THE EVOLVING SNP MARKETPLACE
AND THE ROLE OF STATES

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Conference on Medicare Advantage
Special Needs Plans

Baltimore, MD
September 18, 2007
Introduction and Overview

- Medicare Advantage Special Needs Plans (SNPs) represent a major opportunity to better integrate Medicare and Medicaid acute and long-term care for dual eligibles.

- SNPs face major challenges in enrolling dual eligibles – Over 90% are now in stand-alone prescription drug plans (PDPs).

- State interest in contracting with SNPs to cover Medicaid benefits for duals will likely depend on the state’s interest in providing Medicaid long-term care (LTC) benefits in managed care settings – Medicaid acute care benefits for duals are now very limited.
Special Needs Plans

- SNPs can specialize in serving nursing facility residents, dual eligibles, and others with severe or disabling chronic conditions (SSA, Sec. 1859(b)(6))
  - SNPs are Medicare plans and cover only Medicare services
  - Can contract with Medicaid to cover Medicaid services for duals

- Total number of SNPs in August 2007 – 478
  - Dual eligible – 321
  - Chronic or disabling condition – 73
  - Institutional – 84

- Up from 273 in July 2006
  - 226 dual eligible, 12 chronic, and 35 institutional
Special Needs Plans (Cont.)

- SNPs are Medicare Advantage (MA) managed care plans that also offer Part D prescription drug coverage (MA-PDs)

- Only 13% of SNPs are offered by parent organizations focusing exclusively on SNPs
  - Other 87% are offered by parent organizations that also offer regular MA plans

- Most SNPs (60%) exist alongside other MA plans offered by the same parent organization in the same service area
  - One choice in a menu of options

SNP Enrollment

• Total SNP enrollment (August 2007) – 989,112
  – Dual eligible plans – 709,665
  – Chronic or disabling condition plans – 135,903 (60,945 in PR)
  – Institutional plans – 143,443

• Up from 531,507 in July 2006
  – Major sources of 457,605 increase
    ♦ Rollover of existing membership into:
      • Five new SHMO institutional SNPs in CA and NY (107,366; 23% of total increase)
      • Four new Kaiser dual eligible SNPs in CA, CO, and GA (56,342; 12% of increase)

SNP Enrollment (Cont.)

- 84% of total August 2007 SNP enrollment was in 9 states and Puerto Rico
  - PR, CA, PA, NY, AZ, FL, TX, MN, TN, and AL

- Nearly 60 percent of total enrollment was in 10 companies

- Number of SNPs with fewer than:
  - 10 enrollees – 68
  - 100 enrollees – 138
  - 500 enrollees – 273

SOURCE: SNP Comprehensive Reports on CMS web site
About 200,000 of current SNP enrollment is in plans that “passively enrolled” beneficiaries from Medicaid managed care plans in 2005-2006
  – Most passive enrollment was in PA, AZ, MN, CA, TX, TN, OR, and KY
  – A one-time event; will not be repeated
SNP Enrollment Challenges

- As of January 2007, 6.3 million of 6.8 million full dual eligibles were in stand-alone prescription drug plans (PDPs) (CMS 1/30/07 report)
  - They obtain their other Medicare benefits through traditional fee-for-service (FFS) Medicare
  - About 500,000 were in MA-PD plans, mainly SNPs

- Most SNPs have few ways to identify duals and market to them

- Duals can change Part D plans at any time
  - But few seemed to have moved out of PDPs into MA-PD plans since July 2006
Options for Building SNP Enrollment

- Companies that own both SNPs and PDPs in the same geographic area have contact info for duals in their PDPs (e.g., United, Humana, WellCare)

- SNPs can work through physicians, clinics, community organizations, nursing facilities

- States can help SNPs identify duals and inform duals about integrated care options
  - “CMS encourages states to promote the benefits of enrollment into integrated managed care products for duals, while not directly marketing any one particular Medicare managed care plan.”
  
  July 19, 2006 CMS Marketing “How To” Guide
What Makes SNPs “Special”?

- Question Congress is now asking as they consider extension of SNP authority beyond 2008

- Dual eligible SNPs
  - If they are just one of an array of MA-PD options offered by an MA organization in a service area, what is special about them?

- Chronic condition SNPs
  - How are they different from disease management programs that are already part of most MA-PDs?

