



# **MEDICARE ADVANTAGE SPECIAL NEEDS PLANS: A BENEFICIARY PERSPECTIVE**

## **The Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania**

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The Medicare Advantage Special Needs Plan Experience:  
Beneficiary Perspective from Pennsylvania<sup>1</sup>

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## INTRODUCTION

Special Needs Plans (SNPs) were authorized by the Medicare Modernization Act of 2003 (MMA) as a means of permitting Medicare Advantage (MA) Plans to provide targeted care to special needs populations. The authorization was premised on the assumption that targeted care to specifically meet the populations' special needs would result in good health outcomes for the special needs individuals.

As Special Needs Individuals could, without question, benefit from supplemental benefits targeted to meet their care needs and from having their healthcare be coordinated and managed, the idea of a Special Needs Plan is certainly appealing. It does not appear that the Special Needs Plan option, however, was designed to ensure that such targeting of care is accomplished. Little is required to obtain approval to be a SNP<sup>2</sup> and no additional requirements above what are imposed

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<sup>1</sup> The Pennsylvania Health Law Project is a statewide legal services program that provides free information, assistance, and advocacy to lower income individuals, persons with disabilities, and seniors who are having trouble accessing healthcare coverage or services through publicly funded healthcare programs. PHLP staffs a statewide toll-free helpline which handles approximately 3500 calls from consumers, their caregivers, or their advocates each year. Through the helpline, PHLP has developed its understanding of the beneficiary experience with SNPs. Through efforts to resolve the beneficiary's problems, PHLP has developed its understanding of the flaws in the SNP program as it exists today.

<sup>2</sup> Very little is required for a plan to obtain CMS approval and become a Medicare SNP. A plan must (1) meet all the requirements for being a basic MA coordinated care plan; (2) be approved to provide

on Medicare Advantage plans generally are imposed once approved as a SNP. CMS has not yet promulgated any regulations delineating standards that MA plans must meet to be approved as SNPs or any requirements for approved SNPs to follow in meeting the special needs of their enrollees, despite the MMA requiring regulations to be promulgated on how SNP would work.<sup>3</sup>

While CMS and the insurance industry have broadly promoted, and some would say facilitated, the expansion of Medicare Advantage SNPs to all markets, Special Needs Plans are not wholly embraced by states or advocates. This is primarily because enrollees are not yet seeing care that is specially targeted to meet their needs. Some are having access problems as enrollees of SNPs.

The problems consumers have had with SNPs are not necessarily unique to enrollment in a SNP; some are equally likely to occur to a special needs enrollee in any kind of MA plan. Because Medicare Advantage Special Needs Plans have been given

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Medicare Part D prescription drug benefits to all enrollees; and (3) satisfy all SNP requirements specified by CMS. CTR. FOR MEDICARE & MEDICAID SERV., MEDICARE MANAGED CARE MANUAL, Ch. 1 § 20 (Sept. 2, 2005), <http://www.cms.hhs.gov/manuals/downloads/mc86c01.pdf> (last visited Mar. 20, 2007) [hereinafter MEDICARE MANAGED CARE MANUAL] (“Specialized MA Plans for Special Needs Individuals (special needs plans or SNPs) – An MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth at § 422.4(a)(1)(iv) of the MA regulation and that, beginning January 1, 2006, provides Part D benefits under 42 CFR part 423. A SNP is also an MA plan that has been designated by CMS as meeting the MA SNP requirements, as determined 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.”).

<sup>3</sup> P.L. 108-173, Title II, Subtitle C, § 223(b), 117 Stat. 2207, provides: “The Secretary shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. § 1395w-21 (2006)] to carry out the provisions of this Act [for full classification, consult U.S.C. Tables volumes].” The MMA requires regulations to implement the changes to the MA program. Section 223(b). “Issuance of Regulations.--The Secretary shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act to carry out the provisions of this Act.” *Id.* Further, the MMA explicitly requires the promulgation of regulations for SNPs. Section 231(f)(2). “No later than 1 year after the date of the enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [subsec. (b)(6)(B)(iii) of this section], as added by subsection (b).” While CMS has promulgated a handful of regulations that touch on eligibility and enrollment into SNPs, no regulations have been promulgated on what a SNP must do to be approved as such by CMS nor what it must do to meet the beneficiaries’ needs. 42 CFR § 422.2 (Definitions), § 422.4 (Types of MA Plans), § 422.50 (Eligibility to elect MA plan), § 422.52 (Eligibility to elect MA plan for special needs), § 422.74 (Disenrollment by the MA organization), § 422.254 (Submission of bids), § 423.279 (National average monthly bid amount), and § 423.855 (Definitions – *in section regarding Fall back plans*). Despite requirements and suggestions to the contrary – CMS has not promulgated any substantive operational rules on SNPs. A subregulatory document regarding initial requirements for SNPs from Spring of 2005 stated “. . . CMS intends to solicit comments on this provision of the MMA through rulemaking. Therefore, this interim guidance is subject to change in the future.” RENEWAL AND NONRENEWAL INSTRUCTIONS FOR CONTRACT YEAR 2005 (CALL LETTER) 8, <http://www.cms.hhs.gov/ACR/Downloads/CallLetter.pdf>.

special authorization to target special needs populations, to hold themselves out to the public as specially designated to meet special needs, however, they should be held to a heightened standard. There must be a higher duty of care imposed upon the specially designated SNPs if they are to obtain and retain such a designation.

