

Medicare Advantage SNPs: A New Opportunity for Integrated Care?

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OVERVIEW — *Medicare Advantage special needs plans (SNPs) are a new type of coordinated care plan established by the Medicare Prescription Drug, Improvement and Modernization Act. SNPs were created to encourage greater access to Medicare managed care for certain special needs populations: the institutionalized, persons dually eligible for Medicare and Medicaid, and the chronically ill. Some view SNPs as a new opportunity to integrate acute and long-term care services as well as Medicare and Medicaid financing. Others, however, question the degree to which full integration will become a widespread reality. This issue brief examines the SNP option and the promises and challenges it presents for better coordinated care.*

Medicare Advantage SNPs: A New Opportunity for Integrated Care?

Specialized Medicare Advantage (MA) plans for special needs individuals—known as special needs plans (SNPs)—are a new type of managed care plan established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Congress included the statutory provision authorizing SNPs as part of its effort to increase both plan and beneficiary participation in Medicare managed care. Created to encourage more opportunities for special needs individuals to access managed care, the SNP option allows MA plans to specialize in care for beneficiaries who are residing in long-term care facilities, dually eligible for Medicare and Medicaid, or chronically ill. With the SNP designation, plans may limit enrollment to one of the special needs populations, tailoring benefits and provider networks to best meet the needs of these vulnerable groups.

In addition to expanding Medicare managed care choices for special needs individuals, some view SNPs as a new opportunity to integrate Medicare and Medicaid. Coordination of acute and long-term care services through managed care for high-cost, high-need populations—particularly dual eligibles (low-income Medicare beneficiaries also eligible for Medicaid)—has been an interest of state and federal policymakers for many years. Federal and state experiments to deliver a continuum of acute and long-term care services under a capitated payment structure date back to the 1970s. Since then, congressionally authorized demonstration programs and state waiver demonstrations have explored a variety of managed care and fee-for-service (FFS) approaches to coordinating and even integrating Medicare and Medicaid financing, case management, and service delivery. In this context, SNPs may be viewed as another step toward integration because they encourage access to managed care for special needs individuals without the requirement for a Medicaid waiver or a demonstration from Medicare.

However, many believe the opportunity for integrated acute and long-term care services will not become a widespread reality. SNPs are, first and foremost, Medicare Advantage plans, subject to the same rules and requirements as other MA plans, including a new risk-adjusted payment methodology that was included in the MMA. SNPs are not required to have contracts with state Medicaid programs; they can focus on the delivery of Medicare services and rely on fee-for-service Medicaid to “wrap around” their benefit package for dual eligible enrollees. In addition, not

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all states will be interested in working with SNPs. A state's interest in coordinating and contracting with SNPs will likely depend on its previous experience with managed care, particularly for elderly and disabled populations. Finally, full integration of the two programs will require that SNPs interested in serving dual eligibles be willing and able to meet the inconsistent Medicare and Medicaid requirements regarding marketing, enrollment, operations, reimbursement, and quality assurance. These operational challenges are likely to keep some SNPs from pursuing participation in both programs.

Interest in SNPs is high. In 2006, 276 SNPs will serve Medicare beneficiaries, and the majority of approved plans will serve dual eligible beneficiaries. Some are Medicaid managed care plans seeking to enter the Medicare market. In many respects these plans, with their state contracts and experience serving special needs individuals such as dual eligibles, represent the "ideal" SNP. However, many approved SNPs do not have contracts with state Medicaid agencies and are new to serving special needs individuals. Although it is clear that the new SNP option will generate different models for treating special needs individuals, it is not known whether fully integrated care will result.

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To better understand this new opportunity under Medicare managed care, this issue brief explores the new SNP option and the promises and challenges policymakers face in their efforts to coordinate Medicare and Medicaid services. It also examines the financial incentives that are driving the SNP market.

SNAPSHOT OF DUAL ELIGIBLES

Although the Medicare program serves an important purpose in providing health insurance coverage, it was not designed as a comprehensive benefit and therefore does not meet the full range of health needs of the nation's elderly and disabled populations. Medicare covers hospital care and skilled nursing facility care, but the benefits are time-limited. The program also covers physician visits, hospice care, home health care, diagnostic tests, durable medical equipment, and some, but not all, primary and preventive care. Medicare will offer prescription drug coverage beginning in 2006. Beneficiaries are liable for premiums, deductibles, coinsurance, and copayments that can be quite substantial, especially for individuals with chronic or acute health care needs. As a result, many individuals who have lower incomes and/or high-cost medical needs eventually qualify to have Medicaid cover the costs of care that Medicare does not.¹ These individuals are known as "dual eligibles."

