SNPs AND STATES:
OVERCOMING THE CHALLENGES IN INTEGRATING MEDICARE AND MEDICAID BENEFITS

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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
  - A way for SNPs to show how they can be “special”

- SNPs face major challenges in enrolling dual eligibles
  - Over 80% 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
Moratorium on New SNPs for 2009

  - No new, expanded, or reconfigured SNPs for 2009
  - SNP authority extended for one year, to December 31, 2009
  - Only SNPs in operation on January 1, 2008 are available for beneficiary enrollment

- Monthly lists of 2008 SNPs and their enrollment are on the CMS web site at:
  http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage
  - No state identifiers on CMS list
  - Send e-mail to jverdier@mathematica-mpr.com for list with state identifiers

- For more background on SNPs, see Verdier, Gold, and Davis, “Do We Know if Medicare Advantage Special Needs Plans Are Special?”, January 2008
Special Needs Plans

- Total number of SNPs in April 2008 – 769
  - Dual eligible – 439
  - Chronic or disabling condition – 241
  - Institutional – 89

- Total SNP enrollment in April 2008 – 1,146,404
  - Dual eligible – 829,493
  - Chronic or disabling condition – 180,660
  - Institutional – 136,251

- Increase in number of plans between 12/07 and 1/08
  - Dual eligible – 120
  - Chronic or disabling condition – 168
  - Institutional – 5

SOURCE: SNP Comprehensive Reports on CMS web site
Growth in SNP Enrollment

- May 2007 – 906,857
  - Dual eligible – 670,499
- October 2007 – 1,050,635
  - Dual eligible – 737,125
- Annual election period – 11/15-12/31
- February 2008 – 1,118,061
  - Dual eligible – 804,167
- April 2008 – 1,146,404
  - Dual eligible – 829,493
Concentration of SNP Enrollment

- 82% of total SNP enrollment in April 2008 was in 10 states and PR
  - PR, CA, PA, NY, FL, TX, AZ, GA/SC, MN, and TN
  - Except for GA/SC, all these states have included dual eligibles in Medicaid managed care, now contract with SNPs, or both

- 65% of April 2008 enrollment was in 13 companies
  - Outside of companies in PR, largest enrollment is in United, SCAN, Care Improvement Plus, Kaiser, Managed Health, Inc., WellCare, HealthSpring, Keystone, and Humana
  - All these companies have experience in Medicare, Medicaid, or both
SNP Payment

- SNPs are paid the same way as other MA plans for enrollees with comparable conditions

- Relationship of MA payments to FFS expenditures in 2008 (excluding PR)
  - SNPs (excluding PR) 109%
  - HMOs 112%
  - Local PPOs 119%
  - Regional PPOs 112%
  - PFFS 117%

Low Enrollment in Many SNPs

- Out of 769 SNPs in April 2008:
  - 503 (65%) had fewer than 500 enrollees
  - 347 (45%) had fewer than 100
  - 201 (26%) had fewer than 11

- What will happen to these low-enrollment SNPs and their enrollees if enrollment does not increase?
  - Two-thirds of SNPs are part of larger MA plans, which may be able to offer other options to SNP enrollees
  - Many SNPs may also represent slightly different benefit packages, or different counties, or rural areas
    - Consolidation may not be difficult
SNP Enrollment Challenges

- As of January 2008, 5.3 million of 6.6 million full dual eligibles were in stand-alone prescription drug plans (PDPs) (CMS 1/31/08 report)
  - They obtain their other Medicare benefits through traditional fee-for-service (FFS) Medicare
  - About 1.3 million 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 seem to have moved out of PDPs into MA-PDs since they were auto-enrolled in PDPs in 2006
- Almost all enrollees in dual eligible SNPs are duals, and about half of those in chronic condition and institutional SNPs
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
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 is encouraging SNP contracting with states. See information on CMS “Integrated Care Initiative” at: http://www.cms.hhs.gov/IntegratedCareInt/
SNPs and States (Cont.)

- MedPAC March 2008 Report to the Congress, p. 267:
  - “Without a contract with states to cover Medicaid benefits, it is unclear how a dual-eligible SNP would differ from a regular MA plan.”
  - RECOMMENDATION: “The Congress should require special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.”

  "Indirect contracts could be appropriate if states limit the number of managed care plans they will contract with and SNPs work out contracts with plans that have existing state contracts but may not be SNPs.”
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
Prospects for SNP Contracting With States

- 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
  - Enrollment has grown from 68,000 in 2004 to almost 174,000 in 2008 (Saucier, NHPF, 4/25/2008)
  - 8 to 10 states currently working on new initiatives (Saucier)

- About 13 states currently contract with SNPs
  - AZ, CA, CO, ID, KY, MA, MN, NY, OR, TX, UT, WA, WI
  - Considerable variation in how comprehensive contracts are
  - Most states contract with only a limited number of SNPs
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 March 2008 CHCS report by Kronick and LLanos on Medicaid managed LTC rate setting at:
    http://www.chcs.org/usr_doc/Rate_Setting_for_Medicaid_MLTS.pdf
Challenges for States and SNPs (Cont.)

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

- For more detail on these issues, see January 2007 report to CMS by Saucier and Burwell at: http://www.cms.hhs.gov/PromisingPractices/Downloads/SNPFinalReport.pdf
  - “The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care”
SNP Applications for 2008

- CMS required each SNP type 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 also required to 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
State Access to 2008 and 2009 SNP Application Information

- While no new SNPs will be approved for 2009, all existing SNPs must demonstrate to CMS how they meet the model of care requirement
  - CMS 2009 Call Letter, pp. 29-37

- Although CMS cannot provide proprietary information from SNP applications to states, states can request SNPs interested in contracting with the state to provide this information to them
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 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.