



MEDICARE ADVANTAGE SPECIAL NEEDS PLANS: A BENEFICIARY PERSPECTIVE

Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer

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Issue Brief 1**Medicare Advantage Special Needs Plans
for Dual Eligibles: A Primer****Charles J. Milligan, Jr., J.D., M.P.H., and Cynthia H. Woodcock, M.B.A.***

Abstract: Medicare Advantage Special Needs Plans (SNPs), a new type of Medicare Advantage plan, were authorized by the Medicare Modernization Act of 2003 (MMA). Under the MMA, SNPs may target one of three special needs populations: institutionalized beneficiaries, beneficiaries with severe or disabling chronic conditions, or beneficiaries who simultaneously are eligible for both Medicare and Medicaid benefits (dual eligibles). This brief describes the role of SNPs in the Medicare Advantage program, and the reason these entities were authorized by Congress to serve distinct subpopulations of Medicare beneficiaries. In focusing on dual eligible SNPs, it provides a snapshot on the scale, enrollment, and make-up of dual eligible SNPs. It also identifies the key issues that underlie one of the central goals behind dual eligible SNPs: “the potential to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan so that beneficiaries have a single benefit package and one set of providers to obtain the care they need.”¹ This brief also describes why true coordination between SNPs and Medicaid programs has not taken off, in spite of the benefits that could occur in a coordinated system of care. In specific, in authorizing SNPs, Congress made a policy decision that coordination should be voluntary for all three necessary parties: the SNPs, which may elect just to hold Medicare contracts and offer only Medicare benefits and not coordinate with state Medicaid program; state Medicaid programs, which may choose not to cooperate or coordinate with SNPs operating in their jurisdictions even when the SNPs desire coordination with Medicaid; and the dual eligible beneficiaries themselves, who retain the freedom under Medicare not to join a SNP in the first place. The participation of all three is crucial for seamless coordination of Medicare and Medicaid benefits to occur. Absent reauthorization, the legislative authority for SNPs will expire on December 31, 2008. This brief will shed light on important issues that should be considered in determining whether and how SNPs are reauthorized.

Introduction

Medicare Advantage Special Needs Plans (SNPs), a new type of Medicare Advantage plan, were authorized by the Medicare Modernization Act of 2003 (MMA). This issue brief examines SNPs for individuals who are eligible for both Medicare and Medicaid

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(dual eligibles), one of three special needs populations that the legislation specifies may be targeted by SNPs.

The nation's approximately 7 million dual eligibles have been targeted as a special needs population because these individuals tend to be in poorer health than other Medicare beneficiaries. When compared to other Medicare beneficiaries, dual eligibles are 100 percent more likely to be in poor health, 50 percent more likely to have diabetes, 600 percent more likely to reside in a nursing facility, and 250 percent more likely to have Alzheimer's disease.² Dual eligibles require more resources than other beneficiaries enrolled in Medicare or Medicaid. In 2002, dual eligibles comprised 17 percent of Medicare beneficiaries, yet accounted for 29 percent of Medicare spending. Dual eligibles comprised 14 percent of Medicaid beneficiaries in 2003 and accounted for 40 percent of Medicaid expenditures.³ The benefits provided to dual eligibles through the two programs overlap to some extent (e.g., both Medicare and Medicaid cover many acute and ambulatory care services), but they also tend to be complementary (e.g., Medicare covers hospital care and post-acute rehabilitation, but Medicaid covers long-term nursing home care); efforts have been made over the years to improve the coordination of the two programs, but these efforts have not been as successful as hoped.⁴

This Issue Brief describes Medicare Advantage SNPs for dual eligibles, discusses the provisions of the legislation establishing SNPs, provides a snapshot of the enrollment and participation levels in SNPs, and describes the opportunities and challenges presented by this new type of specialty health plan. Federal and state action to advance the goal of coordinating care for dual eligibles through the vehicle of SNPs is discussed, as well as the outlook for the future.

SNPs: New Medicare Advantage Plans

In the MMA, Congress created Medicare Advantage plans. These are private health plans that receive a capitation payment from CMS to provide an array of services to Medicare beneficiaries. The Medicare Advantage program, also called Medicare Part C, replaced the earlier capitated program in Medicare, which was known as Medicare+Choice.