- Institutional SNPs
  - Are they doing anything to help nursing facilities reduce hospitalizations and improve Rx drug use?
SNP Applications for 2008

- CMS required SNPs to describe their “model of care”
  - Pertinent clinical expertise and staff structures
  - Types of benefits
  - Processes of care
  - How model will meet needs of:
    - Frail/disabled enrollees
    - Enrollees with multiple chronic illnesses
    - Enrollees at the end of life
  - CMS will review compliance in audits

- SNPs must also describe any contracts with states to provide Medicaid services to dual eligibles, and/or any plans to work with states to coordinate Medicare and Medicaid services
SNPs and States

- Dual eligible SNPs that offer only Medicare benefits may have difficulty demonstrating that they are adding value beyond what a standard Medicare managed care plan can offer.

- Partnering with states to cover Medicaid benefits is an opportunity for SNPS to add value for dual eligible beneficiaries and states.

- CMS July 27, 2006 Fact Sheet (“How To” Guides)
  - Improving Access to Integrated Care for Beneficiaries Who Are Dually Eligible for Medicare and Medicaid
    Counter=1912
SNPs and States (Cont.)

- MedPAC June 2007 Report to the Congress
  - “[W]e see that many SNPs are not taking advantage of the opportunity to better coordinate care for special needs beneficiaries. . . . [W]e do not see how dual-eligible SNPs that do not integrate Medicaid could fulfill the opportunity to coordinate the two programs.” (P. 71)
Why Would States Want to Contract With SNPs?

- Improve care coordination for dual eligibles
- Achieve administrative efficiencies
  - Fee-for-service Medicaid wrap-around coverage for duals
    (Medicare cost sharing, Rx drugs excluded from Part D, vision, dental, etc.) can be awkward and inefficient
    ♦ Up-front capitation may work better
- Reduce cost shifting from Medicare to Medicaid
- Save state money
  - If SNP covers vision, dental, hearing, etc. as supplemental benefits with “savings” from below-benchmark bids, may reduce cost of Medicaid coverage of those benefits for duals
- Move toward fuller integration
State Interest in Contracting With SNPs

- Center for Health Care Strategies (CHCS) December 2006 survey of states (37 respondents)
  - 12 had some kind of current relationship with SNPs
  - 9 more planned a relationship in 2007-2008
  - 13 more reported some interest

- Over 85% of August 2007 SNP enrollment (minus PR) was in 15 states that currently contract with SNPs and/or cover dual eligibles in comprehensive Medicaid managed care plans
Medicaid Managed LTC

- States offering or planning to offer managed LTC in Medicaid are best prospects for partnership with SNPs

- AZ, FL, MA, MN, NY, TX, WI currently have managed LTC programs
  - For details, see 11/05 AARP Issue Brief: http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf

- CHCS has made grants to five states to help them develop integrated care programs (FL, MN, NM, NY, and WA) and is working with others, including AZ, MA, and WI
  - For details, see http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=291739
What Medicaid Benefits Could Be Included in SNP Benefit Package?

- In order of increasing complexity and comprehensiveness
  - Medicare premiums and costs sharing
  - Rx drugs excluded from Part D
  - Acute care services not covered or only partially covered by Medicare
    - Vision, dental, hearing, transportation, DME, care coordination, behavioral health
  - Comprehensive care management and personal services
  - Medicaid LTC services not covered by Medicare
    - Nursing facility, home health, home- and community-based services (HCBS)

- For more detail, see October 2006 CHCS primer for states at:
  http://www.chcs.org/publications3960/publications_show.htm?doc_id=412536
Challenges for States and SNPs

- Working with conflicting Medicare and Medicaid managed care rules
  - Rate setting and financing
  - Marketing and enrollment
  - Complaints, grievances, and appeals
  - Monitoring and reporting

- Setting capitated rates for NF and HCBS services
  - Little experience in states or in Medicare
  - Important to give incentives for more use of HCBS
  - See forthcoming CHCS report by Kronick and LLanos

- Serving beneficiaries in NFs and HCBS settings
  - Most managed care plans have little experience

- For more detail, see January 2007 report to CMS on SNPs, states, and LTC at:
Conclusion

- Only a limited number of states are currently in a position to contract with SNPs for extensive coverage of Medicaid benefits.

- But states and dual eligible SNPs should begin to work together now to lay the groundwork for further integration in future years – A major way for SNPs to demonstrate they are “special”.

- CMS is making significant efforts to facilitate state and SNP steps toward integration.