The vast majority of approved SNPs will serve dual eligibles. The approximately 7 million people who are dually eligible for Medicare and Medicaid have low incomes and are aged, blind, or disabled. Six million are considered to be "full benefit" dual eligibles, meaning they qualify

for full Medicaid benefits. Another 1 million individuals are considered “partial benefit” dual eligibles, as they receive assistance with Medicare cost sharing only. Partial benefit dual eligibles are enrolled through three Medicaid eligibility categories: qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), or qualifying individuals (QIs). These are also known as “Medicare Savings Program (MSP)” eligibility groups. The term “dual eligible” encompasses all of these individuals (Table 1).²

Dual eligibles may have complex and costly medical needs. Nursing home residents, many of whom are or become dually eligible, take on average more than six routine prescription drugs per day, and nearly 75 percent have cognitive impairments.³ Chronic conditions [for example congestive heart failure, chronic obstructive pulmonary disease (COPD), HIV/AIDS, and end-stage renal disease] account for 78 percent of the nation’s total medical care costs and almost 80 percent of Medicaid expenditures.⁴

Dual eligibles account for a small share of Medicare and Medicaid beneficiaries (14 percent of Medicaid beneficiaries and 17 percent of Medicare beneficiaries) but a much higher share of program spending (40 percent for Medicaid, 24 percent for Medicare).⁵ In comparison to the general Medicare population, dual eligibles have lower incomes, more chronic illnesses, and higher medical costs, and they are more likely to be in nursing facilities. Dual eligibles are three times more likely to be disabled than the nondual eligible population. One-third of all dual eligibles have difficulty completing three to six activities of daily living (for example, bathing, dressing, feeding). Almost one-quarter of dual eligibles

TABLE 1
Categories of Dual Eligibles

TYPE OF DUAL ELIGIBLE	ELIGIBILITY (Income Limit)	MEDICAID BENEFIT (What Medicaid Covers)
Full Benefit	Less than or equal to 73% FPL*	Full Medicaid benefits plus Medicare Part B premium and cost sharing
Qualified Medicare Beneficiary (QMB)	Up to 100% FPL	Medicare Part B premium and cost sharing
Specified Low-Income Medicare Beneficiary (SLMB)	Between 100% and 120% FPL	Medicare Part B premium only
Qualifying Individual (QI)	Between 120% and 135% FPL	Medicare Part B premium only

* States set their own Medicaid eligibility levels, usually at or below the supplemental security income (SSI) eligibility level of 73 percent of the federal poverty level (FPL). Some states have extended full Medicaid benefits to elderly and disabled beneficiaries with incomes up to 100 percent of the FPL (\$9,570 per year for an individual or \$12,830 per year for a couple in 2005).

reside in an institution, compared with 3 percent of nondual eligibles.⁶ Dual eligibles also are more likely to have multiple chronic conditions such as heart disease, diabetes, and mental and cognitive impairments.⁷

Dual eligibles cost Medicare 60 percent more than nondual eligibles (Table 2).⁸ Total annual spending across all payers for dual eligibles averaged about \$20,840 per person in 2001, more than twice the amount for other Medicare beneficiaries. Because their health needs vary, dual eligibles are not equally

costly. In 2001, the costliest 5 percent of dual eligibles accounted for over 40 percent of total Medicare spending for this population. The least costly 50 percent of dual eligible beneficiaries accounted for only 3 percent of Medicare spending on dual eligibles.⁹

State spending on dual eligibles varies widely and is driven by Medicaid benefit packages and the number and type of dual eligibles in the state's population. The number of dual eligibles varies across states due to different Medicaid eligibility criteria as well as demographics. For example, dual eligibles represent 7 percent of all Medicaid beneficiaries in Alaska and Idaho, compared with 25 percent in Kentucky.¹⁰ In Nevada, Medicaid spent approximately \$7,232

per dual eligible in 2002, whereas Medicaid spending per dual eligible beneficiary in Connecticut was approximately \$27,000.¹¹ Long-term care services account for the majority of state spending on dual eligibles (Figure 1, see next page).

TABLE 2
Comparison of Costs:
Nondual Eligibles versus
Dual Eligibles

Source	Nondual	Dual
Medicare	\$ 5,399	\$ 8,559
Medicaid	85*	8,603
Other	4,570	3,682
	▼	▼
TOTAL	\$ 10,054	\$ 20,844

Note: Total spending includes Medicare, Medicaid, and out-of-pocket spending in addition to spending from other sources of supplemental insurance and public programs (for example, the Department of Veterans Affairs, the Department of Defense).

** Some nonduals have Medicaid coverage for some portion of the year.*

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey, in MedPAC, New Approaches to Medicare, June 2004.

BARRIERS TO SUCCESSFUL CARE COORDINATION

Many will argue there is a systematic lack of coordination among primary, acute, and long-term care providers, in part because our health care system focuses on meeting specific service needs without addressing the interaction of acute and chronic needs. This lack of coordination can be particularly detrimental for the populations SNPs are designed to serve.

Compared with other Medicare beneficiaries, these individuals generally need more care among a broader range of providers in order to prevent the onset of disease or the progression of disabling conditions.

Case management is one approach to coordinating health services. However, a more comprehensive approach is for plans to integrate care and cover the full range of acute and long-term care services. The SNP option presents an opportunity for the managed care market to explore integrated care plans under Medicare. Furthermore, SNPs, if contracting with state Medicaid

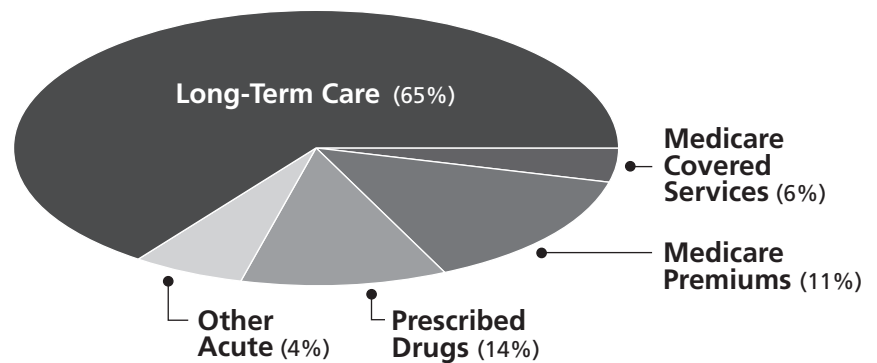
programs, may be able to address concerns about the inconsistencies between the two programs, which have created significant challenges for this particularly vulnerable population.

