dually eligible**”);²³ or
 - People with **severe or chronic disabling conditions**, such as end-stage renal disease, HIV/AIDS, complex diabetes, congestive heart failure, or chronic obstructive pulmonary disease;²⁴ and

- They *must* offer Part D prescription drug benefits.

As is true in mainstream Medicare Advantage plans, institutionalized beneficiaries and those who are dually eligible may enroll in or disenroll from a SNP at any time.²⁵

SNPs were developed in part to broaden the appeal of Medicare Advantage to high-cost beneficiaries.²⁶ Beneficiaries in the three SNP categories were targeted for enrollment because they are perceived as most likely to require hospitalization and institutionalization, two services that generate significant Medicare and Medicaid program expenditures.²⁷ The expectation is that SNPs will design special clinical programs to accommodate groups with distinct health care needs, reducing the need for inpatient hospitalization or institutional or long-term care. In theory, specialized focus will also improve the quality of care received by beneficiaries enrolled in SNPs.²⁸

²² Beneficiaries who qualify for institutional SNPs are those who (1) reside or are expected to reside for 90 days or longer in a long-term care facility (defined as a skilled nursing facility, nursing facility, intermediate care facility, or inpatient psychiatric facility) or (2) are living in the community but require an equivalent level of care to those residing in a long-term care facility.

²³ SNPs that target individuals who qualify for institutionalization and those that target individuals with chronic/disabling conditions may enroll dually eligible beneficiaries as long as they otherwise meet the target criteria.

²⁴ Previously, CMS allowed SNP status to be granted to some managed care plans whose enrollment reflected a “disproportionate” number of individuals in one of these categories.” However, Section 108(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 imposed a moratorium on this activity effective January 1, 2008.

²⁵ All other Medicare beneficiaries who want to enroll in mainstream Medicare Advantage plans must do so either when they first become eligible for Medicare or during the annual open enrollment period that extends from November 15 through December 31 of each year. They have one opportunity between January 1 and March 31 to switch Medicare Advantage plans or return to original Medicare, but they cannot use that opportunity to add or drop prescription drug coverage. Beneficiaries in those mainstream plans are then “locked in” to that plan until the following January 1.

²⁶ Peters, C.P. “Medicare Advantage SNPs: A New Opportunity for Integrated Care?” National Health Policy Forum, Issue Brief No. 808, November 11, 2005.

²⁷ “Special Needs Plans – Fact Sheet and Data Summary,” Centers for Medicare and Medicaid Services, February 14, 2006.

²⁸ See Peters, “Medicare Advantage SNPs.”

A lack of federal standards has raised questions as to whether SNPs are truly serving the needs of their target populations in a cost-effective manner. To date, no federal regulations specify minimum standards with respect to what SNPs must do or how they must function to address their enrollees' special needs. The MMA requires CMS, which administers Medicare and Medicaid, to promulgate regulations governing SNPs, but the only direction to date has been provided in informal documents. The draft 2009 Call Letter for Medicare Advantage Plans does contain some SNP-specific guidance;²⁹ however, both consumer advocates and members of Congress have urged CMS to develop, implement, and enforce regulations, rather than issue guidelines, to protect beneficiaries from potential abuses and to set high standards for Medicare Advantage plans in general³⁰ and SNPs in particular.³¹

SNPs must describe the model of care they will use in delivering care, but they are not held to a particular model of care or plan design. The initial SNP applications asked for very little program detail. Plan sponsors were simply required to briefly describe why the plan's design or care management programs rendered it "appropriate" for its population.³² The process has evolved, however, and now each SNP sponsor must provide a more detailed description of the model of care it will use, including how assessment and problem identification will work. The sponsor must also describe the following:

- How the SNP model of care may be distinguished from that used in mainstream Medicare Advantage plans with respect to benefit design, care management strategies, and health delivery system configuration;
- What and how extra benefits and services will be provided to meet the needs of their enrollees;
- What specific process and outcome measures will be used; and
- How the resulting performance reports will be used to ensure continuous quality improvement.³³

To date, CMS has not established any requirements with respect to how SNP applicants must design or implement their models of care. Nor has CMS specified what criteria it uses in evaluating and approving SNP applications, raising concerns among advocates that "there are no wrong answers." However, in response to the observation that 2008 SNP applications inconsistently articulated elements of their models of care, CMS has stated that SNP plans "must implement a model of care that unequivocally addresses the plan's special needs beneficiaries" in order to fulfill CMS audit requirements.³⁴ Others have noted that, while CMS has made no comment as to whether it plans to

²⁹ See Draft 2009 Call Letter, pp. 28-37.

³⁰ See "Hearing Statement of Senator Max Baucus (D-MT) Regarding the Need for Accountability and Oversight of Marketing by Medicare Private Plans," Hearing before the Senate Finance Committee, February 13, 2008. Available at www.senate.gov/~finance/index.htm.

³¹ See "Recommendations of the Center for Medicare Advocacy," Medicare Advantage Special Needs Plans: A Beneficiary Perspective, October 18, 2007. Available at www.medicareadvocacy.org.

³² Medicare Advantage Coordinated Care Plans Application, 1/21/05.

³³ Medicare Advantage Coordinated Care Plans Application, 11/27/06. See also Draft 2009 Call Letter, p. 30.

³⁴ See Draft 2009 Call Letter, p. 30.

make the results of these audits public, such information would be helpful to beneficiaries seeking to find a SNP that will best fit their needs.³⁵

Although CMS is in the process of developing a set of standard quality measures tailored to the SNP target populations,³⁶ SNP performance is assessed using the same quality performance tools and measurements that are used to evaluate mainstream Medicare Advantage plans. These standard quality measures may not be suitable for evaluating the care of persons with specific chronic health care needs. For example, none of the measures assesses health plan performance on factors that are most critical for frail elderly persons, such as continuity of care, transitions across settings of care, treatment of geriatric syndromes, and management of care across multiple chronic conditions.³⁷

The future of SNPs is unclear. The MMA required that CMS provide a report to Congress by December 31, 2007, “assess[ing] the impact of specialized Medicare Advantage plans for special needs individuals on the cost and quality of services provided to enrollees.”³⁸ As of the publication date of this guide, that report—which is being written by Mathematica Policy Research, Inc.—has not been released. Nevertheless, in December 2007, the Medicare Payment Advisory Commission (hereinafter “MedPAC”) released a set of recommendations about the SNP program.³⁹ These recommendations included requiring SNPs to do the following:

- Report on tailored performance measures and evaluate their performance on those measures within three years;
- Enroll at least 95% of their members from their target population;
- Serve only beneficiaries with complex chronic conditions that influence many of aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems (chronic SNPs only);
- Contract with states in their service areas within three years to coordinate Medicare and Medicaid benefits (dual-eligible SNPs only);
- Eliminate dual eligible beneficiaries’ ability to enroll in Medicare Advantage plans, with the exception of SNPs with state contracts, outside of open enrollment; and
- Allow beneficiaries to disenroll any time of the year to return to fee-for-service.

In addition, MedPAC recommended that CMS provide beneficiaries and their counselors with information on SNPs that captures their benefits, other features and performance, compared to other MA plans and fee-for-service Medicare.

³⁵ See Verdier, J., Gold, M., and Davis, S., “Do We Know if Medicare Advantage Special Needs Plans Are Special?,” Mathematica Policy Research, Inc., for The Henry J. Kaiser Family Foundation, January 2008, p. 36.