Problems occur throughout the beneficiary's encounters with the SNP. Consumers have raised questions and concerns: from issues prior to or upon enrollment, to issues during coverage, to issues as they transition out of the SNP coverage. Issues range from those involving information about how the SNP works, to those involving enrollment and transition planning, to coverage issues, to provider and network adequacy issues.

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### **PENNSYLVANIA'S FIRST EXPOSURE TO SNPS**

Pennsylvania's dual eligibles have considerable experience dealing with Medicare Advantage SNPs and real concerns about them. In late 2005, CMS allowed six Medicare Advantage SNPs in Pennsylvania to "passively enroll" over 110,000 of the poorest and most chronically ill individuals out of the Original Medicare benefit they had chosen and into the Medicare Advantage SNPs. The plan was authorized in a subregulatory "call letter" or request for bids put out to Medicare Advantage plans for the 2006 contract year.<sup>4</sup>

Consumers, advocates, and consumer organizations protested the passive enrollment plan as unlawful and unfair, but CMS refused to dismantle it. In November 2005, a federal class action was filed, challenging the authority of CMS to authorize passive enrollment.<sup>5</sup> While the *Erb* complaint challenged the authority of and process by which CMS passively enrolled dual eligibles, the underlying merits of Medicare Advantage SNPs for dual eligibles were not litigated.<sup>6</sup>

Passive enrollment into SNPs with limited provider networks resulted in wholesale disruption in the enrollees' access to critically needed healthcare. The *Erb* settlement sought to remedy those immediate consequences.<sup>7</sup> Once the chaos of the

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<sup>4</sup> The Passive enrollment plan called for passively enrolling approximately 250,000 Special Needs Individuals in 14 states into selected Special Needs Plans. Over 120,000 of those in the initial passive enrollment pool were dual eligibles from Pennsylvania.

<sup>5</sup> The propriety of Passive Enrollment of Pennsylvania's dual eligibles was litigated in the Eastern District of Pennsylvania in the matter entitled *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005). *Erb v. McClellan* alleged violations of the MMA, the Medicare Act, the Administrative Procedure Act, and constitutional due process requirements.

<sup>6</sup> *See id.*

<sup>7</sup> The case settled in March 2006, resulting in additional notices sent to providers and enrollees, additional disenrollment mechanisms created, and an allowance that the passively-enrolled individuals be able to use the SNP as if it were fee-for-service Medicare (with no imposition of network restrictions, referral requirements, etc.) until the end of June 2006. Settlement Agreement at 1-7, *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

abrupt shift to managed care settled and consumers began actually attempting to obtain necessary healthcare coverage, the issues surrounding SNPs' design and function came to the surface. For dual eligibles, the most significant issue to arise is the capacity and commitment of SNPs to actually meet enrollees' needs.

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## PENNSYLVANIA'S ONGOING EXPERIENCE WITH SNPS

For the over 110,000 dual eligibles who were, in the end, passively enrolled into SNPs as well as those duals who have voluntarily enrolled into SNPs, the most critical issue continues to be the extent to which these SNPs, in fact, coordinate their care and benefits. The Special Needs Plans, even those plans expressly authorized to meet dual eligibles' special needs, are not obligated to take any specific steps to ease the enrollee into the plan, to ensure that her needs are being met while she is enrolled in the plan, or to do anything to facilitate a transition out of the plan. The result has been challenges in accessing necessary care that have not been lessened by the SNP "design." The problems and questions raised by consumers and advocates involve every level of interaction with the plan.

The following is a sampling of some of the key issue areas raised by consumers and advocates about SNPs. Illustrative examples are provided. In some instances, the problems are so prevalent, individual examples are too numerous. Suggestions on how things could be done differently are also included.

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## INFORMATION ISSUES

### *Issue 1: Special Needs Individuals are unfamiliar with Managed Care.*

New enrollees raise many questions and problems that demonstrate their lack of understanding of how managed care works and what their rights and responsibilities will be. These are individuals who have not historically had much experience with enrollment in managed care. Dual eligibles, for example, also trend on the side of lower literacy and, thus, it cannot be presumed that they will gain full understanding from the written materials sent to them.