Inconsistent financing mechanisms, separate management structures, and somewhat different fundamental program objectives between Medicare and Medicaid can lead to fragmented care and a lack of accountability for health outcomes. Currently, dual eligibles may receive services from FFS or managed care in either program, and it is possible to be in FFS for one program and managed care for the other, or even be enrolled in two different managed care programs simultaneously. This fragmentation of delivery systems does not facilitate, and may even hinder, access to and coordination of care.

Because dual eligibles need a wider range of services, coordination and communication can be especially challenging. In certain instances, dual eligible beneficiaries may need to see different providers for certain program-specific benefits. For example, Medicaid covers a full range of mental health services that Medicare does not, which could result in an individual having to change providers when the Medicare benefit runs out. Beneficiaries face the challenge of working between two different benefit packages in order to attain the full range of needed services. Limited or no communication between providers is all too common. For example, primary care physicians or specialists are sometimes unaware when their patients are admitted to nursing facilities, and Medicaid home care case managers might not be informed when their clients are hospitalized.

Many believe that enrolling dual eligibles in managed care will improve care coordination and health outcomes, but experience to date has been limited. Most dual eligibles are enrolled in FFS options in both programs. Many states have utilized mandatory managed care for children and

FIGURE 1
State Spending on Dual Eligibles, 2002



Source: Jennifer Bryant, Lisa Chimento, Melissa Rowan, "Business Opportunities in the Medicare Modernization Act for Community Affiliated Health Plans," The Lewin Group, April 15, 2004.

families, but only a small number of elderly and disabled dual eligibles are enrolled in Medicaid managed care and most have enrolled voluntarily. Further, long-term care services are usually carved out of managed care options. Because Medicaid pays for services not covered by Medicare without any cost to the beneficiary, the incentive for dual eligibles to enroll in Medicare managed care plans is reduced. Currently, 18 percent of noninstitutionalized dual eligibles are enrolled in Medicare Advantage plans.¹² About 10 percent of dual eligibles are enrolled in Medicaid managed care, and this enrollment is concentrated in a handful of states.

Since the early 1970s, policymakers have been exploring ways to create incentives for managed care plans to integrate acute and long-term care services.

EFFORTS TOWARD INTEGRATED CARE

Since the early 1970s, policymakers have been exploring ways to create incentives for managed care plans to integrate acute and long-term care services, providing the full continuum of care. Assuming a per-beneficiary payment is an inherent incentive to provide the most appropriate care in the most cost-effective setting,¹³ a variety of state demonstrations with various degrees of acute care and long-term care coordination and Medicare-Medicaid integration have been implemented. In addition to cost savings, these demonstrations attempt to address the fragmentation in delivery systems, ensure access to primary and preventive care, improve accountability for health outcomes, provide incentives for the appropriate use of medical services, and reduce administrative differences between Medicare and Medicaid.¹⁴

The demonstrations vary with regard to specific populations served, the services provided, and the approach to care coordination and program integration. Early demonstrations under the Program of All-Inclusive Care for the Elderly (PACE) and Evercare Choice are provider-initiated programs.

■ **PACE** replicates the delivery system pioneered by On Lok SeniorHealth Services, an adult day care center that integrated health and social services in the San Francisco area. Initially authorized as a demonstration in 1986, PACE is now a permanent Medicare and Medicaid service delivery model that was specifically authorized in the Medicare and Medicaid statutes in the Balanced Budget Act of 1997. The primary goal of the PACE model is to help frail elderly individuals remain in the community through intensive care management. PACE enrollees are predominantly dual eligibles (96 percent), have seven to eight medical diagnoses, and exhibit some degree of dementia or other cognitive impairment. PACE sites resemble small, staff-model HMOs—with interdisciplinary teams that include physicians, nurses, social workers, case managers, physical therapists, and occupational therapists—designed with the goal of treating “the whole person.” Most PACE sites serve fewer than 200 enrollees, and PACE enrollees can only see PACE providers. There are currently 31 PACE sites operating in 18 states. PACE programs served more than 6,500 frail elderly in 2000.¹⁵

- **Evercare Choice** began in 1987 as a Medicare demonstration and builds on the PACE model, providing case management services for nursing home residents to reduce the need for hospital and emergency room care. Evercare assigns physicians and geriatric nurse practitioners to nursing home residents to provide coordinated primary care. Evaluations of Evercare show that quality of care and health outcomes have improved and hospitalizations have decreased. Evercare has since expanded its service delivery model to serve dual eligibles through community-based managed care plans. In fact, most current Evercare enrollees reside in the community. Evercare began operating as an institutional SNP in 2005.

