

Medicare Special Needs Plans

What Consumer Advocates Should Know
About Integrating Medicare and Medicaid
Benefits for Dually Eligible Enrollees

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The Special Needs Plan Consumer Education Project is an initiative of Community Catalyst that seeks to educate state and federal payers, advocates, health care providers and the public on the opportunities and risks associated with SNPs. The Project is funded by the Retirement Research Foundation.

Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

Special Needs Plans (SNPs) were created in part to provide coordinated care to high-need, chronically ill Medicare beneficiaries. These beneficiaries require care that accounts for their complex health needs and coordinates among providers. 70% of the beneficiaries enrolled in SNP plans across the country are dually eligible for Medicare and Medicaid. Because these beneficiaries are widely recognized as some of the most vulnerable populations, there is a heightened need for coordination between the two governmental programs that pay for their care. This brief discusses how SNPs, when they integrate Medicaid and Medicare benefits, may (1) offer a means of providing high-quality care for dually eligible individuals and (2) help state health access advocates preserve, strengthen and expand coverage to health care in their states.

Background:

The American health care financing and delivery system is confusing, difficult to navigate, and expensive. And, all too often the quality of care is poor. While these challenges are present *regardless* of health or coverage status, the individuals who are at greatest risk are those with complex or serious chronic care needs who don't have the resources or support necessary to get what they need. Many of these individuals are enrolled in Medicare, a number of whom are also Medicaid beneficiaries.

Health access advocates see the effects of these problems in their daily work. Their most vulnerable clients or constituents may have coverage, but too often those individuals are left to navigate the health system on their own, and the care they receive is uncoordinated, impersonal, unresponsive and ineffective.¹ When complex or chronic health care needs are not addressed in comprehensive, appropriate ways, individual health status can decline, and the result frequently is a hospitalization or placement in a nursing home. Many of these poor outcomes could be prevented by better care. There is also a financial dimension to substandard care: it's expensive. Substandard care that results in avoidable hospitalizations or the need for a long-term care placement is a problem. Medicare expenditures are rising rapidly, in part, because of the costs associated with these services. They are also a significant driver of state Medicaid budgets.² And state health access advocates know all too well what happens when Medicaid expenditures are characterized as "budget busters" by policymakers: cuts follow – in eligibility, in benefits, and in provider payments.

Congress created Special Needs Plans (SNPs) in 2003, in part, to improve services for Medicare beneficiaries with serious health conditions who need coordinated, high quality care. They were viewed as having the potential to reduce expensive, avoidable emergency room visits and inpatient hospital and nursing homes admissions for these individuals. There are now 477 SNPs operating in 43 states.³ The vast majority of these plans serve individuals who are dually eligible for Medicare and Medicaid.

This brief describes SNPs and the populations they are meant to serve, with a particular emphasis on dually eligible beneficiaries. It then discusses how SNPs, when they are fully integrated with state Medicaid programs, offer the potential to (1) improve the quality of care for beneficiaries with complex care needs; and (2) produce efficiencies that will give state health access advocates a tool to protect or expand state Medicaid benefits for enrollees.

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

² See, e.g., *The Outlook for Medicaid in Massachusetts*, Massachusetts Medicaid Policy Institute, March 2007, http://www.massmedicaid.org/briefs_11.html.

³ See CMS, *Special Needs Plans Comprehensive Report*, <http://www.cms.hhs.gov/SpecialNeedsPlans/>. See also CMS, *Landscape of Local Plans State-by-State Breakdown*, <http://www.medicare.gov/medicarereform/local-plans-2007.asp>.

Special Needs Plans (SNPs):

SNPs are a type of Medicare Advantage coordinated care plan. They are private sector health plans that contract with the federal Centers for Medicare and Medicaid Services (CMS) to provide all Medicare-covered services to enrollees in exchange for a monthly payment for each enrolled beneficiary. SNPs are required to limit their enrollment to one of the following three categories of Medicare beneficiaries:

- ✓ People who qualify to live in **institutions**;
- ✓ People who receive *both* Medicare and Medicaid (“individuals who are **dually eligible**”); 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.