*Example: Caller very confused about how the plan works, calling for explanation, clarification and assurance that everything will be okay.*

*Example: Consumer does not know who accepts his insurance. Says his knee is crushed and he needs to see someone-a specialist, though he is not sure who or how to find out what specialists he can see. Consumer says he received a provider directory but he was overwhelmed by that and does not read well.*

***Recommendation:*** Upon enrollment, new member should receive an outreach “welcome” call from the SNP that follows a basic outline of how the SNP’s managed care coverage works, how to get information, and how to get help if and when the new member has problems. The call should be a welcoming call that encourages the enrollee to feel comfortable making contact with the SNP for questions and problems.

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***Issue 2: Special Needs Individual not provided clear information on the network composition.***

Special Needs Individuals have complex healthcare needs, many of which have been ongoing for years prior to their SNP enrollment. Many do not know to or simply are not able to take any steps necessary to check with the plan as to whether their providers are in the plan’s network. For those who take steps to confirm that their providers will be in the plan’s network and that there should be no disruption in their ongoing treatment, accurate information as to the network composition is critical but often not provided.

*Example: Consumer with Cerebral Palsy is in the middle of an ongoing course of physical therapy treatment to prevent seizing up of muscles when joins a SNP. Consumer calls plan multiple times- prior to joining SNP- to confirm whether provider is in network. Enrollment takes effect and provider is not in the network.*

***Recommendation:*** As part of the “Welcome” call, the SNP staff should review the new enrollee’s list of providers to see which participate and to explain what transition plan or other options are available to the new enrollee.

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***Issue 3: Special Needs Individuals do not have practical information as to how to use the SNP benefit and how to use it in concert with other coverage.***

Even consumers who understand that enrollment into a SNP means that they are in a managed care plan and must go to the network providers are not always clear on how to use their coverage. This is especially the case for Special Needs Individuals who have multiple coverages. Thus, for example, a dual eligible consumer may not know what steps are necessary to ensure that Medicaid covers its portion of the cost.

*Example: A consumer goes to a SNP provider, showing her exclusively dual SNP ID card but not understanding that she also needs to show her Medicaid card. Consumer gets billed for her share of costs (balance billed) because Medicaid was not billed because of her failure to show the Medicaid card.*

*Example: Enrollee calls confused as to how the balance bill is submitted to Medicaid – does SNP do this? Does provider do this? Does enrollee?*

**Recommendation:** SNPs should:

1. Capture the Medicaid ID number or other insurance information for each enrollee;
2. produce distinct SNP ID cards that indicate that the person is a dual or has other insurance;
3. inform providers and provider staff of the meaning of the distinct SNP ID card; and
4. instruct providers to contact the SNP for any questions about the billing or about whether there is a secondary insurer.

As part of the “Welcome” call, the SNP staff should describe how the distinct SNP ID card works, explain the new enrollee’s obligation to show her distinct SNP ID card, remind the enrollee not to pay any bills that are sent to them but instead to contact the SNP if they get billed, and encourage the new enrollee to remind all providers of her secondary insurance.

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***Issue 4: Special Needs Individuals do not have a clear understanding of the actual costs and benefits of the SNP.***

Both before and after enrollment takes effect, the consumer is directed to the Summary of Benefits for explanation of the costs and benefits under the SNP. The uniform Summary of Benefits each plan must produce is not specifically designed to answer how Medicaid wraps around the Medicare benefit. The Summary of Benefits form is a standard template and specific information about the Medicaid coverage in the given state is not included or is incorrect.<sup>8</sup> This is true even for Summary of Benefits for exclusively dual eligible SNPs. Inaccurate information can lead consumers to misunderstand their benefits.

*Example: Consumer who wanted to join a SNP did not understand from the published Summary of Benefits that Medicaid would cover the many “costs” to the beneficiary listed on the SNP’s Summary of Benefits because these were listed as the member’s responsibility. Instead of joining the lower cost SNP, the dual eligible consumer with high utilization paid a higher premium to enroll in a non-SNP MA-PD that appeared to have lower co-payments per service.*

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<sup>8</sup> It is arguably more understandable that a disproportionately dual or institutional or chronic condition plan may need to present the benefit package as it applies to non-duals, but one can hardly imagine a justification for an exclusively dual SNP to not have to fully and accurately convey the benefits and obligations of enrollment.

*Example: SNP submitted Summary of Benefits to state Medicaid program for review of information about Medicaid coverage. Medicaid program sent back substantial revisions to the information. Plan declined to make the changes. State went to CMS. CMS Regional Office said they had no authority over the accuracy of the Medicaid information in the plans marketing materials.*

**Recommendation:** SNPs should be required to include in their SNP summary of benefits documents accurate information, as confirmed and approved by the State's Medicaid agency, describing Medicaid's coverage of services not covered by the SNP as well as Medicaid's coverage of the beneficiary's cost-sharing obligations within the SNP. An additional column should be added to the standard template to articulate how the stated costs differ if the individual has Medicaid. And, the template should be modified for exclusively dual SNPs to state the costs to the beneficiary as they are after Medicaid pays its portion.