³⁶ CMS has contracted with the National Committee for Quality Assurance (hereinafter “NCQA”) to evaluate SNPs. NCQA is phasing in its evaluation approach and issued draft structure and process measures in December 2007. It is expected to release its final version of these measures on March 15, 2008. Information about the NCQA evaluation process is available at www.ncqa.org/tabid/620/Default.aspx.

³⁷ Bringewatt, R. “Special Needs Plans: Building a Successful Care System for High-risk Beneficiaries,” *Medicare Patient Management*, September/October 2006.

³⁸ See MMA, [Pub. L. 108–173](#), title II, § 231(e), Dec. 8, 2003, [117 Stat. 2208](#).

³⁹ Podulka, J., “Special Needs Plans,” Presentation at the Integrated Care Program Policy Summit, December 12, 2007. Available at http://www.chcs.org/usr_doc/Future_Integrated_Care_Podulka.pdf.

The original MMA legislation included a sunset provision for SNPs of January 1, 2009. Although MedPAC recommended that Congress extend authority for three years to December 2011, Congress passed legislation in December 2007 extending this authority for only one year and imposed a moratorium during that time on the approval of new SNPs and on the expansion of existing SNPs into new geographic areas.⁴⁰

⁴⁰ See Section 108 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (S.2499).

WHAT DOES THE SNP MARKETPLACE LOOK LIKE?

The number of SNPs in the marketplace has grown exponentially since 2005, when they were first permitted to begin operating. In 2004, eleven SNPs were approved to begin enrolling beneficiaries. A short three years later, 477 SNPs had been approved to operate in forty-three states.⁴¹ A total of 769 plans have been approved to operate for 2008. Of these, 439 will serve dually eligible beneficiaries, 241 will serve beneficiaries with chronic or disabling conditions, and 89 will serve institutionalized beneficiaries.⁴² A handful of SNPs are federal/state demonstration projects that coordinate or integrate Medicare and Medicaid benefits; most of these were in operation at the time the MMA was enacted. Although some SNPs are sponsored by nonprofit entities, the majority are sponsored by for-profit companies.⁴³ As of 2007, three firms—UnitedHealthcare, Humana, and Kaiser Permanente—account for almost 40% of the SNP market.⁴⁴

SNP Marketplace Snapshot

<i>Target Population</i>	<i># of Health Plans</i>	<i>Enrollment</i>
Dually eligible beneficiaries	439	804,167
Institutionalized beneficiaries	89	139,084
Beneficiaries with chronic or disabling conditions	241	174,810
Total	769	1,118,061

Source: Centers for Medicare and Medicaid Services

It should be noted that growth in the SNP *beneficiary* population has not mirrored the kinds of growth demonstrated by SNP plans themselves: more than 25% of SNPs have fewer than 100 enrollees.⁴⁵ Nor is it clear that the growth which has occurred has been the product of beneficiary choice. As discussed below, passive enrollment seems to have played as much a role as active choice with regard to any increase in the number of SNP beneficiaries.⁴⁶ All told, SNP enrollees comprise 12% of the total Medicare Advantage market.⁴⁷

Market observers suggest that reimbursement mechanisms available to Medicare Advantage plans are the major drivers behind the rapid growth of the SNP market. The general

⁴¹ See “Special Needs Plans Comprehensive Report,” February 2008, and “Landscape of Local Plans State-by-State Breakdown,” Centers for Medicare and Medicaid Services, 2007. Available at www.cms.hhs.gov.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ See Verdier, J., et al, pp. 23-30.

⁴⁵ Ibid, p. vi.

⁴⁶ Ibid. Active enrollment accounts for only half of current SNP enrollment.

⁴⁷ Ibid.

overpayment to private Medicare Advantage plans described previously makes many health plans view Medicare Advantage as a profitable business. In addition, the shift to risk-adjusted payments has made individuals eligible to enroll in SNPs a very attractive target population. Because the three categories of SNP-eligible beneficiaries generally represent those with the highest levels of health needs, they are also the beneficiaries for whom the highest reimbursement levels are available.

SNPs are attractive to Medicare Advantage plan sponsors for enrollment-related reasons.

Unlike mainstream Medicare Advantage plan beneficiaries, who are locked into their health plans from March until January of the following year, beneficiaries who are either dually eligible or who meet the definition of “institutionalized” may be enrolled in a SNP throughout the year. The effect of this exception to the “lock-in” rules is that the only marketing activity likely to produce new plan members from March to January is connected with SNPs.

SNP Penetration in Various States as of July 2007

Highest Enrollment	
Puerto Rico	> 200,000
California	> 180,000
Pennsylvania	> 100,000
New York	> 70,000
Lowest Enrollment	
New Mexico	< 700
Idaho	<500
Oklahoma	< 500
Delaware	< 400
Indiana	<400
Maine	< 200
Nebraska	< 200
Iowa	< 100
Nevada	< 100
No Enrollment	
Alaska	0
Kansas	0
Montana	0
New Hampshire	0
Vermont	0
West Virginia	0
Wyoming	0

Source: Kaiser Family Foundation, “Do We Know if Medicare Advantage Special Needs Plans Are Special?” (January 2008)

Past use of passive enrollment contributed to the growth of the SNP marketplace. Following the passage of the MMA, many of the *Medicaid* managed care plan sponsors in states that permitted or required dually eligible beneficiaries to enroll in Medicaid managed care received approval to operate Medicare Advantage SNPs. In fall 2005, the federal government provided a one-time opportunity for those plans to passively enroll their dually eligible Medicaid members into their SNP plans. The plans were simply required to send the Medicaid members a letter notifying them of the change. The burden was on the member to notify the plan if she/he did not wish to enroll in the

SNP. Passive enrollment resulted in approximately 200,000 dually eligible SNP enrollees.⁴⁸ Although dually eligible beneficiaries can opt out of SNPs and mainstream Medicare Advantage plans at any time, the passive enrollment process created significant hardship and disrupted care for a substantial number of individuals. Many did not understand the notices they received or did not realize they had to take action if they did not want to be enrolled. The result was that some beneficiaries lost access to long-time health care providers or found that their SNP did not cover specific prescription drugs they needed.⁴⁹

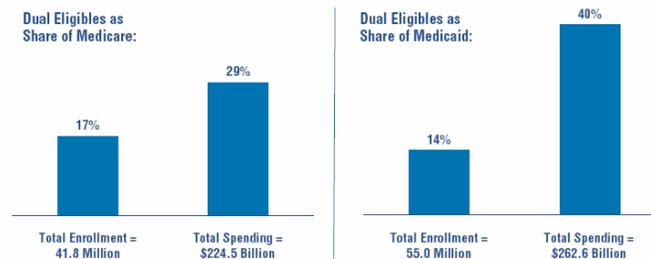
⁴⁸ Verdier, J., "Forging Successful Partnerships Between Health Plans and States," Presentation to the Second Annual Conference on Reaching, Retaining and Serving Low-Income Beneficiaries, July 24, 2007. Available at www.mathematica-mpr.com.

⁴⁹ See *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

WHAT UNIQUE CHALLENGES DO INDIVIDUALS WHO ARE DUALY ELIGIBLE FACE IN THE HEALTH CARE SYSTEM?