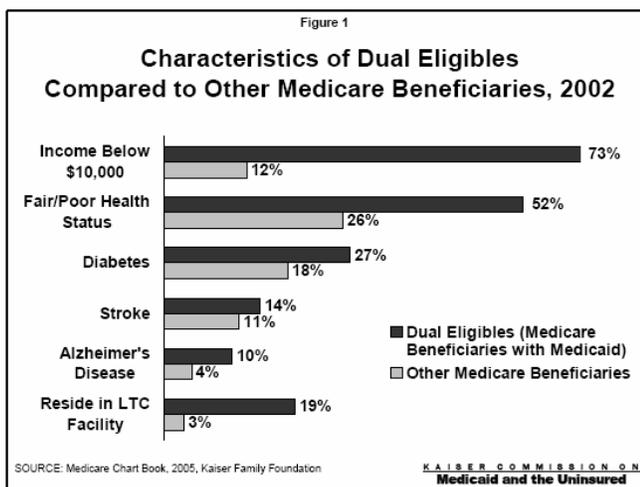
The table to the right displays the SNP enrollment figures as of October 2007.⁴

<i>Target Population</i>	<i># of Health Plans</i>	<i>Enrollment</i>
Dually eligible beneficiaries	320	737,125
Institutionalized beneficiaries	84	144,748
Beneficiaries with chronic or disabling conditions	73	168,762
Total	477	1,050,635

Dually eligible and institutionalized beneficiaries may enroll in – or disenroll from – a SNP at any time. Those enrolled in chronic care SNPs have more limited enrollment periods.⁵ Most of the 477 SNPs are sponsored by for-profit companies.⁶ The greatest numbers of enrollees are located in Puerto Rico, California, Pennsylvania and New York.⁷

Dually Eligible Beneficiaries

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. (See Figure 1) There are about seven million dually eligible individuals in the country today. 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 gaps in prescription drug coverage, extended home health aide assistance, personal care attendants, a broader range of assistive technologies and, most significantly, long-term care.

⁴ See JM Verdier, Mathematica Policy Research, Inc., “Medicare Advantage Special Needs Plans Overview of Issues by Type of Plan,” Presentation to the Conference on Medicare Advantage Special Needs Plans: A Beneficiary Perspective. October 18, 2007. Presentation available at <http://www.mathematica-mpr.com/publications/PDFs/VerdierSNPs10-18-07.pdf>.

⁵ In fall 2005, the federal government provided a one-time opportunity for certain Medicaid managed care plans to passively enroll their dually-eligible Medicaid members into their SNP plans. Passive enrollment resulted in approximately 200,000 dually eligible enrollees. Though this type of enrollment provided an easy transition for many, it created a significant hardship and disrupted care for significant numbers who lost access to long-time health care providers or found that their SNP did not cover specific drugs they needed. See *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

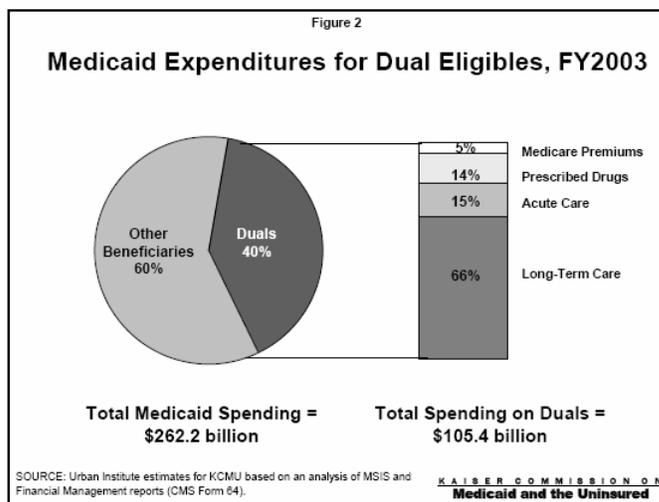
⁶ The three largest SNP sponsors are: UnitedHealth Group, WellCare, and Humana. *Special Needs Plan Comprehensive Report*, CMS, May 2007.

⁷ *Id.*

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 – 40% of Medicaid spending and 24% of Medicare spending. (See Figure 2) In comparison to the general Medicare population, dual eligibles have lower incomes and higher medical costs, and they are more likely to live in nursing homes. They are also three times more likely to be disabled. One third of all duals have difficulty completing three to six activities of daily living, e.g. bathing, eating and dressing. They are much more likely to have multiple chronic conditions such as heart disease, diabetes, and mental and cognitive impairments.⁸

In short, dually eligible beneficiaries could benefit from a coordinated care plan that provides a comprehensive set of benefits *and* helps them navigate the health care system. However, because there is currently no requirement that SNPs coordinate with state Medicaid programs, very few states have created formal mechanisms for doing so. Advocates have already identified a number of concerns with the way some non-integrated SNPs are operating. These include:

- SNP networks that include providers who don't accept Medicaid, which has meant that some dually eligible SNP members have been billed by providers for Medicaid-covered services;
- Failure of SNPs to inform their enrollees that Medicaid may cover services or prescriptions that are not included in the SNP benefits; and
- Failure to assist enrollees in obtaining those Medicaid-covered benefits and services.⁹



Why Integration Matters: For the Beneficiary

In the ideal scenario, Medicare and Medicaid dollars should be *combined*, with a SNP organizing, arranging, and coordinating the delivery of all necessary resources and services for the beneficiary. Under this scenario, the services, in effect, are seamless across the full spectrum of Medicare and Medicaid covered benefits. The combined payment allows the health plan to take a more flexible approach to benefits, for example, by: substituting additional home health aide or personal care attendant hours for confinement in a skilled nursing facility; providing primary care services at home or in other convenient settings; or providing a piece of durable medical equipment that allows the individual to remain safely at home or active in the community.

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. A significant additional benefit, though, is a reduction in the confusion inherent in being enrolled in two separate health coverage programs. There is a single enrollment mechanism, a single ID card and member handbook, a single, consistent provider network, and a single appeals process.

Why Integration Matters: For Health Access Advocates

If properly organized, administered and closely monitored, integration offers the opportunity for dually eligible clients and constituents to receive better care – care that is not fragmented and that more effectively addresses individual needs. Integration also offers the potential to introduce a degree of financial predictability and stability over the longer term to the Medicare program *and* to state Medicaid budgets while maintaining the beneficiary's entitlement to benefits and services. Good coordinated care is care that prevents or delays the declines in health and functional status that often result in hospitalization or nursing home placement. With

⁸ CP Peters, *Medicare Advantage SNPs: A New Opportunity for Integrated Care?* National Health Policy Forum, Issue Brief No. 808, November 11, 2005

⁹ A Halperin, P Nemore, V Gottlich, "What's So Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for 'Dual Eligibles'," *8 Marquette Elder's Advisor*, 2007.

well-coordinated care, the beneficiary gets to remain living in the community, and the public programs benefit from the use of lower-cost services. Any reduction in expenditures 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.

State Medicaid programs may also view integration as 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 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 – which is reimbursed by Medicaid – might transfer an individual to a hospital – which is funded by Medicare – rather than provide the medical care the individual needs in the nursing home setting. It is then paid by Medicaid to hold the bed open for a period of time, although it is incurring none of the costs associated with the individual's care when he or she is not actually using the bed. Similarly, a Medicare managed care plan might encourage placement of a chronically ill member (who is dually eligible) in a nursing home, paid for by Medicaid.¹⁰ Full integration substantially reduces the incentive to cost shift. Further, states could require that SNPs cover Medicare deductibles and co-insurance as a condition of Medicaid participation, and they could work with federal policymakers to ensure that Medicare savings are shared with the state.

Various models of integration are being utilized across the country. For example, Commonwealth Care Alliance in Massachusetts has utilized a three-way contract among the state, CMS, and the plan. Similar models have been used for years by the Minnesota Senior Health Options program and the Wisconsin Partnership Program. Different models exist in Texas and Arizona, and other approaches are currently being developed elsewhere.

Conclusion:

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.

Appropriately designed SNP benefits and health delivery structures could improve the health and quality of life of SNP enrollees *and* have a stabilizing effect on public program costs. To date, however, very few SNPs have formally contracted with their state Medicaid programs to offer coordinated benefits to their enrollees. Without a joint federal/state effort, SNPs will 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 represent most of the nation's health care expenditures.

An Important Final Word:

While a number of SNPs have already demonstrated the ability to provide high-quality coordinated care to their members, there are no federal regulations to date that specify minimum standards with respect to what SNPs must do or how they must function to address their enrollees' special needs. CMS has not yet 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 a SNP application. Furthermore, CMS has not yet developed a set of standard quality measures tailored to the SNP target populations. Efforts to integrate Medicare and Medicaid benefits will be wasted unless CMS establishes strict quality standards along with strong regulatory oversight and enforcement capability, to ensure that SNPs provide meaningful, appropriate care coordination.

¹⁰ *Integrating Medicare and Medicaid Services Through Managed Care*, Congressional Research Service, RL33495, October 20, 2006.