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***Issue 5: SNP Enrollee does not get a "notice" of termination of benefits or changes to network composition.***

Whether because of low literacy or high stress with managing multiple health conditions or otherwise, special needs individuals do not always read or comprehend their annual notices of plan changes.

*Example: Consumer finds out after going to 6 month-long dental visit that her SNP coverage dropped the dental benefit that she had with them for prior years. Consumer reports that she had no notice of this plan change. Dental care is a Medicaid covered service that would have been fully covered by Medicaid if she had gone to a Medicaid participating dentist instead of the SNP Network dentist. Consumer would have gone to a Medicaid participating dentist if she had known. Now she has been billed for the care.*

**Recommendation:** SNP should be required to send bright colored, single paged written notices to consumers about benefit changes, ensure that providers are aware of benefit changes, hold consumers harmless who do not receive notice about benefit changes, and make outreach calls to individuals who have used providers that will no longer be in the network. Additionally, consumers should have arrangements with former providers for out-of-network payments where consumers erroneously see that provider.

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***Issue 6: SNP enrollee does not get notice of termination from SNP.***

Each SNP is supposed to have an established policy concerning termination of enrollment from a dual SNP after Medicaid eligibility ends. Enrollees sometimes do not

get written notice of the termination of Medicaid and are not always aware that termination of Medicaid coverage means ineligibility for the SNP. While the SNP is supposed to provide the enrollee with 30 days written notice of the SNP termination of coverage, many enrollees are not receiving these notices.

*Example: Many people with problems of not getting notice of termination of SNP enrollment.*

*Example: Notice of disenrollment not received. Went to a SNP provider and got billed. Consumer will owe balance and states that she would have sought out another MA-PD if she had known she was losing SNP coverage.*

**Recommendation:** SNP must send 30-day advance written notice of termination from SNP, as required in the SNP Guidance and hold consumer harmless if notice not sent.

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## **ENROLLMENT AND TRANSITION ISSUES**

### ***Issue 7: The Special Needs Individual has trouble demonstrating LIS eligibility for a SNP.***

As many SNP enrollees are dual eligibles, they qualify for the full low-income subsidy. The SNPs rely on the Part D low-income subsidy (LIS) data transferred from the Social Security Administration, through CMS to the SNP to confirm LIS eligibility. However, full dual eligible consumers, even some of those that were passively enrolled in a SNP, have had trouble getting the SNP to recognize their low-income subsidy eligibility. The data from SSA does not transfer that person is a full dual eligible and the consumer must persuade the SNP to treat them as a full dual.

*Example: Consumer was passively enrolled as a dual eligible into the plan. The SNP doesn't question her eligibility for the SNP, per se, but insists on charging her the higher Part D co-payments because the SNP has not received data regarding her LIS eligibility.*

**Recommendation:** SNPs for dual eligibles should be expected to treat anyone they have enrolled as full LIS eligible and to take affirmative steps to assure that Best Available Evidence is requested of the consumer and entered into their system until such time as the Medicare/SSA data transfers confirming their eligibility.

***Issue 8: SNP does not provide consumer with continuity of care upon new enrollment into a SNP.***

Many Special Needs Individuals are in the middle of a course of treatment or have a major surgery scheduled at the time their SNP enrollment takes effect. SNPs are not required to capture all their enrollees' ongoing care needs or treatments through any pre-enrollment screening mechanism and often are unaware of the enrollees' ongoing healthcare needs. There is no continuity of care requirement to guarantee that new enrollees' treatment plans are not unnecessarily disrupted by the enrollment.

*Example: At the time her enrollment takes effect, a consumer with Cerebral Palsy is in the middle of an ongoing course of 3-times a week physical therapy treatments to prevent seizing up of muscles. SNP is unaware of the course of treatment and consumer faces access problems upon enrollment.*

**Recommendation:** Continuity of care provisions must be spelled out so that consumers entering SNPs in the middle of a course of treatment can continue with that course of treatment and so that consumers leaving a SNP in the middle of a course of treatment know who is responsible for the remainder of the treatment.

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***Issue 9: SNP does not have transition plan to allow for new enrollee to have access to established providers who may not (yet or plan to) be in the network while enrollee transitions to new provider, persuades provider to join plan, or leaves plan.***

Not only are Special Needs Individuals often going to be in the middle of a course of treatment, but they are going to be well-invested in their relationship with their ongoing providers. A part of the *Erb* settlement agreement included a requirement that plans allow new enrollees to continue to see their non-participating providers for six months while the enrollee picks and establishes contact with a new provider, persuades the non-participating provider to join the plan, waits for the plan to process the provider's credentials, or decides to leave the plan. No such ongoing transition plan exists for new enrollees into a SNP.