Medicare Advantage plans can be 1) health maintenance organizations, 2) preferred provider organizations, or 3) private fee-for-service plans.⁵ Partly as an inducement for enrollees to join, and partly because of the flexibility offered in capitated programs, Medicare Advantage plans typically offer beneficiaries additional benefits beyond those available in traditional fee-for-service Medicare. Once a beneficiary enrolls in a Medicare Advantage plan, he/she agrees to obtain care through the health plan's participating network of providers.

Section 231 of the MMA authorized SNPs as special type of Medicare Advantage plan. They are Medicare Advantage plans, and meet all the requirements of a traditional Medicare Advantage plan, but they were authorized by Congress to enroll targeted subpopulations within Medicare that have special needs. As a Medicare Advantage plan,

SNPs offer Medicare beneficiaries the option to enroll in a private capitated health plan rather than to receive their care through the traditional Medicare fee-for-service program.

Provisions of the MMA

The MMA defines a SNP as a specialized Medicare Advantage plan for one of the following three groups of individuals with special needs: institutionalized beneficiaries; beneficiaries with severe or disabling chronic conditions; and beneficiaries who are eligible for both Medicare and Medicaid. Unlike other Medicare Advantage plans that must accept all beneficiaries in the service area who select the plan, SNPs may restrict enrollment to individuals who are within one or more of these three special needs groups. In addition to allowing restricted enrollment, the MMA allowed regulations to enable individual SNPs to enroll a disproportionate share of special needs individuals in comparison to the share of those individuals in the general population.

In broad terms, dual eligible SNPs were authorized for two reasons. First, the characteristics of Medicare beneficiaries who also qualify for Medicaid, on the basis of poverty or disability, are associated with higher-than-average needs – special needs.⁶ Second, these individuals not only qualify for Medicare benefits, but they also qualify for Medicaid benefits, and the coordination of the benefits across the two programs creates a unique opportunity for a specialty health plan to organize and coordinate the combined set of services in a single delivery system. As the Centers for Medicare and Medicaid Services (CMS) has noted: “SNPs [for dual eligibles] have the potential to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan so that beneficiaries have a single benefit package and one set of providers to obtain the care they need,”⁷ without having to secure special Medicare demonstration authority from CMS.⁸

As with other Medicare Advantage plans, Medicare pays SNPs a capitated payment for each enrollee to provide Medicare Part A (Hospital Insurance) and Medicare Part B (Supplementary Medical Insurance) benefits; SNPs therefore receive the same payment rates that other MA plans would have received for the same enrollees. However, because payments to Medicare Advantage plans are risk-adjusted to reflect the anticipated costliness (based on health status) of each plan’s enrollees, the actual amounts that SNPs receive are generally higher, to reflect a generally sicker and more at-risk population of enrollees.

The MMA requires that the Secretary of the U.S. Department of Health and Human Services report to Congress by December 31, 2007, on the impact of SNPs on the cost and quality of services provided to enrollees, as well as the costs and savings to the Medicare program. This report to Congress will be considered when the program is up for reauthorization; the current authorization of SNPs “sunset” on December 31, 2008.

Growth of SNPs

The number of authorized SNPs has grown rapidly. As shown in Table 1, the number of SNPs has grown from 11 plans in 2004 to 477 plans in September 2007, with total enrollment of more than 1 million Medicare beneficiaries. SNPs for dual eligibles now

total 320 plans, comprising two-thirds of all SNPs and enrolling 722,286 individuals for their Medicare benefits. To put this in context, only about 10 percent of dual eligible beneficiaries have chosen to enroll in a Medicare Advantage SNP. CMS reports that the 320 dual eligible SNPs are offered through 204 approved contracts. Contractors range from large national health insurance companies to regional Blue Cross/Blue Shield plans. In 2006, 87 seven percent of SNPs were offered by organizations that also offered regular Medicare Advantage programs.⁹

Table 1
Special Needs Plans: Number of Plans and Enrollment
United States, 2004 to 2007¹⁰

Year	All SNPs*		Dual Eligible SNPs	
	Number of SNPs	Enrollment	Number of SNPs	Enrollment
2004	11	Not available	Not available	Not available
2005	125	Not available	42	N/A
September 2006	276	602,881	256	491,877
September 2007	477	1,021,800	320	722,286

* Includes all types of SNPs.
Source: Centers for Medicare and Medicaid Services

As shown in Table 2, however, enrollment in capitated *Medicaid* managed care programs for dual eligibles has been far below even the relatively modest enrollment in Medicare managed care SNPs. Of the seven states with existing capitated Medicaid managed care programs targeting dual eligibles,¹¹ only three have Medicaid enrollments that exceed 10,000 enrollees, and the largest of these programs enrolls just 35,000 dual eligibles.