Seeing opportunities to improve continuity of care, provide nontraditional benefits, and coordinate systems of care with interdisciplinary teams, states have attempted to expand the scope of the earlier demonstrations with their own state-specific waiver programs.¹⁶ Federal law requires states to seek waivers of certain Medicare and Medicaid requirements in their efforts to integrate care. Section 222(b) of the Social Security Act Amendments of 1972 provides authority for demonstrations that experiment with Medicare payment methodologies, and section 1115 of the Social Security Act authorizes demonstrations for Medicaid program innovations. Federal policy requires that demonstrations be budget neutral, meaning that the expenditures under the waiver must be no higher than they would be without the waiver. States also seek waivers of section 1915 of the Social Security Act for certain Medicaid managed care acute and long-term care integration programs. Waivers of section 1915(b) permit states to mandate enrollment in managed care settings, whereas waivers of section 1915(c) permit states to place beneficiaries needing the institutional level of care in home and community-based care settings. In some instances, states have pursued combination 1915(b) and (c) waivers to coordinate home and community-based care under capitated payment arrangements.

- **Minnesota Senior Health Options (MSHO)** integrates acute and long-term care services and Medicare and Medicaid financing in a managed care setting. Using section 1115 and section 222 waiver authority, MSHO enrolls the full range of dual eligibles, including those who are healthy, institutionalized, or frail but living in the community.¹⁷ Minnesota is the only state to have such a program, in part because it limits a Medicare beneficiary's choice of providers, an extremely controversial feature. Its sister program, Minnesota Disability Health Options (MnDHO) provides managed care services to individuals with disabilities. MSHO and MnDHO integrate Medicare and Medicaid financing and service delivery. Enrollees are assigned a care coordinator who is involved in all aspects of their care from scheduling primary care visits to arranging home and community-based care. MSHO is converting to a SNP.

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- **Texas STAR+PLUS** is a Medicaid waiver program that provides acute and long-term care services on a capitated basis. Program officials originally planned on a fully integrated mandatory program that included Medicare services and providers but learned that the Centers for Medicare & Medicaid Services (CMS) would not grant a combined Medicaid-Medicare waiver for an integrated care program. As a result, the program integrates Medicaid services only, through 1915(b) and 1915(c) waivers. Enrollees have the choice of three managed care organizations, including one that provides both Medicare and Medicaid benefits. Enrollees choosing the same plan for Medicaid and Medicare services receive an enhanced prescription drug benefit. Texas STAR+PLUS is also converting to a SNP.
- **The Wisconsin Partnership Program** operates under Medicaid section 1115 and Medicare section 222 waiver authority, combining benefits of both under one program. Through community providers, the program serves elderly individuals who require a nursing home level of care. The demonstration also includes a comprehensive managed care plan for individuals aged 18 to 65 with physical disabilities at risk of nursing home placement who are covered by Medicaid only or are dual eligibles.

The SNP option may be the logical next step toward integrated acute and long-term care services in managed care settings.

Many states find the complexity of planning and implementing a demonstration and the extended times for the federal review process to be too great. Some states, like Texas, end up curtailing efforts for Medicare-Medicaid integration and focus instead on the integration of acute and long-term care services under Medicaid. In addition federal rules require the renewal of existing demonstrations, such as Evercare, every two years. These and other factors led to a lobbying effort for a permanent option under Medicare to create and market plans designed specifically to facilitate serving special needs individuals.

ANOTHER STEP TOWARD INTEGRATED CARE?

With the current integrated care demonstrations serving as prototypes, the SNP option may be the logical next step toward integrated acute and long-term care services in managed care settings. CMS comments in the final regulations governing SNPs that the plans are “primarily intended to encourage more choices for certain populations by allowing organizations that specialize in the treatment of beneficiaries with particular needs to have Medicare Advantage (MA) contracts.” CMS further states that this provision could “encourage organizations to develop new products in the marketplace by giving them the opportunity to develop expertise in efficiently serving special needs populations.”¹⁸ Actual integration of care, however, will depend on the SNP’s choice of service delivery approach, states’ willingness to work with SNPs, and the effectiveness of marketing efforts in generating beneficiary interest. The ideal service

delivery approach is a “dually capitated” managed care plan that would receive payments from both Medicare and Medicaid. However, the more likely scenario will be that Medicare managed care plans will focus their efforts on delivering Medicare services and rely on Medicaid fee-for-service to provide wraparound benefits.

SNP Authority and Regulations

Section 231 of MMA (P.L. 108-173) authorizes “specialized MA plans for special needs individuals” defined as “MA plans that exclusively serve special needs individuals.” The law briefly defines a special needs individual as an “MA eligible individual who is institutionalized (as defined by the Secretary); is entitled to medical assistance under XIX; or meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan...for individuals with severe or disabling chronic conditions.”¹⁹ Other provisions in the law include a sunset provision of January 1, 2009 for SNPs [section 231(c)] and a mandated report to Congress that “assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees” by December 31, 2007 [section 231(e)]. The SNP provisions were effective on the date of enactment of the MMA.

The final regulations (codified in the Code of Federal Regulations, part 42, section 422) and additional operational guidance from CMS provide more details regarding the SNP target populations.

- **“Institutionalized”** is defined in section 422.2 as “an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long-term care facility which is a skilled nursing facility (SNF), nursing facility (NF), SNF/NF, an intermediate care facility for the mentally retarded (ICF/MR), or an inpatient psychiatric facility.” CMS further states in its final regulation that it will “consider as institutionalized those individuals living in the community but requiring a level-of-care equivalent to that of those individuals in the aforementioned long-term care facilities.”
- **“Severe or disabling chronic condition beneficiaries”** are not defined in the regulation. CMS was concerned that a detailed definition would limit the availability of SNPs and wanted to provide as much flexibility as the law allowed for this new untested type of MA plan. Section 422.2 states that CMS will review and evaluate proposals for specialized MA plans that serve severe or disabling chronic conditions “on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against ‘sicker’ members of the target population.” Single or multiple health criteria can be used to define enrollment.