*Example: Consumer was on a kidney transplant list and nearly lost her spot because she didn't know her surgeon would not be in the new SNP network.*

*Example: Consumer, scheduled to have an urgent tonsillectomy because she was struggling to breath, couldn't get out of her plan quickly enough and her hospital and surgeons did not participate in new SNP.*

*Example: Consumer who was just diagnosed with aggressive lung cancer and scheduled to start chemotherapy nearly couldn't get the treatment because her provider was not in her new SNP's network.*

*Example: Consumer has had multiple prior brain surgeries with established brain surgeon at out-of-state hospital, however, course of treatment not complete and additional surgery is scheduled already at time of enrollment. SNP wants her to see in-network brain surgeon.*

**Recommendation:** SNPs should have 60-day transition plan for prescriptions and providers the individual was using or seeing prior to enrollment.

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***Issue 10: SNP enrollee is not provided with continuity of care upon disenrollment from SNP.***

It is important that consumers have clarity on what they can expect if they leave a plan in the middle of a course of treatment. This is particularly important with individuals who have Special Enrollment Periods and can move in and out of plans with some frequency. Not all consumers can or do think ahead to what happens if, for example, a provider has sent in a mold to have a crown made for a consumer's tooth and the individual leaves the plan before the crown is installed.

**Recommendation:** A clear policy articulating how transition coverage plays out should be developed and should be communicated to the consumer upon her making a disenrollment request.

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## **COVERAGE ISSUES**

Once enrolled, the consumer faces challenges in accessing care. Many of these relate to coordination of care and benefits between providers and insurers.

***Issue 11: SNP doesn't coordinate the benefits of a dual eligible for Medicare covered services, for supplemental services, or for non-covered services.***

A SNP is a Medicare Advantage Coordinated Care Plan that is responsible for only those Part A, B, and D services the SNP deems medically necessary that are provided according to the SNP's access rules and by appropriate providers. It is important to note that there are no additional benefits beyond the basic Part A, B, and D benefits that SNPs must provide to enrollees. SNPs are not required as an MA plan generally or as a SNP specifically to offer any specific additional or "supplemental"

benefits that would facilitate their meeting their enrollees' special needs. Any such benefits are optional, at the election of the SNP to offer as supplemental benefits.

With regard to dual eligibles, Medicaid will often cover:

- Balances due on Part A and B services provided by the SNP
- Part A and B type hospitalization and medical services that do not meet the Medicare coverage criteria but may meet the Medicaid coverage criteria and
- Additional services such as well visits, dental , vision, transportation, and some excluded drugs that the SNP does not have to cover (although it may have chosen to cover some of these as “supplemental benefits”)

Coordination with Medicaid to ensure that dual eligibles get all the services they need and that the services get covered by all the appropriate payers is a critical service that Special Needs Individuals require.

Not only are SNPs not required to offer any supplemental benefits, but they are not required to coordinate benefits, except as much as to ensure that Medicare is payer of last resort where appropriate.<sup>9</sup>

*Example: Where the medical necessity standard for Medicaid coverage is less stringent than the Medicare standard and SNP won't cover the service, there is no help from the SNP to request the service through Medicaid.*

*Example: Enrollee covered for Medicare portion of a Medicare covered service, no SNP help to assure that Medicaid even gets the claim (much less processes it) and provider balance bills patient then submits the bills to collections.*

*Example: Dental care is not a Medicare covered benefit but a limited supplemental benefit offered by the SNP. Dental care is also Medicaid-covered benefit. SNP has network of dental providers, none of whom accept Medicaid. SNP has no mechanism to assist in obtaining authorization for Medicaid coverage of dental care beyond the SNP's limited coverage.*

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<sup>9</sup> The regulations articulate how Medicare Advantage plans must coordinate insurance when a Medicare Advantage plan enrollee has other insurance in addition to Medicare. These rules, known as the Medicare Secondary Payer rules, focus on ensuring that Medicare is the payer of last resort in appropriate circumstances. 42 C.F.R. § 422.108. Generally, Medicare pays first before retiree health plans and Medicaid. Medicare may be secondary to group health insurance obtained as a result of active employment, depending on the size of the employer and the circumstances under which the beneficiary became eligible for Medicare. The regulations also articulate minimum requirements around Medicare Advantage plans' obligations to coordinate the insurance coverage or benefits when the Medicare Advantage plan holds the contract for both the Medicare coverage and any other coverage an enrollee might have through Medicaid, Employer-Based Insurance, or Retiree Insurance. 42 C.F.R. § 422.106.