Table 2
Dual Eligible Enrollment in Medicaid Managed Care Programs
Targeting Dual Eligibles in States with at Least 10,000 Enrollees

State	Enrollment
Minnesota	35,000
Arizona	24,000
Texas	20,000

Source: Saucier, Paul and Burwell, Brian: "The Impact of Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care," January 2007, accessed at www.hcbs.org

As shown in Table 3, SNPs for dual eligibles operate in 42 states and Puerto Rico. States with the most plans are Florida (58 plans), New York (45 plans), and California (26 plans). Puerto Rico ranks high as well with 33 plans. None of these jurisdictions operate large Medicaid managed care programs for dual eligibles. The rapid growth of Medicare SNPs in Florida may be due, in part, to the approval of Florida Senior Care, a new Medicaid managed care program scheduled by the State of Florida for implementation in pilot areas of the state in 2008.

One-third of dual eligible SNPs are located in the seven states with operational capitated Medicaid programs that coordinate Medicare and Medicaid benefits. Enrollment in these plans, for the dual eligibles' Medicare benefits, totals 188,271, or 26 percent of total enrollment in dual eligible SNPs. Two of the seven states—Arizona and Texas—have mandatory Medicaid managed care programs, although the Texas program does not operate statewide.¹² The other five states with operational capitated Medicaid managed care programs for dual eligibles—Massachusetts, Minnesota, New York, Washington, and Wisconsin—have voluntary programs.

Other states with a significant enrollment in Medicare dual eligible SNPs are Alabama, Oregon, Tennessee, and especially Pennsylvania, with more than 100,000 enrollees. Yet none of these states operates companion Medicaid managed care programs for dual eligibles.

Table 3
Special Needs Plans for Dual Eligibles:
Number of Plans and Total Enrollment by State
United States, September 2007

State	Number of SNPs	Total SNP Enrollment	State	Number of SNPs	Total Enrollment
States with <i>Operational</i> Programs to Coordinate Medicare and Medicaid Benefits			Louisiana	3	2,063
Arizona	11	47,557	Maine	2	309
Massachusetts	6	9,277	Maryland	3	4,591
Minnesota	13	36,028	Michigan	1	764
New York	45	52,438	Mississippi	1	939
Texas	19	38,922	Missouri	3	923
Washington	3	1,474	Montana	-	-
Wisconsin	4	2,575	Nebraska	2	101
States with <i>Planned</i> Programs to Coordinate Medicare and Medicaid Benefits			Nevada	2	178
Florida	58	55,879	New Hampshire	-	-
New Mexico	1	269	New Jersey	1	2,049
Other States			North Carolina	1	4,463
Alabama	3	17,789	North Dakota	-	-
Alaska	-	-	Ohio	3	3,929
Arkansas	5	847	Oklahoma	1	311
California	26	76,305	Oregon	8	17,318
Colorado	4	6,484	Pennsylvania	11	100,214
Connecticut	6	2,308	Puerto Rico	33	182,990
Delaware	1	-	Rhode Island	2	2,845
District of Columbia	-	-	South Carolina	1	286
Georgia	8	3,313	South Dakota	1	170
Hawaii	3	1,038	Tennessee	13	27,336
Idaho	1	652	Utah	2	2,178
Illinois	5	4,821	Vermont	-	-
Indiana	1	384	Virginia	1	266
Iowa	-	-	West Virginia	-	-
Kansas	1	11	Wyoming	-	-
Kentucky	1	9,638	U.S. Total	320	722,286*

* Includes 54 enrollees that are not included in the state totals. For SNPs with enrollment of less than 11, CMS does not specify enrollment in order to comply with privacy law requirements.

Source: Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report, September 2007.

Accessed 10/5/07 at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp>.

Opportunities and Challenges

A dual eligible SNP, as a specialty health plan focused on a frail and poor subset of the Medicare population, has the opportunity to significantly improve the care provided to dual eligibles by offering better care coordination, developing more effective institutional diversion programs, and promoting improved disease and pharmacy management programs.