Most SNPs have opted to target enrollment to individuals who are dually eligible.⁵⁰ Dually eligible individuals qualify for Medicare by virtue of age or disability and for Medicaid because they have very low incomes, very high health care costs, or both. There are about seven million dually eligible individuals in the country today, about six million of whom qualify for full Medicaid benefits. The remainder receive Medicaid assistance for some or all Medicare cost-sharing, *i.e.*, the Medicare Part B premium and the Part A and B co-insurance and deductibles. Dually eligible individuals represent a relatively small percentage of Medicare beneficiaries (14%) and Medicaid recipients (17%). Nevertheless, they account for a significant share of spending in both programs: 24% of Medicare spending and 40% of Medicaid spending.

Dual Eligibles as a Share of Medicare and Medicaid Enrollment and Spending, 2002–2003



SOURCE: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2001 MSIS data applied to CMS-64 FY2003 data.

Source: Kaiser Family Foundation, *Medicare Chartbook 2005*

For dually eligible individuals who receive full Medicaid benefits, Medicare is their primary coverage source, and Medicaid functions as “wraparound” coverage. This means that if both Medicare and Medicaid cover a benefit or service, Medicare pays. Medicaid pays for those Medicaid benefits and services that are not covered or are limited by Medicare, including extended home health aide assistance, personal care attendants, a broader range of assistive technologies, and, most significantly, long-term care.

Dually eligible individuals tend to have more serious and complex health needs than the broader Medicare and Medicaid populations. In comparison to the general Medicare population, dually eligible beneficiaries are more likely to live in nursing homes. They are also three times more likely to be disabled, and they are more likely to have multiple chronic conditions, such as heart disease, diabetes, and mental and cognitive impairments. One third of all dual eligible beneficiaries have difficulty completing three to six activities of daily living, *e.g.*, bathing, eating, and dressing.⁵¹

⁵⁰ The other two types of SNPs – those targeted to institutionalized beneficiaries and those targeted to beneficiaries with serious disabilities and/or chronic conditions – may also enroll dually eligible beneficiaries, but they must also enroll non-duals who fall within the target population.

⁵¹ Peters, “Medicare Advantage SNPs.”

Dually eligible individuals are poorer than the majority of Medicare beneficiaries. Seventy three percent have annual incomes below \$10,000, compared to 12% of all other Medicare beneficiaries. And 61% have less than a high school education, compared to 25% of all other beneficiaries.⁵²

The majority of individuals who are dually eligible obtain their care through the traditional Medicare fee-for-service system. This often means that no individual or entity (*e.g.*, primary care physician, case manager, or care team) serves as the “point person” for these individuals, and there is no organized mechanism for either monitoring or taking responsibility for health outcomes. Dually eligible individuals with complex care needs generally need to see multiple providers and take multiple prescription drugs. Providers may not always communicate with one another, and they often do not have access to a common medical record. Many in this population could benefit from home visits and social or behavioral support, but some or all of these services may not be covered under state Medicaid programs. Where that is the case, most individuals cannot afford to purchase them. In addition, medical care and behavioral health services are rarely integrated; as a consequence, physical or mental deterioration is not always caught or addressed. The end result will often be a costly hospitalization or admission to a long-term care facility.

Dually eligible individuals are designated a target population for SNPs in part because of their complex care needs. In contrast to the traditional Medicare fee-for-service system, CMS expects Medicare Advantage coordinated care plans in general and SNPs in particular to coordinate their members' care with regard to covered services and to coordinate with available community and social services. Although the health plans' performance of this function may be uneven, at least their contracts with CMS provide a framework for setting out expectations and obligations. Traditional Medicare does not offer a similar mechanism for ensuring accountability.

⁵² Fact Sheet, “Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,” Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2006. Available at www.kff.org.

WHAT DOES IT MEAN TO INTEGRATE MEDICAID AND MEDICARE BENEFITS?

On the one hand, individuals who are dually eligible have some of the most comprehensive health coverage there is in the United States: together, Medicare and Medicaid cover the full spectrum of health care, from primary to long-term care. On the other hand, they face a special set of complications because they receive these benefits through two sets of payers—Medicare and Medicaid—with two different sets of program rules and requirements. This situation contributes to fragmented care, significant beneficiary confusion, and lack of accountability for health outcomes. Integration of Medicaid and Medicare benefits presents an opportunity to simultaneously improve care quality for beneficiaries while containing program costs.

In the ideal scenario, integration means that Medicare and Medicaid dollars are *combined*, and a single contracting entity—for these purposes, a health plan authorized to operate as a SNP—organizes, arranges, and *coordinates* the delivery of all necessary resources and services for the beneficiary. The services, in effect, are seamless across the full spectrum of Medicare and Medicaid covered benefits. The combined payment to the health plan, known as a prepaid capitation, is risk-adjusted to reflect the actual cost of providing the full array of benefits. The prepaid capitation allows the health plan to take a more flexible approach to benefits. For example, in lieu of confinement in a skilled nursing facility, a health plan might substitute additional home health aide or personal care attendant hours, provide primary care services at home or in other convenient settings, or provide a piece of durable medical equipment that allows the beneficiary to remain safely at home or active in the community. The health plan is at partial or full financial risk for the provision of care, and it is subject to strict, meaningful performance measures to assure quality of care and member satisfaction. Oversight is the joint responsibility of the state Medicaid program and CMS.

The dually eligible beneficiary benefits from integration primarily because care is coordinated and, under the ideal scenario described above, the focus is on helping the individual remain living in the community. As a significant additional benefit, integration reduces the confusion inherent to being enrolled in two separate health coverage programs. An integrated system involves a single enrollment mechanism, a single identification card and member handbook, a single, consistent provider network, and a single appeals process.

Lack of integration can create serious problems for dually eligible SNP enrollees in accessing Medicaid benefits. Because there is currently no requirement that SNPs coordinate with state Medicaid programs, advocates have identified a number of concerns with the way some SNPs are operating. These include the following:

- SNP networks that include providers who do not accept Medicaid, which has meant that some dually eligible SNP members have been billed by providers for Medicaid-covered services;

- SNP networks that fail to protect dually eligible beneficiaries who lose Medicaid eligibility;⁵³
- SNPs that fail to inform their enrollees that Medicaid may cover services or prescriptions that are not included in the SNP benefits; and
- SNPs that fail to assist enrollees in obtaining those Medicaid-covered benefits and services.⁵⁴

Full integration of Medicare and Medicaid may further the goals of health access advocates and their constituencies in two ways. *First*, if properly organized, administered, and closely monitored, coordinated care should result in a higher quality of care that emphasizes enabling dually eligible individuals to remain living and active within their larger communities. Coordinating care well reduces fragmentation in services, thereby more effectively addressing individual needs and either preventing or delaying the declines in health and functional status that often result in hospitalization and nursing home placement. *Second*, integration offers the potential of maintaining the beneficiary's entitlement to benefits and services while introducing a degree of financial predictability and stability over the longer term to the Medicare program *and* to state Medicaid budgets. Any reduction in expenditures resulting from better coordinated care is important to the financial sustainability of both Medicaid and Medicare, particularly if one—or both—of them is being looked to as a vehicle for broader health access reform.