*Example: Plan has vision benefit and list of providers the enrollees must see to take advantage of the vision benefit. Plan does not know whether any of its network providers accept Medicaid and claims the beneficiary is obligated to find out. Consumer cannot access vision benefit directly from Medicaid provider because Medicaid is payer of last resort.*

**Recommendation:**

1. Include in SNP marketing materials explanations of the “coordination of care” and “coordination of benefits” benefits, in addition to Parts C and D covered benefits, which dual eligibles can obtain from their SNP.
2. Adopt minimum uniform standards for coordinating and integrating the Medicare and Medicaid benefits. These standards must be incorporated into the SNP contracts with CMS, and their compliance with these standards must be measured during site reviews and other CMS compliance evaluations.
3. Provide real disease management programs involving continuing contact with enrollees, health professionals, and social workers and not just the mailing of not one-time flyer or newsletter telling people with a specific chronic conditions what to eat or how to manage their chronic conditions.
4. Include as a SNP benefit “coordination of benefits” to include all services involved in coordination and integrating the enrollees’ multiple insurances (primarily Medicare and Medicaid). Failure to provide these coordination and integration services should trigger beneficiary appeal rights through the Part C appeals process.

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***Issue 12: SNP does not coordinate care for individual enrollee.***

To be eligible for an institutional level of care, consumers must have established complex care needs. Most individuals who need this level of care are frail, medically involved, and high users of healthcare and other supportive services. Ensuring that these individuals are able to access the full extent of services prescribed for them often involves negotiation between different healthcare providers and often between different healthcare systems or coverage. Case management is not available to all consumers. Some consumers who have requested case management from their SNP have been denied this service. Care needs are not evaluated at the point of enrollment, or preferably prior to enrollment, to determine what assistance the consumer will need. And, services prescribed may get a denial without assistance in accessing an alternative service.

*Example: Dual SNP enrollee with AIDS who requests case management is informed that he is not eligible for the service. According to CMS, plans may establish their own criteria for case management services.*

*Example: Consumer has been calling Member Services of his SNP for help coordinating the specialty dental care (involving sedation) he needs for his adult son with Mental Retardation. Member services will not help and does not refer him to case management/care coordination to make the arrangements that he is finding impossible to make on his own.*

*Example: The pharmacy informs the consumer that coverage for a new prescription has been denied. Consumer calls member services to try to negotiate the coverage decision, but he cannot get through on a Saturday.*

**Recommendation:** SNPs should be required to:

1. Arrange for an evaluation of Medicaid coverage when a prescription is denied at the pharmacy, and, where applicable, direct the pharmacist to bill Medicaid. All SNPs should program their systems with medications Medicaid will and will not cover.
2. Design prescription drug or medical claims denial letters to state, "If you have Medicaid, note that this prescription medication or service may be covered by Medicaid. Please ask your provider to obtain this item through Medicaid. For any assistance with this, please call member services."
3. Train member services personnel regarding details of what Medicaid benefits are available and how to obtain them.

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***Issue 13: SNP staff does not explain or assist consumer in accessing the SNPs benefits or in using the Part D formulary exceptions process.***

Consumers having trouble accessing services within their SNP often face obstacles of how to navigate the requirements of the SNP. Help is needed to satisfy the coverage requirements for obtaining prior authorizations or formulary exceptions from the plan.

*Example: Consumer is prescribed Ambien, but the plan only covers the generic version, unless an exception is obtained. Consumer has history of bad reaction (including hospitalization) to generic Ambien. SNP takes no steps to assist consumer in obtaining documents consumer says her doctor will have for proving the need for exception.*

*Example: Consumer seeking prior authorization for dental services. Repeated calls and SNP authorization for coverage of services is not being sent to provider. Consumer cannot get SNP to fax or mail her a copy of the prior authorization for her to take with her to the dentist.*

*Example: Consumer cannot get plan to approve brand-name medicine for GERD. Plan denies and tells her to try other generic medications. No effort to coordinate or reach out to provider to understand the prescription for the brand-name medication. Consumer appeals but gets no response to appeal request.*

**Recommendation:** SNP should make available special needs units and case management services, and publicize their availability to all enrollees for obtaining assistance in accessing referrals, understanding plan policies and procedures and coordinating challenging care needs.

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***Issue 14: SNP does not provide continuity of care when there are changes to the benefits of plan.***

*Example: Consumer enrolled in SNP in 2006. In 2007, consumer receives no notice that the hospital she uses is no longer in the network. She now is billed for a 2007 hospitalization and tests.*

*Example: Consumer goes to get medication refilled but her drug is no longer on the formulary. Consumer believes she got no notice of the change, though the information may have been included somewhere in the extensive annual notice of change. The SNP need not provide any transition coverage or continuity of care coverage when it changes its benefit package.*

*Example: Consumer gets dental work and doesn't learn until after 5 fillings are put in that dental care has been terminated from the dental package.*

**Recommendation:** Upon a change in benefits from year to year (e.g. items taken off formulary or cancellation of a supplemental benefit like vision coverage) SNPs must provide some continuity of benefits as members get transitioned to a new prescription. For this population, a "notice" or revised SOB is not enough.