Because of their inherent focus, dual eligible SNPs also have the opportunity to improve the coordination of Medicare and Medicaid benefits for dual eligibles. In addition to their contracts with CMS to deliver Medicare-financed services, SNPs potentially could enter into formal relationships with state Medicaid agencies to coordinate the delivery of Medicare benefits with state-administered Medicaid benefits. These formal relationships could take several forms, ranging from the SNP's receipt of a separate capitation payment from a state Medicaid agency to deliver Medicaid benefits in coordination with Medicare, to a non-risk based contract under which a SNP and state Medicaid program could share clinical or utilization information with each other (e.g., a SNP could alert a Medicaid agency when a dual eligible beneficiary enters a Medicare-financed hospital stay, to coordinate with Medicaid to secure access to Medicaid-financed services such as attendant care upon the person's discharge from the hospital; similarly a Medicaid agency could alert the SNP when a dual eligible enters a custodial nursing home stay, to arrange Medicare-financed primary care supports inside the institution that might help avoid unnecessary hospitalizations).¹³

Whatever the particular vehicle for coordination between a Medicare-financed SNP and a state Medicaid agency, one key objective would be to serve the needs of the dual-eligible enrollees by devising individual plans of care that coordinate Medicare services (such as physician visits, pharmacy, hospital care, skilled nursing facility, and skilled home health) with Medicaid services (such as custodial long-term care, attendant care, home and community-based services [HCBS] authorized under Medicaid waivers, and non-emergency medical transportation).

More coordinated, cost-effective care, with improved outcomes for the beneficiary, should result, if the SNP effectively delivered Medicare benefits and worked in conjunction with state Medicaid programs. For example, as mentioned above, better coordinated hospital discharge planning (hospital care is a Medicare service) could help avoid an unnecessary and lengthy nursing home stay (a Medicaid service) in favor of home and community-based services. Community-based long-term care could be improved by better coordinating the use of physician, skilled home health services, and prescription medications (all Medicare benefits) with attendant care, non-emergency medical transportation, and HCBS waiver services (all Medicaid benefits). Similarly, active quality monitoring of long-term nursing home stays (typically a Medicaid service) could help avoid unnecessary hospitalizations (a Medicare service) related to pressure ulcers, infections, or falls.

To date, SNPs' primarily coordinate with state Medicaid programs under capitated Medicaid managed care programs. To date, SNPs and state Medicaid programs have not

entered into non-risk forms of coordinated care arrangements to any appreciable degree. In the existing formal arrangements that involve separate capitation payments to the same entity (acting as a Medicare SNP and a Medicaid managed care organization [MCO]), there have been favorable outcomes for dual eligibles:

- In Arizona, the percent of dual eligibles with a nursing facility level of care who resided in the community (with supports), instead of in an institution, rose from 5 percent to 63 percent over 17 years.¹⁴
- In Texas, dual eligibles received 31 percent more personal care, and 38 percent more adult day health services, than they had in the fee-for-service system.¹⁵
- In Texas, hospitalizations were reduced by 22 percent and emergency room visits were reduced by 38 percent.¹⁶
- In Minnesota, 94 percent of the program's beneficiaries would recommend their care coordinator to another person.¹⁷

However, to date this vision of well-coordinated services, at the health plan level, has not been well realized. Despite the rapid growth in SNPs (see Table 1), just 12 percent of the dual eligible population is enrolled in a SNP.¹⁸ On the Medicaid side, even fewer dual eligibles nationwide—but *not even necessarily the same individuals*—are enrolled in Medicaid managed care plans. Clearly, SNPs still have far to go to achieve a substantial share of the dual eligible market. SNPs face an even greater challenge when it comes to increasing enrollment in coordinated Medicare-Medicaid plans. It is unknown just how many SNPs have formal relationships with their host state, either through coordinated Medicare-Medicaid programs, administrative service organization (ASO) arrangements, or data sharing agreements.