States may look to SNPs as a less burdensome means of integrating Medicare and Medicaid benefits. Prior to the creation of SNPs, states that wanted to undertake Medicare/Medicaid integration projects had to do so under various federal demonstration project authorities. Obtaining waiver approval from the Medicare program for a demonstration project was often a protracted, resource-intensive process that many states were simply unwilling to undertake. In authorizing SNPs, Congress essentially eliminated the need for states to obtain a Medicare waiver. Thus, if a state wants to develop an integrated program, its administrative burden is now substantially reduced, especially if its Medicaid state plan provides for voluntary enrollment in Medicaid managed care of individuals who are dually eligible.⁵⁵

State Medicaid programs, in particular, may find integration to be a reasonable stabilization strategy. *First*, under the fee-for-service system, the state is subject to open-ended financial risk for the cost of all Medicaid covered benefits and services. The incentive for providers is to provide as many services as possible. The use of a prepaid capitation amount effectively caps that liability, introducing greater predictability to the Medicaid budget. *Second*, where Medicaid and Medicare

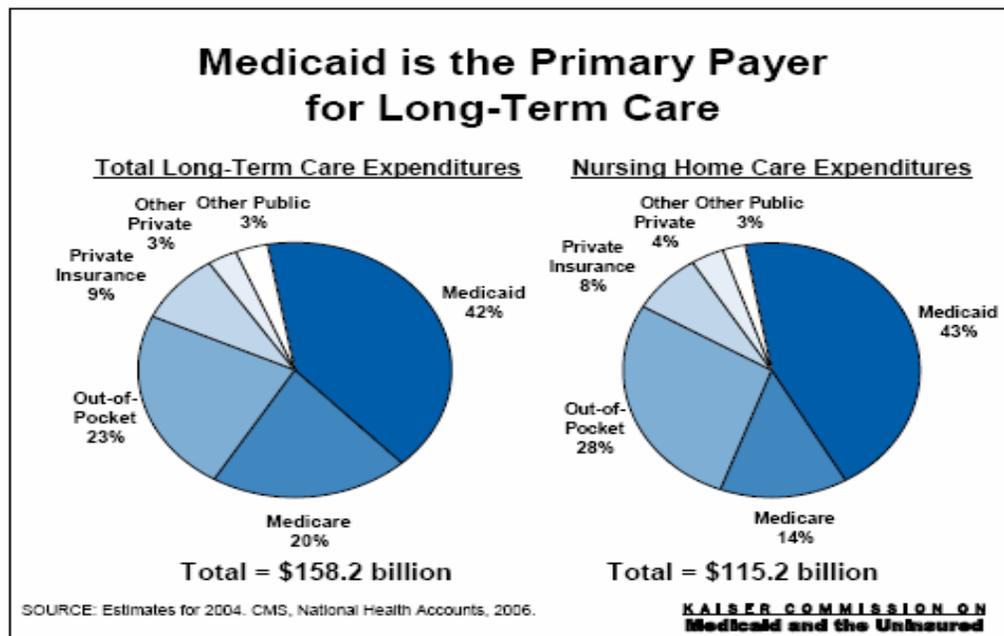
⁵³ Because these individuals may regain Medicaid eligibility, CMS guidelines require plans to “deem” them temporarily eligible for the SNP for a “deeming period,” set by the SNP in the plan contract, of 30 days to 6 months. During that deeming period, the SNP is required to provide all plan benefits and adhere to all cost-sharing agreements. Moreover, CMS has stated that “[i]t is the SNP’s responsibility to protect members” who lose Medicaid eligibility during the deeming period: where loss of Medicaid eligibility would normally shift costs to the beneficiary, the SNP must bear those costs itself if it has not previously contracted with providers who have formally agreed to forgo payment. Draft 2009 Call Letter, p. 35.

⁵⁴ Halperin, A., Nemore, P., and Gottlich, V., “What’s So Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for ‘Dually eligible beneficiaries,’” *8 Marquette Elder’s Advisor*, 2007.

⁵⁵ A state that wants to institute mandatory Medicaid managed care enrollment for individuals who are dually eligible still needs to obtain a *Medicaid* waiver from CMS.

are not integrated, incentives for providers to shift costs to other providers also result in cost-shifting between the two programs. For example, a nursing home reimbursed by Medicaid might transfer an individual to a hospital, funded by Medicare, rather than provide the medical care the individual needs in the nursing home setting. In this scenario, the nursing home is then paid by Medicaid to hold the bed open for a period of time even though it is incurring none of the costs associated with the individual's care. Similarly, a Medicare managed care plan might encourage a dually eligible, chronically ill member to be placed in a nursing home that is reimbursed by Medicaid.⁵⁶ Full integration substantially reduces this incentive to cost shift.

Despite the potential benefits of Medicaid and Medicare integration, some state policymakers are concerned that any cost savings realized through integration will be realized primarily by Medicare or by the managed care plan. This is because reductions in utilization would primarily be in Medicare-funded services (*e.g.*, emergency room visits, inpatient hospitalization, short-term stays in skilled nursing facilities), and increases in utilization would be Medicaid-funded services (*e.g.*, home- and community-based services). However, as the chart below illustrates, Medicaid is the primary payer for long-term care. It follows that any reduction in the use of these services would result in savings for Medicaid state budgets. Also, a state could save significantly if a SNP plan's bid included coverage of applicable Medicare deductibles and co-insurance. The state Medicaid program would otherwise be responsible for some or all of these amounts in connection with dually eligible individuals enrolled in SNPs. Finally, if CMS were to view integration as a valuable policy direction for dually eligible beneficiaries, states could require that Medicare share some of its cost savings as a condition of state participation.



Source: Kaiser Commission on Medicaid and the Uninsured, *Long-Term Services and Supports: The Future Role and Challenges for Medicaid*, September 2007

⁵⁶ "Integrating Medicare and Medicaid Services Through Managed Care," Congressional Research Service, RL33495, October 20, 2006.

Full integration of Medicaid and Medicare services and payments through a three-way agreement between the state Medicaid agency, CMS, and the Medicare Advantage plan offers the greatest potential to maximize care coordination. However, arriving at terms mutually acceptable to all stakeholders and satisfactorily addressing all of the programs' inconsistent requirements can be a long process. As a result, CMS has identified three other integration models that address some of the care coordination concerns described in this guide that may be easier for states to implement.⁵⁷ Very briefly, these three models are as follows:

- A buy-in wraparound model. In this partial integration model, the state encourages Medicare Advantage plans to offer a Medicare supplemental benefit package which includes some or all of the Medicaid benefits not covered by Medicare. The state then opts to purchase the supplemental coverage for dually eligible individuals and provides for payment of the premiums in its Medicaid State plan. The state is serving merely as a financing mechanism, and it exercises no oversight of the Medicare Advantage plan.
- A capitated wraparound model. In this partial integration model, the state enters into a companion capitated Medicaid contract with health plans that also have regular Medicare Advantage or SNP contracts. In contrast to the buy-in model, the state is a party to a contract rather than just purchaser of coverage. As such, it oversees the Medicaid contract.
- The plan-level integrated contract. This is a model that is fully integrated *at the health plan level*. The plan itself integrates the benefits, and it negotiates separate contracts with Medicare and Medicaid. The plan must develop a single set of policies and procedures for the enrolled dual-eligible populations addressing both Medicare and Medicaid requirements. Since neither the state nor CMS initiates the model, they both deal with the health plan as they would with any other contracting health plan.

⁵⁷ A thorough treatment of these integration options may be found in "State Guide to Integrated Medicare & Medicaid Models," Centers for Medicare and Medicaid Services, March 2006. Available at www.cms.hhs.gov. See also Milligan, C.J. and Woodcock, C.H., "Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans," The Commonwealth Fund, February 2008. Available at www.commonwealthfund.org.

WHAT PROMISING SNP PRACTICES CAN CONSUMER ADVOCATES LOOK TO?