Proposals to serve subsets of SNP populations will be considered by CMS. In its guidance, CMS states that it will “consider requests for SNPs that serve certain subsets of dual eligibles and institutionalized individuals based on common characteristics such as a specific network of facilities and Medicaid eligibility (e.g., full benefit duals only) on a case-by-case basis.” It is important to note that SNPs cannot serve QMBs or SLMBs exclusively. This provision is designed to keep plans from “cherry picking” these healthier segments of the dual eligible population.

CMS guidance states that managed care organizations with existing MA plans that serve defined special needs individuals may apply to have their plan “redesignated” as an MA SNP. Organizations that do not have an MA contract (for example, a Medicaid managed care plan) and want to offer an MA SNP must first apply for an MA contract and meet the requirements of an MA plan before they can receive the SNP designation.

The rest of the regulatory requirements regarding SNP operations are not unique to SNPs because SNPs are MA plans. SNPs are subject to the same rules and requirements, such as enrollment, quality criteria, marketing, and payment methodology, as all other MA plans.

The Plan Perspective

SNP application activity has exceeded expectations; 125 plans were approved for operation in 2005. These are predominantly managed care plans that already have MA contracts with CMS. An additional 151 new SNPs have been approved for 2006, bringing the total number of SNPs serving Medicare beneficiaries in 2006 to 276. The 2006 plans include Medicaid managed care plans looking to become MA SNP plans.

Not surprisingly, over 80 percent of SNPs—226 of the 276 approved plans—will serve the dual eligible population (thus called “dual eligible SNPs”). CMS has approved 37 institutional SNPs, and 13 plans will serve beneficiaries with chronic conditions.²⁰ A number of approved plans are already serving SNP target populations, but many others will be new to providing services to these groups.

One of the driving forces behind managed care organizations’ interest in SNPs were the new risk-adjusted payment formula for MA plans. Low payment rates was one of the main reasons cited for plans leaving or never participating in Medicare+Choice (the predecessor to Medicare Advantage) in the late 1990s and early 2000s. To generate plan interest in Medicare managed care, the MMA included several changes to payment rates for plans, including immediate payment increases for 2004 and 2005. Further, payments will be adjusted for the expected costs of the enrollees, based on their health status rather than demographic factors, as was the

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case previously. In 2006, 75 percent of the payment will be adjusted by health status, the rest by demographic factors. By 2007, the payment will be entirely adjusted by health status.

This risk-adjustment formula translates into higher payments on behalf of enrollees with the most costly health conditions. The formula will also include additional payments—8 percent for dual eligibles, 8 percent for long-term institutionalized elderly, and 21 percent for long-term institutionalized disabled—as part of the risk-adjusted MA payment rate for Medicare beneficiaries.²¹ Concerns have been raised that this formula may lead to overpayment for plans with relatively healthy dual eligible enrollees.

CMS pays MA plans the additional 8 percent for all dual eligibles, regardless of whether they are full benefit duals with incomes below the federal poverty level or partial benefit dual eligibles—QMBs, SLMBs, or QIs—with higher incomes. These MSP enrollees are generally healthier and less costly than full benefit dual eligibles. Therefore, plans enrolling larger numbers of MSP beneficiaries may enjoy greater financial gains. In fact, marketplace analysts say that this enrollment strategy is the key to the bottom line of SNPs. According to the Gorman Health Group, QMB, SLMB, and full benefit dual beneficiaries are historically associated with 10 percent higher costs than the average Medicare beneficiary but result in 25 to 35 percent higher payments to plans. They also assert that the financial benefits of enrolling this population will continue to improve as risk adjustment is fully implemented.²²

Many more Medicare beneficiaries are eligible for some form of Medicaid assistance than are currently enrolled. The Medicare Payment Advisory Commission (MedPAC) reports that, of those who are eligible, only 16 percent of SLMBs and between 55 and 75 percent of QMBs are enrolled.²³ Starting in 2006, states will be required to screen Medicare beneficiaries for participation in MSPs during eligibility screening for subsidies related to the Medicare drug benefit. CMS anticipates that another 13 percent of Medicare beneficiaries are eligible for MSPs but are not enrolled. The agency has predicted that screening efforts could result in enrollment of millions of additional partial benefit dual eligibles. Given the financial incentive, SNPs are likely to design marketing efforts to encourage enrollment of this healthier segment of the dual eligible population.

The Beneficiary Perspective

Moving beneficiaries from traditional FFS Medicare into SNPs may be challenging. Medicare beneficiaries are motivated to join MA plans to reduce out-of-pocket costs, such as premiums and cost sharing, and to have access to supplemental benefits not covered by traditional Medicare. For example, many MA plans replace the 20 percent copayment rate for physician visits

SNPs enrolling larger numbers of MSP beneficiaries may enjoy greater financial gains.

under traditional Medicare with a flat \$10 copayment per visit, and they include coverage for services omitted from traditional Medicare, such as vision and dental services. Despite these incentives, however, only 13 percent of the overall Medicare population is enrolled in managed care.