One reason that growth of a fully-realized and coordinated approach to care, across Medicare and Medicaid, has been slow is that the program is voluntary for all three key participants. First, the MMA in no way obligates SNPs to form any relationship with the state Medicaid program in its host state (not even to share clinical and utilization data on the Medicare services delivered by a SNP to its dual eligible enrollees). This is true even when the host state is anxious to work with the SNPs in its jurisdiction. Congress did not want to inhibit the development of SNPs by mandating a formal relationship between SNPs and states as a condition of SNP contracts with CMS; such a requirement might have chilled SNP interest in Medicare Advantage, given the very real concerns some SNPs might have about the experience, politics, and leadership at the state level. Similarly, nothing compels a state Medicaid agency to coordinate with a *willing* SNP that operates within the state (not even to share clinical and utilization data on the Medicaid services delivered to the SNP's dual eligible enrollees). This is true even when the SNP is anxious to forge a relationship with a state Medicaid program to coordinate care for the dual eligibles it enrolls. The law respects states' traditional rights to set Medicaid priorities and to focus on other kinds of reforms if they choose to do so.

Finally, nothing in the MMA or elsewhere altered Medicare’s core beneficiary right of “freedom of choice.” This right permits Medicare beneficiaries to choose the institution, agency, or individual to provide their Medicare benefits, and to remain in fee-for-service or to select a Medicare Advantage plan (such as a SNP), in the beneficiary’s sole discretion.¹⁹ This freedom of choice, while a key beneficiary right and a cornerstone of Medicare, complicates efforts to coordinate Medicare and Medicaid benefits. A dual eligible may choose to enroll in a SNP or another type of Medicare Advantage plan, or the individual may choose to remain in traditional Medicare fee-for-service.

That each of the three key parties described above —the SNP, the state, and the dual-eligible beneficiary—has the right not to participate in a coordinated approach to care delivery, yet the participation of *all three* is crucial for seamless coordination of benefits, is the crux of the coordination challenge.

The Advantages of Coordinated Care

When Medicare and Medicaid benefits are delivered in a coordinated manner:

- **Each program has a financial incentive to avert unnecessary or inappropriate care financed by the other program.** Many individuals linger in nursing homes when they could have gone home because the initial post-acute, Medicare-financed stay in the nursing home did not include active discharge planning and resulted in a long-term, Medicaid-financed nursing home stay. Similarly, if Medicaid-financed nursing home services are not high quality, then a Medicaid-sponsored nursing home resident could have a fall, become infected, or suffer a pressure ulcer that results in a Medicare-financed hospitalization.
- **Beneficiaries receive higher quality care with respect for individual preferences.** For example, coordinated Medicaid-financed attendant care services to assist with bathing and dressing, combined with Medicare-financed home health nursing services, may be the perfect complement to keep a dual eligible beneficiary highly functioning, independent, and living in the community. A coordinated plan of care that incorporates both Medicare and Medicaid services is the best approach to avoid what most dual eligible beneficiaries fear—an unnecessary institutionalization.

Federal Action to Encourage SNPs

The federal government has taken a number of actions to encourage growth in the development of SNPs for dual eligibles.

In 2005, CMS allowed 42 SNPs in 13 states to “passively enroll” dual eligibles into the their plan effective January 1, 2006, if the individual was already enrolled in a Medicaid managed care plan offered by the same health plan. Passive enrollment means that the individual would be enrolled even without taking any action to enroll, provided there was a pre-existing relationship with the health plan. This ensured continuity of care with the health plan in which the individual already was enrolled. Because of Medicare’s freedom of choice rights, individuals were allowed to freely opt *out* of this passive enrollment and

go back to Medicare fee-for-service, but until then there was an imputed choice of continued enrollment in the beneficiary's prior health plan. The passive enrollment process, part of the implementation of the Medicare Part D drug benefit, significantly increased the number of individuals enrolled in a health plan with both a Medicare and Medicaid contract.^{20,21}

Passive enrollment also was accountable for significant growth in the Minnesota, Texas, and Arizona capitated Medicaid managed care programs for dual eligibles: Minnesota added 23,000 enrollees into its Medicaid managed care program through passive enrollment, and passive enrollment added 16,000 in Texas and 8,000 in Arizona.²²

To assist states in partnering with SNPs to provide more comprehensive benefit packages to dual eligibles, CMS has created "how to" guides on aligning Medicare and Medicaid program rules regarding marketing, enrollment, quality, and rate setting.²³ A "how to" guide on the Medicare bidding process is forthcoming, as are new performance measures for SNPs. A new CMS policy allows SNPs to target enrollment to certain subsets of a state's dually eligible population provided that the enrollment limitations parallel the structure and care delivery patterns of the Medicaid wraparound program or the Medicaid plan that is being integrated with the SNP.²⁴