To date, there is insufficient information to determine whether SNPs are delivering higher quality, more cost-effective care. However, a small group of SNPs—some of which began as federal/state demonstration projects serving dually eligible individuals, as well as some that traditionally served individuals who are eligible only for Medicaid—is piloting innovative ways to achieve this potential. This section provides examples of some of the promising practices identified among these health plans that, if implemented by SNPs at large, will go a long way toward fulfilling SNPs' potential for providing quality, coordinated care to our most vulnerable populations.

Coordinated care. Quality care for special needs beneficiaries begins with coordinated care.⁵⁸ This requires establishing mechanisms to coordinate clinical staff and other providers offering care to SNP members. Models of coordination vary, but they include the single coordinator model, the nurse/social worker team model and the multidisciplinary or interdisciplinary team approach.⁵⁹ Commonwealth Care Alliance, a nonprofit care delivery system located in Massachusetts, uses a primary care team approach in delivering care to its members. The team is made up of nurse practitioners, nurses, behavioral health clinicians and/or non-professional peer counselors. These

SNP Case Study: Commonwealth Care Alliance Massachusetts “Patricia” is a 44-year-old woman with cerebral palsy, a severe speech impediment, spastic quadriplegia, moderate mental retardation, a complex seizure disorder, and depression. She lives in a group home in the Boston area. Before becoming a member of CCA, Patricia had no consistent primary care and received care through multiple uncoordinated specialty clinics at a Boston teaching hospital. Her group home staff had no option but the emergency room for all clinical issues, minor or serious. As a result, she was hospitalized multiple times for seizures, aspiration pneumonia, and urinary tract infections. There was little attention paid to her psychosocial issues. Since enrolling with CCA, Patricia has a primary care team made up of her physician and a nurse practitioner, who evaluate her in her group home or work site. Her care team provides 24/7 personalized support and responds to problems raised by her group home staff members. An integrated psychiatric nurse clinician and psychopharmacology management oversees her complex psychiatric and seizure medications. As a result, Patricia's emergency room and hospital use has fallen dramatically.

teams are authorized to order all needed services, thereby entrusting those closest to the patient to make decisions about care in consultation with the patient. Care Oregon, a SNP serving dually eligible beneficiaries in seven Oregon counties, also established a care coordination team structure which includes clinical pharmacists and social workers. At Mercy Care, a SNP serving dually

eligible beneficiaries in Arizona, case managers are assigned to each member. The case manager has two primary roles: first, to help the member navigate the healthcare delivery system; second, to maintain contact with the clinicians who manage the member's medical care.⁶⁰ At Denver Medical Health Plan, high-risk members are assigned case managers to develop and oversee implementation

⁵⁸ The Center for Medicare Advocacy has also recommended that care coordination be a prerequisite for CMS approval as a SNP. See “Recommendations of the Center for Medicare Advocacy.”

⁵⁹ Clark, W., Bishop, C., Leutz, W., Gurewich, D., Ryan, M., and Thomas, C., “Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers,” Brandeis University, March 2007.

⁶⁰ Lukens, E., Murphy, L., and Bloom, J., “Medicare Advantage Special Needs Plans: Six Plans' Experience with Targeted Care Models to Improve Dual Eligible Beneficiaries' Health and Outcomes,” Association for Community Affiliated Plans, November 2007, p. 10.

of the member's individual plan, while "health coaches" maintain constant—sometimes daily—contact with the member.⁶¹ Members have a single point of contact within the SNP, regardless of whether their question is clinical or administrative in nature. Finally, at the Community Health Plan of Washington, every SNP enrollee is assigned a "Patient Navigator" that helps enrollees schedule appointments with primary and specialty care providers and access needed social services, among other things.⁶²

Specially selected care networks. It is important that a SNP identify provider networks that understand the particular needs of the target population and agree with the coordinated care model employed by the SNP. Commonwealth Care Alliance, for instance, has been successful in identifying primary care practices, medical and behavioral health specialists, durable medical equipment vendors, and other service providers that share its commitment to bringing clinical decision-making to the member and substituting home and community-based services for hospital and institutional services. To date, Commonwealth Care Alliance contracts with 11 primary care networks in Massachusetts, including both non-profit group medical practices and a number of community health centers. Other SNPs, including Mercy Care in Arizona and Affinity Health Plan in New York, have found that using their already-existing network of Medicaid providers ensures provider commitment to their care coordination models.⁶³ Denver Health Medical Plan, by contrast, developed its care coordination model in collaboration with its network providers, all of whom belong to the city's safety net health system.⁶⁴

Twenty-four hour access. SNPs should provide primary care and care coordination services on a "24-hour, 7-days-a-week" basis in order to ensure continuity of care across all clinical settings (*e.g.* inpatient, sub-acute, skilled nursing facility). All providers and on-call staff should have access to a centralized medical record to eliminate questions about what medications the member is taking, what treatments they have received, and what other services have been and are being provided. In certain cases, access to this information might also be used to aid with early intervention and to flag potential problems. Clinicians at Denver Health Plan, for example, have full access to members' records, which are stored electronically.⁶⁵ The plan is currently developing protocols whereby its "health coaches" can use the electronic record to address issues such as lapsed prescriptions and missed appointments directly with members with the goal of avoiding preventable hospitalizations.⁶⁶

Integration between Medicare and Medicaid. As described earlier, while dually eligible beneficiaries are only a small percentage of Medicare and Medicaid beneficiaries, they account for a disproportionate share of program spending. Though the vast majority of SNPs today serve dually eligible beneficiaries, very few have formally contracted with their state Medicaid departments to

⁶¹ Lukens, et al., p. 30. It should be noted that members who have been identified as "lower risk" receive care coordination primarily through Denver Health Plan's community health clinics, where they are also able to access social workers and other community-based providers.

⁶² Phone interview with David DiGiuseppe, Director, Product Development, Community Health Plan of Washington, October 17, 2007.

⁶³ Lukens, et al, pp. 11-12, 38.

⁶⁴ *Ibid.*, p. 30.

⁶⁵ *Ibid.*, p. 31.

⁶⁶ *Ibid.*

offer coordinated benefits to their enrollees. This lack of coordination, resulting in two separate payment, delivery and oversight systems, causes enormous administrative waste. The most serious consequences, however, befall the dual eligible beneficiaries, for whom a lack of continuity of medical, behavioral health and long-term care services can have enormous personal and clinical costs. In Arizona, a three-way contract between the state, CMS, and Mercy Care has allowed the plan to successfully implement an integrated payment model with the intention of improving both care coordination and the efficient use of resources.⁶⁷ The plan has found that supplementing members' Medicare benefits with Medicaid home health care benefits has reduced both the length of members' hospital stays as well as the number of discharges to Skilled Nursing Facilities that tend to follow.⁶⁸ Other plans, in the absence of formal contracts to provide Medicaid managed care services, have found creative ways to supplement members' care. Blue Cross Blue Shield of Rhode Island, partnering with Neighborhood Health Plan of Rhode Island, identified lack of immediate access to transportation services and limited dental services as two key problems facing the state's Medicaid population.⁶⁹ Blue Cross Blue Shield responded by granting SNP enrollees full access to its dental provider network. The plan also arranged taxi services for SNP enrollees, who were previously forced to rely on transportation services that included wait times of one to two weeks.⁷⁰

SNP Case Study: Community Living Alliance, Wisconsin Partnership Program "Helen" is a woman with morbid obesity, on oxygen, with significant anxiety issues. Within her first year in the Community Living Alliance, Wisconsin Partnership Program, Helen fell and the leg fracture prevented her from walking. Her leg became infected, requiring IV antibiotics. Helen's electricity was then disconnected. Loss of electricity meant Helen's antibiotics could not be kept in her refrigerator, her oxygen concentrator did not work, preparing foods was very limited, and her mobility was compromised. Helen was terrified of going to a skilled nursing facility. Helen's Partnership team recognized the serious risks of her staying at home, talked with her about their concerns, and worked with her to minimize those risks. The nurse practitioner ordered an antibiotic that did not require refrigeration and arranged temporary home delivered meals; the personal care worker came twice daily and remained in close contact with the nurse. Helen received more frequent in-home mental health care to help her manage stress and anxiety, and the social worker aided in working out a budget and negotiating a payment plan with the electricity company. These interventions were more cost-effective than a nursing home stay and were responsive to Helen's safety and quality of life.