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**PROVIDER AND NETWORK ISSUES**

***Issue 15: SNP does not help consumer find providers within the SNP network, generally, or specifically those that will also take Medicaid.***

When consumers come to understand the process for obtaining services through the SNP and how to use their secondary insurance, they can still face obstacles to getting needed care. Consumers that are told their provider will not accept Medicaid might call the SNP for a name of a network provider that does accept Medicaid. The SNP member services staff often cannot answer this question or will not take steps to help member find a provider they can use.

*Example: Consumer is a dual who gets regular dialysis. At a routine visit to dialysis center, he complained about the way some of his medications were being administered. Dialysis center asked him to leave and has refused to see him again. No other center in network will accept him. SNP told him they cannot help, that they cannot require a dialysis center to see him.*

*Example: Provider refuses to take Medicaid. Consumer calls plan to find out which providers take Medicaid. Plan gives member a list of names and tells member to call the providers directly.*

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***Issue 16: SNP network does not include enough providers and specialists in the service area.***

Network composition requirements are important to SNP enrollees for many reasons. SNP enrollees have complex healthcare needs that often require regular, if not urgent or emergent, access to specialized providers. If the SNP is allowed to serve a larger proportion of such individuals but does not have any greater proportion of specialty providers in its network to serve those individuals, network composition would, arguably, be inadequate.

Network composition, however, is left to the discretion of the plan.<sup>10</sup> In a nutshell, the regulations allow each plan to determine and ensure that it maintains the network it needs to serve its membership's needs.<sup>11</sup> No CMS guidance or contract language imposes any additional requirements. Members' experience with network adequacy demonstrates that SNP networks may be more concentrated in some parts of the service area than others. Rural areas may have limited numbers of providers.

*Example: Enrollee lives in rural county and the only local hospital in the very rural area is not in the SNP network*

*Example: Enrollee moved from one county to another (within the service area) and there are no providers in the new county.*

*Example: Consumer with epilepsy and multiple prior brain surgeries gets denied out-of-state brain surgery with her established surgeon. SNP claims their neurosurgeons can do the surgery. SNP provides her with the contact information for four neurosurgeons in the service area. None has any experiences with epilepsy.*

**Recommendation:** There should be provider access standards based on time and distance and based on capacity of provider. Consumer should not have to travel more

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<sup>10</sup> Under federal regulations, Medicare Advantage plans must only "Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served." 42 C.F.R. § 422.112(a).

<sup>11</sup> See 42 C.F.R. § 422.112.

than x number of minutes/miles to see a provider and shouldn't have to wait more than x days for new visit, y days for well visit, z days for urgent visit, etc. If network cannot provide access to meet the standard, consumer should be allowed to see out-of-network providers. This works well in Medicaid managed care.

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***Issue 17: SNP does not reach out to enroll an out-of-network provider or excludes an out-of-network provider that wants to enroll.***

Enrollees often do not understand the impact of their SNP enrollment until after their enrollment becomes effective. As stated earlier, when an enrollee learns that her provider is a non-network provider, she needs time to find a new provider, to persuade the non-participating provider to join, or to switch plans to stay with an established provider.

*Example: Skilled nursing facility residents (SNF) in Tennessee were passively enrolled in a SNP plan in which their SNF did not participate. At the suggestion of CMS, the nursing home Ombudsman asked the SNF to apply to participate in the plan. The plan, however, wouldn't accept SNF. A resident subsequently is hospitalized, becomes eligible for Medicare coverage in the SNF, but the SNF in which she resided is not part of the SNP network.*

*Example: Meanwhile, a SNP terminated the contracts of 12 providers serving significant numbers of SNP enrollees for "cost" reasons and patients were scrambling to figure out what to do. (50-60% of one of the provider's patients were in the SNP.)*

**Recommendations:**

1. SNP must have generous policy for paying Out of Network providers – especially ancillary providers to a hospitalization where hospital is in network but not all providers/diagnostic services, etc. are in network.
  2. SNPs should have to conduct rigorous outreach to contract with pre-existing providers of patients entering SNP.
  3. SNPs should not be allowed to terminate providers that see large percentage of enrollees without notice and extra protections for consumers.
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***Issue 18: SNP network does not include ancillary providers and SNP doesn't pay out-of-network providers.***

A SNP network does not have to be approved as adequate upon any CMS review. The network adequacy is solely up to the SNP to decide. A network that

includes a hospital by none of the individuals with privileges to practice at the hospital cannot be viewed as adequate.

*Example: Consumer was in the hospital unexpectedly. Although the hospital was in plan network, most of the doctors that treated consumer were not. The providers want her to come in for follow-up visits but, if she returns to the non-network doctors who treated her, the care will not be covered by the SNP.*

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***Issue 19: SNP does not take responsibility for contractors and care delivered.***

In addition to its network of providers that are under contract, SNPs often subcontract out the behavioral health benefits or dental benefits that they offer. These arrangements make it hard for consumers to identify the entity with which they must deal in attempting to resolve access problems. The SNPs must be ultimately responsible for the care that is or is not provided.