The incentive for dual eligible beneficiaries to join MA plans is not as strong as for other beneficiaries and varies by type of eligibility. Medicaid pays Medicare premiums and cost sharing for dual eligibles and also provides wraparound coverage for services Medicare does not cover, such as prescription drugs, long-term care, vision, and dental services. So the dual eligible beneficiary does not currently stand to gain a great deal from joining an MA plan unless the plan can offer the beneficiary something he or she currently is not getting under the two separate programs. In addition, many seniors have a generally negative impression of managed care, in part because of the perception that they will have to change doctors and go to new locations to access their care.

Medicare managed care enrollment of dual eligibles varies by category (Table 3). In 2005, only 14.5 percent of full benefit dual eligibles enrolled in an MA plan, but nearly one in every four SLMB eligibles²⁴ selected an MA plan. Like full benefit dual eligibles, SLMBs have the Medicare Part B premium paid by Medicaid; however, unlike full benefit dual eligibles, SLMBs must pay Medicare copayments, deductibles, and coinsurance out of pocket. Research has shown the level of MA plan payment affects enrollment of dual eligibles, with higher MA payment rates leading to higher enrollment among low-income Medicare beneficiaries.²⁵ MA plans receiving higher payments are more likely to offer supplemental benefits and reduce cost-sharing and/or premium requirements, making those plans more desirable and more affordable to beneficiaries than FFS Medicare. Analysts have estimated that a \$10 increase in MA payment reduces the probability that a dually eligible individual will remain in Medicare FFS by 11 percent.²⁶

The State Perspective

Medicare SNPs can create opportunities for states that wish to enhance and better coordinate care. A variety of factors, most importantly state experience with managed care for the elderly and disabled, will affect states' decisions whether to work with SNPs.

SNPs interested in coordinating with Medicaid programs provide states an opportunity to make managed care more attractive to dual eligibles. States have fewer dual eligibles in managed care than other populations: only 10 percent of the dual eligibles were enrolled in Medicaid managed care in 2002,²⁷ compared to nearly 60 percent of the overall Medicaid population.²⁸ Obstacles to implementing managed care programs for dual eligible populations include the inability to manage the Medicare portion of the benefit and concerns about the ability to limit Medicare beneficiaries'

TABLE 3
Medicare Advantage Enrollment of Dual Eligibles,* by Type of Eligibility

TYPE OF DUAL ELIGIBLE	PERCENT ENROLLED
Full Benefit	14.5%
QMBs	15.8%
SLMBs	23.8%

* Includes only noninstitutionalized, age-eligible beneficiaries.

Source: 2001 MCBS Cost and Use File updated with 2005 enrollment figures, as cited in Adam Atherly and Kenneth Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Emory University, September 20, 2005, 7.

freedom of choice of providers. Through SNPs and their networks of providers, issues of fragmentation, chronic care management for frail populations, and capitated payments for long-term care services can be addressed. Working with dual eligible SNPs might also help states avoid “pay and chase” situations in which beneficiaries use Medicaid cards instead of their Medicare identifications when receiving services, forcing states to pay the provider and then seek reimbursement from Medicare.

Limited contracts with SNPs for certain services will be of interest to some states. For example, states may contract with SNPs for care coordination after hospitalization or to wrap around the Medicare prescription drug benefit and gather drug utilization data. States often cite the need for drug utilization data as important to their ability to coordinate care.

Institutional SNPs may be viewed by states as an opportunity to explore capitated long-term care arrangements. Because state Medicaid programs have significant long-term care expenses, they may have a compelling interest in managing the nursing facility costs for dual eligibles (see Figure 1). Institutional SNPs could help states manage such expenses by specializing in, for example, PACE-type models. On the other hand, long-term care services are currently carved out of most Medicaid managed care programs. States, therefore, may not be interested in pursuing such arrangements with institutional SNPs.

Current Medicaid managed care plans face fewer start-up challenges than others now applying for MA contracts, and they may need to participate in the SNP market in order to hold on to their share of dual eligible enrollees. In fact, such plans may even have a marketing advantage. CMS is allowing a one-time option for dual eligible SNPs that have a current Medicaid managed care contract to passively enroll their current Medicaid plan members, who have previously been in Medicare FFS, into the MA SNP. (The beneficiary will have an opportunity to opt out of being enrolled in the SNP.) Only dual eligible SNPs can passively enroll Medicaid managed care beneficiaries, and SNPs cannot passively enroll individuals who are already enrolled in another MA plan. On October 1, 2005, beneficiaries received notice about passive enrollment and had until October 31, 2005 to opt out of the process. SNPs must notify passive enrollees of their SNP enrollment by November 30, 2005.²⁹

As noted earlier, state Medicaid programs have entirely different requirements for managed care plans. Some of these differences are due to federal or state statutory and regulatory requirements. Others are based on long-time state practices or administrative arrangements. For those and other reasons, there will need to be a significant commitment of state staff and other resources if SNPs are to contract to deliver Medicaid services along with the Medicare services.

Medicaid managed care plans may need to enter the SNP market in order to hold on to their share of dual eligible enrollees.