Mechanism for consumer voice to be heard. It is essential for SNPs to create formal mechanisms through which they regularly seek members' feedback about plan design and implementation. There is no single best mechanism for allowing the consumer voice to be heard. Rather, SNPs might consider a variety of strategies, including working with leaders from the consumer and disability communities, holding public meetings and focus groups, and forming advisory and oversight committees.⁷¹ Affinity Health Plan of New York, for example, relied on consumer focus groups during its planning stages, which resulted in the plan's instituting a single point of contact when consumers call.⁷² This SNP continues to actively engage its membership community by intentionally headquartering its offices in the same neighborhoods from which its membership is drawn. Affinity also opened storefront "Community Service Centers" where members can receive

⁶⁷ Ibid, p. 12.

⁶⁸ Ibid.

⁶⁹ Ibid, pp. 25, 27.

⁷⁰ Ibid, p. 27.

⁷¹ Barth, J., "The Consumer Voice in Medicaid Managed Care: State Strategies," Center for Health Care Strategies, March 2007.

⁷² Lukens, et al., p. 37.

face-to-face enrollment and health education services, among others.⁷³ Commonwealth Care Alliance contracts with Health Care For All, the leading statewide consumer health advocacy organization, to facilitate regular meeting with its members to solicit their feedback on the care they receive through the plan. Minutes are taken at each meeting, and members' comments—stripped of personal names—are given to Commonwealth Care Alliance which then addresses identified problems. The plan also has established a Patient Care Assessment and Consumer Advisory Committee to gather ongoing member feedback.

Case Management: SNPs must work to develop and regularly update case management plans that are tailored to the health needs and circumstances of each member. For SNP populations, one size cannot fit all. Good case management begins with an initial assessment. Last year, the Santa Clara Family Health Plan launched an electronic Health and Environmental Interview tool that helps Santa Clara staff develop a plan that meets the specific needs of the member. With the member's

SNP Case Study: VNSNY CHOICE Select, New York Mark, a 70-year-old male with multiple chronic illnesses and a history of alcohol abuse. During Mark's first two months on the VNSNY CHOICE Select plan, he was hospitalized. Upon discharge, his care manager worked with physicians, pharmacies, and facilities to coordinate all aspects of the member's care. Specifically, the care manager facilitated primary care physician appointments, arranged prescriptions, and validated adherence to the plan's medication and disease management programs. By using the care management programs to stay in touch with Mark, the care manager was able to confirm that he was taking his medications, checking his blood sugar, and adhering to a healthy diet. The care manager also encouraged the member to make use of the plan's transportation benefit in order to ensure he kept his physician appointments. Additionally, the plan gathered valuable information about the member's health via its Health Risk Assessments, surveys that evaluate members' clinical and social needs. The plan conducts an initial HRA for all members, then based on the responses, has nine secondary HRAs that probe more deeply on specific conditions. Members' responses are compiled and used to indicate appropriate disease and medication management programs. In Mark's case, the HRAs helped identify potential diabetes-related and alcohol abuse concerns. To mitigate these potential complications, the care manager enrolled the member in the plan's diabetic disease management program and referred the member for mental health counseling. Today, Mark is undergoing counseling and education to manage his alcohol abuse and cease smoking, and he is under the care of an endocrinologist to manage his diabetes. Importantly, this member has had no hospitalizations for over three months.

permission, this comprehensive interview is conducted by home health aides in the member's home and is used to assess important categories such as medical and equipment needs, safety, living arrangements, treatment, and limitations.⁷⁴ Similarly, Denver Health's case management plan includes targeted glucose monitoring for members with diabetes. In addition to ensuring that members make and keep medical appointments, health coaches issue quarterly report cards so that members have a visual record of how well they are managing their disease.⁷⁵ Finally, Care Oregon utilizes a care management program through which a "personal care plan" is developed for each member. The personal care plan is based on five separate criteria and sets goals that, as a Care Oregon representative puts it, "have nothing to do with the member's coverage, but have everything to do the member's life."⁷⁶

SNPs must also design benefits that take into account the unique needs of the target population they serve. Recognizing that office-based care does not work well for its members with cognitive disabilities, Commonwealth Care Alliance has established a unique partnership with Vinfen, an organization that specializes in populations with cognitive disabilities. Through this partnership, members with cognitive disabilities are now being seen by health care providers in their homes.

⁷³ Ibid.

⁷⁴ Phone interview with Dennis Collins, MD, Medical Director, Santa Clara Family Health Plan, October 1, 2007.

⁷⁵ Lukens, et al., p. 31.

⁷⁶ Phone interview with Patrick Curran, Medicare Director, Care Oregon, June 12, 2007.

Consumer role in governance. It is important for a SNP to establish a model of governance that provides a meaningful role for members served by the plan. Community Living Alliance, which was created in 1998 by a group of people with disabilities, has established a model through which its members have a fundamental role in the governance of the plan. Members serve on focus groups, the grievance advisory and ethics committees and the Board of Directors. Approximately 50% of the Board is elected from CLA membership. At Commonwealth Care Alliance, the Board of Directors is selected by Health Care For All and the Boston Center for Independent Living, the two founding organizational members of the plan.

WHAT OPPORTUNITIES & RISKS DO SNPs PRESENT FOR INDIVIDUALS WHO ARE DUALY ELIGIBLE FOR MEDICARE AND MEDICAID?

Appropriately designed SNP benefits and health delivery structures, coupled with strong regulatory oversight and enforcement capability, could improve the health and quality of life of SNP enrollees and have a stabilizing effect on public program costs. Without these marketplace controls, however, SNPs may represent nothing more than a lost opportunity to address one of the thorniest issues in health care policymaking: how to meet the health needs of the minority of individuals who account for the majority of the nation's health care expenditures.