The newest guidance from CMS seeks to better focus SNPs on their unique potential for providing targeted care to Medicare's most vulnerable beneficiaries. Encouraging dual eligible SNPs to enter into partnerships with state Medicaid programs to offer as integrated a product as possible is a priority. CMS is also promoting development of specialized models of care for SNP special populations.²⁵

State Action to Encourage Coordination with SNPs

A number of states are considering ways to coordinate Medicare and Medicaid benefits using SNPs. In a 2007 survey of states conducted by the National Association of State Medicaid Directors, 21 states reported interest in such initiatives.²⁶

Since the MMA became law in 2003, three states have developed new programs that coordinate Medicare and Medicaid benefits for dual eligibles using SNPs, again utilizing the vehicle of capitated Medicaid managed care programs that contractually assign responsibility for the delivery of Medicaid benefits in the hands of a Medicaid MCO that is also a Medicare SNP.

In June 2005, Washington began enrolling dual eligibles in its voluntary Medicare Medicaid Integration Program in two counties. This program, offered through SNPs, provides a capitated wrap-around Medicaid benefit.

Florida Senior Care, approved by CMS and scheduled for implementation in two pilot counties in 2008, is also intended to take advantage of SNPs for coordinating Medicare and Medicaid benefits. The Section 1915(b) waiver application states that "the state of Florida is exploring options to further integrate care and financing for dually eligible

Medicaid participants under Florida Senior Care through integration with Medicare Special Needs Plans.”²⁷

New Mexico has submitted to CMS applications for Section 1915(b) and Section 1915(c) waivers for Coordinated Long-Term Services, a mandatory (for Medicaid beneficiaries), statewide program scheduled for implementation in July 2008. The state anticipates initial participation by two Medicaid MCOs, who will be required to obtain approval as SNPs. The MCOs will be expected to coordinate primary, acute, and long-term care for individuals who enroll in the same plan for their Medicare and Medicaid benefits.

Outlook and Reauthorization

In a number of states, SNPs are in discussion with the Medicaid agencies to develop coordinated health care delivery programs for dual eligibles. Emerging programs range from initiatives to simply better coordinate Medicare and Medicaid benefits to programs that more fully integrate financing and delivery of services in health plans.

This movement is likely to gain even more momentum. The National Governors Association recently urged greater coordination of Medicare and Medicaid benefits and specifically recommended that states be granted access to Medicare Part D claims data.²⁸ The federal Medicaid Commission recommended a number of reform proposals to support the development and expansion of integrated care programs for dual eligibles.²⁹ However, with legislative authority for SNPs scheduled to expire on December 31, 2008, 2009, unless Congress reauthorizes the program, health plans and states alike may become increasingly reluctant to develop new initiatives in the face of uncertainty in pursuing this course.

As it takes up the debate on reauthorizing SNPs, Congress should consider improvements that could be included in new legislation. These improvements could include provisions that promote better coordination between SNPs and state Medicaid programs to serve the dual-eligible enrollees who choose to enroll in SNPs. New provisions, which would promote coordination, would include: (1) a requirement that dual eligible SNPs share utilization, encounter, diagnostic, and key health events data (such as alerts when Medicare-financed admissions to nursing facilities occur) with state Medicaid programs in which they operate; (2) a requirement that state Medicaid agencies similarly share data with dual eligible SNPs regarding Medicaid-financed services; (3) an easing of the Medicaid waiver requirements to permit states to more readily contract with SNPs for Medicaid-financed services without the need for a Medicaid waiver; and (4) enhanced federal Medicaid matching funds for data sharing activities such as joint electronic health records – between states and SNPs – for dual eligibles receiving services in both systems.

¹ Centers for Medicare and Medicaid Services, “Improving Access to Integrated Care for Beneficiaries Who are Dually Eligible for Medicare and Medicaid.” Fact Sheet, July 27, 2006. Available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912>.

² The Henry J. Kaiser Family Foundation, *Medicare Chartbook*. Third Edition, Summer 2005.

³ Ibid.

⁴ See, e.g., Jennifer Ryan and Nora Super, “*Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy*,” NHPF Issue Brief, September 30, 2003.

⁵ Congressional Budget Office, June 28, 2007.

⁶ See note 2.

⁷ Centers for Medicare and Medicaid Services, “Improving Access to Integrated Care for Beneficiaries Who Are Dually Eligible for Medicare and Medicaid,” July 27, 2006. Available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912>.