*Example: Consumer had partial denture made with wrong materials. Doctor will not give the consumer, a dual eligible, the denture unless she pays for the error, \$175. Client cannot obtain the supplemental benefit from the SNP and SNP won't interfere with the provider to get the denture for the client.*

*Example: Vision subcontractor is insisting on copayment from dual eligible consumer at time she sees vision providers for Medicaid covered services for which Medicaid would be liable on a balance bill. SNP not aware subcontractor is doing this.*

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***Issue 20: SNP Provider refuses to accept Medicaid. SNP provider refers client to specialist that won't take Medicaid.***

In Pennsylvania, a Medicare provider can balance bill Medicaid, i.e., bill Medicaid for Medicare cost-sharing, even if the provider is not a Medicaid-participating provider. It is unclear whether providers understand that billing Medicaid for the balance owed on one dual eligible does not require them to enroll to accept any Medicaid patient. It is clear, however, that SNP networks include providers who do not accept Medicaid or who are unwilling to bill Medicaid for Medicare covered services, even when the SNPs are designated as serving dual eligibles.

*Example: Provider refuses to take Medicaid. Consumer calls plan to find out which providers take Medicaid. Plan tells them to call the providers directly.*

*Example: SNP provider is charging full dual \$20 for each visit because provider refuses to bill Medicaid for copayment on outpatient visits.*

*Example: SNP not helping consumer find orthopedist and ob-gyn who take both SNP and Medicaid. Provider referrals are to SNP providers only.*

**Recommendation:** SNPs should be required to make sure all network providers to participate in Medicaid or accept the SNP's payment as payment in full.

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***Issue 21: SNP Provider balance bills dual eligible instead of billing Medicaid.***

Too many consumers are being billed for costs that Medicaid covers, and many complain that their medical debt is mounting. Consumers are very fearful when they are billed, especially as so many Special Needs Individuals are without the means to pay the bills. Those who forego other necessities to pay their medical bills are not certain to get reimbursed for their expenses since the Medicaid program cannot reimburse an individual for money spent on care. The consumer, thus, has to try to persuade the provider to bill Medicaid and get a refund from the provider.

*Example: Enrollee has called us for help with her bills that have now gone to collections.*

*Example: Three nuns in a personal care home with only \$60/month personal needs allowance were being balanced billed by SNP providers who refused to bill Medicaid.*

*Example: Hospital billing a SNP enrollee for balance on outpatient hospitalization procedure. Consumer is very worried about the bill. A local charity pays the hospital on the consumer's behalf then learns that Medicaid was responsible for the balance.*

*Example: One hospital was billing a dual eligible for balance even though it had submitted the bill to Medicaid. Consumer was being billed because Medicaid was too slow to pay the submitted claim.*

**Recommendation:** SNP should be required to instruct all network providers on applicable state and federal prohibitions against billing Medicaid consumers for Medicare cost sharing that should be covered by Medicaid and to contractually prohibit them from balance billing.

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***Issue 22: SNP provider does not understand what Medicaid covers or how Medicaid works.***

It is often the case that network providers are unable to tell members what services their Medicaid will cover, if not covered by the SNP. Network providers are

often without information on how services are accessed through Medicaid and how claims are submitted.

*Example: Advocate wrote psychiatrist with instructions to stop balance billing dual eligible. Provider's office responded that they do not participate in so will not bill Medicaid.*

**Recommendation:** SNP should be required to instruct all network providers on what Medicaid covers and how to access Medicaid payment for balances due. SNP should also have staff members who are available to respond to inquiries about Medicaid and other coverage.

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## CONCLUSION

Dual eligibles, persons with chronic conditions, and institutionalized individuals could **potentially** benefit from coordinated, integrated, and managed care from a plan specially designed to meet their needs, since they generally have substantial and complex healthcare needs. Accordingly, SNPs do present the possibility or opportunity for better care through coordination, integration, and targeted care management. Although plans may take steps to deliver these benefits to meet the special needs of their members, CMS imposes no formal requirements that a SNP actually take these or any other steps to deliver on the promise of better care.

The SNP option is built on incentives alone. There are no obligations or expectations. There are no standards applied. Consumers that are facing access problems can do nothing to prompt their SNPs to do things differently except ask. If nothing is required of the SNP with regard to care coordination, for example, the consumer denied care coordination cannot appeal the denial.

Absent minimum standards for meeting the special needs of the populations they serve, labeling these plans as specially designed to do so is misleading. CMS needs to commit to ensuring that coordinated, integrated care is delivered. Beneficiaries need substantive regulations that establish minimum standards for what SNPs must do and how SNPs must function to meet their special needs. These regulations must clearly set forth the expectation that SNPs will take affirmative steps to assist enrollees with navigating both their Medicare and Medicaid coverage to ensure that they receive all needed covered services regardless of whether the SNPs themselves are financially responsible for covering the service. Only then will the potential benefits of specialized managed care actually inure to beneficiaries.

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