Coordination between MA SNPs and states is viewed by many as critical for the success of SNPs as integrated care plans. CMS stresses coordination with state Medicaid programs in their MA SNP guidance and regulations, but CMS cannot mandate this relationship. It is likely that state interest in coordinating with SNPs will vary and will depend on a number of factors, particularly the level of existing managed care activity within the state. At this point, dual eligible enrollment in Medicaid managed care is concentrated in a fraction of the states. About 80 percent of dual eligible enrollment is concentrated in ten states.³⁰ Also, over 90 percent of Medicaid managed care dual eligibles are enrolled in plans that serve other populations. Only a handful of Medicare managed care programs exclusively serve certain segments of the Medicaid population, such as beneficiaries eligible for nursing home care or supplemental security income (SSI).³¹ Tennessee, California, Oregon, and Arizona are among the states with large numbers of dual eligible managed care enrollees, and there is a great deal of interest in SNPs in these states, as well as in Florida and Massachusetts.

CMS stresses coordination with state Medicaid programs but cannot mandate it.

Provider “buy-in” is critical to making special needs plans work. Serving special needs populations such as chronically ill enrollees and dual eligibles is different from serving other Medicare beneficiaries or commercial populations, and plans cannot simply overlay the SNP population on a commercial provider network. Access to specialists and other specific providers will be needed in order to effectively meet the needs of these populations.

Managed care plans are not required to have contracts with states for payment of dual eligibles’ Medicare premiums and cost sharing in order to receive the SNP designation. States are not required to pay premiums on behalf of dual eligible enrollees who elect Medicare managed care. Furthermore, states have the option to pay cost sharing for dual eligibles based on Medicaid provider rates, which may be lower than Medicare rates. Therefore, SNP providers may not be able to collect the full cost sharing for dual eligibles. About one-third of state Medicaid programs currently do not pay the 20 percent Medicare Part B copayment on behalf of dual eligibles.³² This could affect SNP’s ability to develop an adequate provider network. Nonpayment of cost sharing can lower provider reimbursement, which may keep providers from joining a SNP network. However, some believe the higher risk-adjusted payment rates may allow plans to reimburse providers at a level that will compensate for this loss.

In the short run, establishing SNP contracts will not likely be a priority for many states. The MMA implementation process has generated many immediate and high-priority demands on states, including managing new eligibility processes for the Medicare drug benefit, recalculating managed care and provider rates to remove prescription drug costs, and assessing state “clawback” requirements.³³ However, some argue there are too many “win scenarios” for states to ignore SNPs for long.

SNP CHALLENGES

Medicare SNPs face a variety of challenges and uncertainties. First, there are a significant number of operational issues. Managed care plans seeking to become dually capitated SNPs may face conflicting and duplicative administrative requirements under Medicare managed care and state and federal Medicaid managed care rules and regulations. Not all Medicaid managed care plans, for example, are licensed by the state to be risk-bearing entities. In order to be a SNP, plans must meet Medicare reserve and solvency requirements and be licensed by the state to be a risk-bearing entity. Conflicts regarding enrollment, member materials, state licensure, quality assurance provisions, marketing, solvency and reserve requirements, and appeals processes can potentially lead to inefficient administration for plans and states and confusion for beneficiaries. In addition to meeting different requirements for each program, there may be requirements specific to SNPs. For example, SNPs serving dual eligibles are required to meet the same quality and data reporting requirements as other MA plans. CMS, however, is also exploring special quality measures for the institutional and chronic condition SNPs.³⁴

Although the new risk-adjusted payment formula (which includes the additional amounts for dual eligibles and institutionalized elderly and disabled) may provide financial gains to plans with healthier enrollees such as MSP beneficiaries, the payments may not be sufficient for SNPs with high numbers of frail and disabled enrollees without “frailty adjusters.” According to the General Accounting Office (now called the Government Accountability Office), “research has shown that while diagnosis-based risk adjusters improve the overall accuracy of Medicare payments to health plans, they tend to underestimate the cost for plans concentrating on frail beneficiaries.”³⁵ CMS stated in its guidance for 2006 that frailty adjusters will only apply to PACE programs and certain other demonstrations. CMS is continuing to conduct analyses to determine the feasibility of implementing a frailty adjuster for the MA program. The earliest this would occur is 2007. Competing with other MA plans may be difficult. In order to be competitive, SNPs must be able to offer low-cost plans. It is not yet clear whether SNPs that have only special needs enrollees can be financially viable.

CONCLUSION

While some plans and states are jumping on the SNP bandwagon immediately, others are taking a “wait and see” approach. For states with dual eligible managed care programs and/or demonstrations, SNPs provide new opportunities to better coordinate—even integrate—care in a way that is logical and relatively easy to implement. For others, observing how some of the risks and uncertainties play out before deciding whether to participate in this new market niche may be wise.

Although integrating acute and long-term care services and Medicare and Medicaid financing may be viewed as an ideal objective of SNPs,

there are no guarantees. Regardless of how the SNP market evolves, it is clear that policymakers are committed to the concept of providing managed care to the frail elderly and disabled and that they support moving more Medicare beneficiaries into managed care arrangements over time. The creation of a permanent option for managed care plans to specialize in care for high-need, high-cost populations is a significant step. It is a step toward a delivery system that, under ideal circumstances, can allow the provision of appropriate, cost-effective services along the continuum of care regardless of payer.