Some opportunities that SNPs present include the following:

- **Vulnerable individuals may reap the benefits of health care tailored to their specific needs and medical situations.** If SNPs actually succeed in delivering on the promise of special programming, benefits, and networks, then beneficiary health and well-being will be enhanced. Similarly, if SNPs can actually reduce the need for hospitalization and other high-cost services utilized by their member beneficiaries *without compromising care*, they could contribute to Medicare program sustainability.
- **Integrating SNPs with Medicaid offers the potential of coordinated, integrated, full-spectrum care for dually eligible individuals.** A coordinated care plan that is financed by combined capitated payments from both Medicare and Medicaid and that encompasses the full care continuum in a seamless fashion is viewed by many medical practitioners and policy experts as the most effective and flexible way to address dually eligible beneficiaries' health needs.⁷⁷ The capitation allows the health plan and its providers the freedom to develop individualized approaches to care, and it places accountability for health outcomes squarely on the health plan.
- **Integrating SNPs with Medicaid offers the potential to increase stability and predictability in expenditures for both programs.** The benefits of a capitated payment system, coupled with care coordination that substitutes more cost-effective home- and community-based services for expensive hospitalizations and nursing home placements, will have a positive impact on public program budgets. Reining in program costs in a manner that forces better care coordination may obviate the need for cost control efforts that result in reductions in benefits or eligibility.
- **SNP benefit and delivery structures can serve as a care model for individuals who are disabled but eligible only for Medicaid.** Dually eligible individuals represent just one segment of high-cost Medicaid populations. There are others—in particular, the SSI-eligible Medicaid recipients who must wait two years before they are eligible for Medicare—who could benefit from care coordination principles and practices that would be developed

⁷⁷ See Peters, "Medicare Advantage SNPs"; see also Master, R., and Eng, C., "Integrating Acute and Long-Term Care For High-Cost Populations," *Health Affairs*, 20:6, 2001.

through Medicare/Medicaid integration. These individuals generally are eligible for the same full spectrum of benefits available to dually eligible beneficiaries, but their expenses are financed solely by Medicaid. A coordinated care model that could maintain persons with disabilities in the community, reducing their hospitalization and institutionalization rates or otherwise stabilizing the costs associated with their care, would be a significant contribution to Medicaid program sustainability.

SNPs also present potential risks to beneficiaries. These include the following:

- **SNPs will not distinguish themselves from mainstream Medicare Advantage plans.** By permitting SNPs to target their enrollment to specific categories of Medicare beneficiaries, Congress laid the groundwork and set the expectation for a new type of health plan that would tailor its benefits and services to the special needs of those beneficiaries. If the necessary mechanisms for assessing SNP program design and operations are never developed or implemented, SNPs may not fulfill their promise.
- **Quality oversight measures will not be sufficient.** Currently, SNPs and mainstream Medicare Advantage plans are subject to the same quality and outcome measures. Experts agree that these measures are insufficient or, in some cases, inappropriate for the populations to which SNPs are targeted. CMS must move quickly to develop the necessary measures appropriate to SNPs, to develop mechanisms for reporting and disseminating that information, and for taking corrective action when there is non-compliance.⁷⁸ Appropriate quality oversight is also critical with Medicare/Medicaid integration efforts. At a minimum, there must be coordination and agreement between federal and state regulators on performance measures, data collection, oversight responsibility, and sanctions.
- **The risk adjustment methodology used to establish Medicare Advantage plans' reimbursement will not adequately reflect the cost of caring for SNP beneficiaries with the highest level of health care needs.** The current reimbursement method may not fully account for the health problems that might affect a person's need for health care. Moreover, it may not account for differences in the scope and nature of the services that plans actually provide to meet their enrollees' health needs. This may particularly disadvantage those health plans that enroll a disproportionate number of the highest-cost beneficiaries. In a competitive marketplace, this under-reimbursement could drive certain SNPs—in particular, nonprofit, mission-driven plans—out of the market.
- **The benefits of full-spectrum care coordination will be lost if SNPs are not integrated with state Medicaid programs.** By itself, special programming will not make a significant difference in the care challenges faced by dually eligible beneficiaries. The real problems arise for this population when they need to transition from one level of care to another or when they need to utilize their Medicaid benefits. When there is little or no integration with Medicaid, dually eligible beneficiaries essentially face the same challenges that are present in the fee-for-service system: lack of continuity of care and an absence of accountability for

⁷⁸ See NCQA proposed SNP evaluation measures. Critics have observed that these measures are not sufficiently tailored to the needs of SNP populations, nor are they typically administered at the plan level. See, *e.g.*, Verdier, et al, p. 36.

outcomes. However, effective integration will require strong regulatory oversight, as well as both the authority and capacity to enforce those regulations with sanctions.

- **State Medicaid budgets will be negatively impacted if they do not ensure tight coordination of care with dual eligible SNPs.** Without integration, SNPs have no incentive to manage costs that could be shifted to the Medicaid program. Indeed, cost shifting could enhance their profitability. For example, a SNP could discourage home care coverage for an individual, necessitating placement in a long-term facility for which Medicaid would be financially responsible, or they could refer a member for Medicaid-funded home and community-based services rather than pay for these services themselves. *Even with integration*, it will be important for states to ensure that their Medicaid budgets are not disadvantaged because of a greater reliance on Medicaid-financed home- and community-based services. This may require state Medicaid programs, with the support of consumer health advocates, to request that Medicare share in any cost savings attributable to expanded use of those non-institutional services.
- **Passive enrollment may be revived as a mechanism for moving dually eligible beneficiaries into SNPs, potentially creating hardship for those individuals.** In its early efforts to assist state Medicaid programs in thinking through the potential for Medicaid/Medicare integration, CMS has suggested that if a Medicaid managed care plan that enrolls dually eligible beneficiaries also offers a SNP, states should consider allowing auto-enrollment of the dually eligible individual in that SNP. In the absence of tight coordination of benefits and a seamless provider network, auto-enrollment could result in the same massive disruptions in care experienced by some dually eligible beneficiaries in the run up to implementation of the MMA. While the legality of utilizing passive enrollment would be questionable (as it was in 2006),⁷⁹ state Medicaid program administrators, with the support of some SNP sponsors, might conclude that passive enrollment is the best way to achieve “critical mass” in SNP enrollment relatively quickly.
- **Extension of the enrollment “lock-in” rule could present problems for enrollees.** Currently, dually eligible individuals and beneficiaries that meet the definition of “institutionalized” can enroll in or disenroll from Medicare Advantage plans, including SNPs, at any time. Maximum flexibility is important for these populations, given their typically high health care needs. Nevertheless, it is possible that Medicare Advantage plans, including SNPs, will complain about the administrative burden created by frequent disenrollments and may ask CMS to institute some sort of lock-in mechanism. There is no indication that this will occur, but advocates should be alert to the possibility.
- **SNP-eligible beneficiaries may be prime targets for marketing abuses.** Aggressive marketing tactics in the Medicare Advantage program have received significant media attention. This conduct has been driven in large part by the high levels of federal reimbursement for Medicare Advantage plans. Some plan sponsors are eager to attract enrollees, and so they are willing to pay high commissions to brokers and agents, who in turn try to entice beneficiaries to sign up. SNP-eligible beneficiaries are a prime target

⁷⁹ See *Erb v. McClellan*.

because their generally poorer health means they bring higher rates with them under the risk-adjustment system. Moreover, their poorer health may mean they are more vulnerable to improper marketing tactics.⁸⁰ The potential for abuse is further heightened by the fact that individuals who are dually eligible are not subject to the lock-in. Thus they may be targeted for aggressive marketing during the times that other beneficiaries are unable to switch health plans. Although state insurance regulators have some limited capacity to prevent or punish most of these practices through state consumer protection laws, the MMA effectively preempted most state laws, leaving CMS to police marketing conduct. Marketing abuses may continue to be a problem absent better oversight, whether that means providing CMS with additional enforcement resources, or loosening the preemption provisions to permit more state oversight.⁸¹

⁸⁰ Lipschutz, D., Precht, P., and Burns, B., "After the Goldrush: The Marketing of Medicare Advantage and Part D Plans," California Health Advocates and the Medicare Rights Center, Issue Brief #4, January 2007. Available at www.cahealthadvocates.org/advocacy/.