⁸ Paul Saucier and Brian Burwell, *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*. Thomson Medstat, January 2007.

⁹ Medicare Payment Advisory Commission, *Report to Congress: Promoting Greater Efficiency in Medicare*, June 2007, p. 72.

¹⁰ Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report, September 2007. Accessed 10/5/07 at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp>.

¹¹ The seven states are Minnesota, New York, Massachusetts, Arizona, Texas, Wisconsin and Washington.

¹² A “mandatory” program is described in detail in the companion issue brief, “*Coordinating Medicare and Medicaid Services for Dual Eligibles: Different Models that Link State Medicaid Programs With Medicare Advantage Special Needs Plans*.”

¹³ Three distinct models in which SNPs and state Medicaid programs could coordinate care are discussed in the companion issue brief found at note 11.

¹⁴ State of Arizona claims data.

¹⁵ Sema K. Aydede, PhD, “The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients,” Institute for Child Health Policy, September 2003.

¹⁶ Ibid.

¹⁷ “2004 Consumer Assessment of Health Care: MSHO Nursing Home Population.” Minnesota Health Data Institute, August 2004.

¹⁸ Percentages were calculated using these data: 6,229,000 full dual eligibles, 722,286 dual eligibles enrolled in SNPs (see Table 1), and 722,671 dual eligibles enrolled in Medicaid managed care. Sources: Kaiser Family Foundation, “Dual Eligible Enrollment, 2003,” statehealthfacts.org; Kaiser Family Foundation, “Total Dual Eligible Enrollment in Medicaid Managed Care, as of June 30, 2006,” statehealthfacts.org; and Centers for Medicare and Medicaid Services, Special Needs Plan Comprehensive Report, September 2007, <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp>.

¹⁹ §1802 of the Social Security Act.

²⁰ James M. Verdier, *Medicare Advantage Rate Setting and Risk Adjustment: A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefits*. Center for Health Care Strategies, Inc., September 2006.

²¹ Karen Tritz, *Integrating Medicare and Medicaid Services Through Managed Care*. Congressional Research Service Report for Congress, Order Code RL33495, June 27, 2006.

²² Paul Saucier and Brian Burwell, *The Impact of Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care*, January 2007, accessed at www.hcbs.org.

²³ Centers for Medicare and Medicaid Services, "Integrated Medicare and Medicaid Models." See http://www.cms.hhs.gov/DualEligible/04_IntegratedMedicareandMedicaidModels.asp#TopOfPage.

²⁴ Centers for Medicare and Medicaid Services, "Permissible enrollment subsets for dual eligibles enrolled in Special Needs Plans," Guidance to Medicare Advantage Organizations, August 10, 2006. Available at http://www.dads.state.tx.us/medicare/news/2006/Dual_Eligibles_SNP.pdf; Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors, August 11, 2006. Available at <http://www.cms.hhs.gov/DualEligible/downloads/specialneedsplanletter.pdf>

²⁵ Centers for Medicare and Medicaid Services, *Medicare Advantage: 2008 Call Letter*. Retrieved September 2007 at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>.

²⁶ See www.nasmd.org.

²⁷ State of Florida, Agency for Health Care Administration. *Section 1915(b) MCO Waiver Program: Florida Senior Care Waiver Proposal*. Approved by the Centers for Medicare and Medicaid Services, effective November 1, 2006. p. 3. Available at http://ahca.myflorida.com/Medicaid/long_term_care/pdfs/1915b_fsc_approved_waiver_091306.pdf.

²⁸ National Governors Association, Letter to The Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, February 12, 2007. Available at <http://www.nga.org/portal/site/nga/menuitem.cb6e7818b34088d18a278110501010a0/?vnextoid=b36368325b6b0110VgnVCM1000001a01010aRCRD>.

²⁹ *Final Report and Recommendations: Medicaid Commission*, Presented to Secretary Michael O. Leavitt, December 29, 2006. The Commission recommended four reform proposals to support the development and expansion of integrated care programs for dual eligibles: a) through SNPs or other mechanisms via the state plan; b) integrated care management programs with "universal" (automatic) enrollment of dual eligibles with an opt-out provision; c) reducing administrative barriers to an integrated approach to care; and d) a new program for dual eligibles called *Medicaid Advantage* (Recommendation E.2.).