ENDNOTES

1. For more information on Medicare and Medicaid coverage see the Kaiser Family Foundation Web site (www.kff.org), or see The Basics: Medicare (www.nhpf.org/pdfs_basics/Basics_Medicare) and The Basics: Medicaid (www.nhpf.org/pdfs_basics/Basics_Medicaid).
2. For more information on dual eligibles, see Jennifer Ryan and Nora Super, "Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?" National Health Policy Forum, Issue Brief 794, September 30, 2003; available at www.nhpf.org/pdfs_ib/IB794_Duals_9-30-03.pdf.
3. Vicki Gottlich, "Issues for Medicare Beneficiaries in Long-Term Care Settings: An Analysis of MMA and Proposed Regulations," Henry J. Kaiser Family Foundation, September 2004, 1; available at www.kff.org/medicare/7161.cfm.
4. Center for Best Practices, "Disease Management: The New Tool for Cost Containment and Quality Care," National Governors Association, Issue Brief, February 2003, 2; available at www.nga.org/cda/files/031403DISEASEMGMT.pdf.
5. Medicare Payment Advisory Commission (MedPAC), *New Approaches in Medicare*, June 2004, 71; available at www.medpac.gov/publications/congressional_reports/June04_Entire_Report.pdf.
6. MedPAC, *New Approaches in Medicare*, 75.
7. M. Booth *et al.*, "Integration of Acute and Long-Term Care for Dually Eligible Beneficiaries through Managed Care," University of Maryland, Center on Aging, August 1997.
8. MedPAC, *New Approaches in Medicare*.
9. MedPAC, *New Approaches in Medicare*.
10. Jennifer Bryant, Lisa Chimento, Melissa Rowan, "Business Opportunities in the Medicare Modernization Act for Community Affiliated Health Plans," The Lewin Group, April 15, 2004, 13.
11. Bryant, Chimento, and Rowan, "Business Opportunities." Figures reflect total federal and state Medicaid spending.
12. Adam Atherly and Kenneth Thorpe, "Value of Medicare Advantage to Low-Income and Minority Medicare Beneficiaries," Emory University, September 20, 2005, 7.
13. General Accounting Office (GAO), *Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*, GAO/HEHS-00-94, August 2000, 9; available at www.gao.gov/cgi-bin/getrpt?GAO/HEHS-00-94.
14. GAO, *Medicare and Medicaid*.
15. National PACE Association, "PACE Profile"; available at www.npaonline.org/website/article.asp?id=66.
16. GAO, *Medicare and Medicaid*, 3.

Endnotes / continued ►

Endnotes / continued

17. The state has since switched from a section 1115 waiver to 1915(b) and 1915(c) combination waivers.
18. Code of Federal Regulations, “Eligibility to elect an MA plan for special needs individuals,” title 42, section 422.52.
19. The MMA establishes several new chronic care improvement programs and demonstration programs, including a large-scale pilot program targeting FFS beneficiaries. For more information, see Nora Super, “Medicare’s Chronic Care Improvement Pilot Program: What is Its Potential?” National Health Policy Forum, Issue Brief 797, May 10, 2004; available at www.nhpf.org/pdfs_ib/IB797_ChronicCare.pdf.
20. Centers for Medicare & Medicaid Services (CMS), “Special Needs Plans Fact Sheet & Data Summary,” updated November 9, 2005; available at www.cms.hhs.gov/healthplans/specialneedsplans/2006specialneedsplanreport11092005.pdf.
21. CMS, Medicare Advantage Ratebook; available at www.cms.gov/healthplans/rates/default.asp.
22. John Gorman, “Building Alliances with Part D Sponsors to Maximize MSP Enrollment,” Power Point Presentation at “Improving Access to Health Care in a Changing Landscape: Facilitating Enrollment in Medicare Savings Programs and Medicare Part D,” State Solutions Spring Summit, May 12, 2005; available at [www.statesolutions.rutgers.edu/Springsummit05/GORMAN State Solutions MSP Enrollment%2005-12-05.ppt](http://www.statesolutions.rutgers.edu/Springsummit05/GORMAN%20State%20Solutions%20MSP%20Enrollment%2005-12-05.ppt).
23. Bryant, Chimento, and Rowan, “Business Opportunities,” 11.
24. The Thorpe study counted all individuals who were *income eligible* as SLMBs, not necessarily those who were *enrolled*.
25. Atherly and Thorpe “Value of Medicare Advantage.”
26. A. Atherly and B. Dowd, “The Effect of Medicare Advantage Payments on Dually Eligible Medicare Beneficiaries,” Health Care Financing Review, Spring 2005, 26; available at www.cms.hhs.gov/review/05spring/05springpg93.pdf.
27. Bryant, Chimento, and Rowan, “Business Opportunities,” 14.
28. Most states include Primary Care Case Management Programs (PCCMs) in their definition of managed care.
29. Dual eligibles can disenroll from MA plans through a Special Election Period (SEP) that continues as long as they are dually eligible.
30. Bryant, Chimento, and Rowan, “Business Opportunities,” 14.
31. Bryant, Chimento, and Rowan, “Business Opportunities,” 15.
32. Atherly and Thorpe “Value of Medicare Advantage,” 6.
33. For more information on the Medicare Part D clawback provisions for states, see Lee Partridge, “A Report from the Forum Session: Implementing the Medicare Prescription Drug Benefit: Continuing Challenges for States,” National Health Policy Forum, Meeting Report, September 22, 2005; available at [www.nhpf.org/pdfs_other/MMA MtgRpt\(07-12-05\).pdf](http://www.nhpf.org/pdfs_other/MMA%20MtgRpt(07-12-05).pdf).
34. CMS Fact Sheet “Medicare Special Needs Plans” August 2, 2005 available at www.cms.hhs.gov/healthplans/specialneedsplans/factsheet8-02-05.pdf.
35. GAO, *Medicare and Medicaid*, 26.



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