⁸¹ It is worth noting that the updated Medicare Advantage Audit Guide includes a newly inserted section to target the three areas that CMS deems to be "critical" aspects of SNP regulation, namely: enrollment, disenrollment, and marketing. See Draft 2009 Call Letter, p. 36. In a February 2008 hearing before the Senate Finance Committee, CMS Administrator Kerry Weems testified that CMS has taken steps towards addressing marketing abuses by Medicare Advantage plans and is considering introducing regulations that would limit private insurance agents' commissions and set parameters on their ability to contact potential plan beneficiaries. See "Testimony of Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, before the Senate Finance Committee on 'Selling to Seniors: The Need for Accountability and Oversight of Marketing by Medicare Private Plans, Part 2,'" February 13, 2008.

APPENDIX A: GLOSSARY

Capitation: A specified amount of money paid to a health plan or doctor for each enrolled member. The amount, which is actuarially calculated, reflects the cost of all covered benefits and services for a particular length of time.

Care transition: The movement of people between health care settings as their conditions and care needs change during the course of a chronic or acute illness.

Centers for Medicare and Medicaid Services (CMS): The federal agency that administers the Medicare program and that works jointly with states to administer the Medicaid program.

Cherry-picking: Policies or practices used by insurers to target individuals who use low levels of covered services and to discourage the initial or continued enrollment of individuals who use or are likely to use high levels of services.

Co-insurance: The percentage of charges that an enrollee must pay after the payment of any deductible.

Coordinated Care Plans: Medicare Advantage plans that coordinate care for members. They include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), and preferred provider organizations (PPOs). Generally, coordinated care plans require their enrollees to use providers in the plan's network. PPOs permit enrollees to receive some services outside of the provider network, but enrollee cost-sharing is higher.

Co-payment: A fixed dollar amount a health plan enrollee must pay when s/he obtains certain services or prescription drugs.

Cost sharing: A term that refers to the out-of-pocket payments an enrollee must pay in connection with his/her health coverage. It includes co-insurance, co-payments, deductibles, and premiums.

Deductible: The amount an individual must pay out of pocket for services before a third-party payer such as Medicare or a private insurer begins to pay for medical services.

Demonstration project: A federally approved experimental approach to financing and/or delivering health care through the Medicare or Medicaid programs. See "Federal waiver."

Dually eligible individual: A person who is eligible for both Medicare and Medicaid. Individuals who are dually eligible receive Medicaid coverage for some or all of their Medicare out-of-pocket expenses, as well as coverage of Medicaid benefits that are not available through Medicare.

Federal waiver: Federal authorization to waive certain provisions in the Medicare and/or Medicaid statutes, enabling the federal or state government to develop approaches that deviate from statutory

program requirements. Waivers typically are used to allow states or the federal government to test new approaches to health care financing and delivery or to advance certain policy and political priorities.

Fee-for-service: The traditional payment system for Medicare, where Medicare pays health care providers directly for each service when it is rendered.

For-profit: A form of business that is organized and structured to return a profit to private owners or shareholders.

Health maintenance organization (HMO): A type of health insurance plan which provides or arranges for all covered services for an individual enrollee in exchange for a fixed, prepaid fee. Enrollees typically must receive most of their care from providers (*i.e.* hospitals, physicians, etc.) who contract with the HMO.

Medicaid: A program, funded by both the federal and state governments, that provides medical coverage for certain categories of persons with low incomes. Medicaid programs are subject to broad federal standards, but they are administered by the states, which may establish their own eligibility standards and benefits within those federal parameters.

Medical savings account (MSA): A Medicare Advantage option that couples a high-deductible insurance plan with an individual savings account that is funded by Medicare. The Medicare beneficiary must exhaust the savings account and then pay a fairly significant deductible before his/her insurance benefits become available.

Medicare: The federal social insurance program that provides health coverage to people who are 65 and older and to those under 65 with significant disabilities. Medicare beneficiaries do not need to satisfy an income or asset test.

Medicare Advantage: Also called Medicare Part C, Medicare Advantage delivers Medicare-covered benefits to voluntarily enrolled Medicare beneficiaries through private-sector health plans. The government pays these plans a monthly amount for each enrollee.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): The legislation that established SNPs. It also added a prescription drug benefit to Medicare.

Medigap coverage: Supplemental insurance sold by private insurers to fill some or all out-of-pocket Medicare expenses, such as deductibles and co-insurance, that are incurred by individuals who do not enroll in a Medicare Advantage plan.

Network: The doctors or other health care providers under contract to a health plan to provide covered services to health plan enrollees. Depending on the type of plan, an enrollee must obtain his/her non-emergency care from a network provider in order for the care to be covered, *or* the enrollee receives a financial incentive to obtain care from a network provider, *e.g.*, a lower co-payment or co-insurance level.

Nonprofit organization: A form of business that is organized and structured to further a non-commercial purpose (e.g., charitable, cultural, scientific, religious, educational). Nonprofit organizations are expected to operate for the benefit of the public good and not to provide monetary benefit to private owners or shareholders. Some SNPs are nonprofit entities.

Open enrollment period: A fixed period of time during which a person may enroll in an insurance plan or switch from one plan to another.

Out-of-pocket expenses: A term used to refer to the amount of money an individual must pay in connection with his/her insurance coverage, including premium payments, co-insurance, deductibles, and co-payments.

Part A (Medicare): Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Part B (Medicare): Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Part C (Medicare): See "Medicare Advantage."

Part D (Medicare): Optional prescription drug coverage offered through Medicare. To obtain such coverage, Medicare beneficiaries must enroll in a private sector prescription drug plan or a Medicare Advantage plan that includes prescription drug coverage.

Passive enrollment: Enrolling persons in plans, or switching enrollees from one plan to another, without first obtaining the enrollee's consent. In the context of Medicare Advantage plans, individuals who are passively enrolled have the opportunity to opt out, but they must affirmatively exercise that option.

Preferred provider organization (PPO): A managed care plan in which an enrollee has a financial incentive to use providers who contract with the plan, i.e., network providers. A PPO enrollee using an out-of-network provider generally pays more out of pocket.

Premium: The amount an individual must pay for insurance coverage, usually broken down into monthly increments.

Provider-sponsored organization (PSO): A group of doctors, hospitals, and other health care providers that agree to provide a set of covered benefits to enrollees in exchange for a fixed monthly amount. This type of managed care plan is operated by physicians or other providers themselves, not by an insurance company.

Risk adjustment: A payment methodology used by Medicare that factors in the health status of a beneficiary enrolled in a Medicare Advantage plan in calculating how much it will pay the plan for the beneficiary's care. The beneficiary's health status is determined by the diagnoses appearing on the enrollees Medicare claim during the prior year.

Severe or chronic disabling condition: Conditions that typically are considered severe or chronic include such things as end-stage renal disease, HIV/AIDS, complex diabetes, congestive heart failure, and chronic obstructive pulmonary disease. For SNPs that are established to cover individuals with severe or chronic disabling conditions, CMS has decided not to specify which conditions are appropriate foci, ostensibly to allow for maximum flexibility.

Special Needs Plan (SNP): A type of Medicare Advantage coordinated care plan that is permitted to limit its enrollment to Medicare beneficiaries who meet the statutory definition of “institutionalized,” who are dually eligible for Medicare and Medicaid, or who are suffering from a severe or chronic disabling condition.

Sunset provision: A legislative provision that states that a law will expire by a certain date.

Wraparound coverage: Coverage that fills in the gaps in Medicare. It can include Medigap, Medicare supplemental coverage, or Medicaid for those individuals who are dually eligible.

Sources: Centers for Medicare and Medicaid Services; Kaiser Family Foundation

APPENDIX B: RESOURCES FOR ADVOCATES

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