

WHAT'S SO SPECIAL ABOUT MEDICARE ADVANTAGE SPECIAL NEEDS PLANS? ASSESSING MEDICARE SPECIAL NEEDS PLANS FOR "DUAL ELIGIBLES"

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INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),¹ best known for adding Medicare Part D prescription drug coverage also changed Medicare Part C, which authorizes private health insurance plans to provide services covered by original fee-for-service Medicare.² Among other amendments, the MMA changed the name of the Part C program from "Medicare+Choice" to "Medicare Advantage" (MA) and created new types of delivery vehicles, including Medicare Advantage Special Needs Plans (SNPs).³ The addition of Part D and the changes to Part C, as designed by Congress and implemented by the Centers for

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1. Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C.A. §§ 1395w-101 to -152).

2. *See id.* The extensive changes the MMA made to the entire Medicare program are beyond the scope of this article.

3. 42 U.S.C.A. § 1395w-21 (Westlaw current through Dec. 22, 2006). The statute authorizes plans for three different special needs populations: institutionalized individuals, dual eligibles, and "individuals with severe or disabling chronic conditions." 42 U.S.C.A. § 1395w-28(b)(6)(B) (Westlaw current through Dec. 22, 2006).

Medicare & Medicaid Services (CMS), have significant implications for beneficiaries eligible for both Medicare and Medicaid, a population referred to as "dual eligibles."

An official government analysis of the SNPs authorized by the MMA is not expected until the end of 2007.⁴ Early experience regarding SNPs that serve only dual eligibles prompted this article.

In late August 2005, Pennsylvania health law advocates learned of an industry-initiated and CMS-approved plan to forcibly enroll over 110,000 of Pennsylvania's dual eligibles into Medicare Advantage SNPs.⁵ Instead of automatically enrolling these dual eligibles into stand-alone Part D plans to ensure Medicare drug coverage beginning on January 1, 2006, as authorized by the statute,⁶ CMS allowed six Medicare Advantage SNPs in Pennsylvania to "passively enroll" these poor and chronically ill individuals out of original Medicare and into the Medicare Advantage SNPs that included prescription drug coverage.⁷ While the law permitted automatic enrollment

4. MMA § 231(e), 117 Stat. at 2208.

5. The plan involved the forced enrollment of approximately 220,000 dual eligibles in fourteen states into MA SNPs; over 110,000 of the dual eligibles to be passively enrolled were in Pennsylvania. See James M. Verdier, Mathematica Policy Research, Inc., Dual Eligible Populations and Special Needs Plans: Current and Future Strategies, Presentation at the Third National Medicare Conference (Oct. 16, 2006) (slideshow available at <http://www.mathematica-mpr.com/publications/pdfs/dualeligible.pdf> (last visited Mar. 14, 2007)).

6. 42 U.S.C.A. § 1395w-101(b)(1)(C) (Westlaw current through Dec. 22, 2006) (requiring the Secretary of Health and Human Services to establish process for enrollment into prescription drug plans of dual eligibles who failed to enroll in prescription drug plan or MA-PD).

7. After expressly rejecting this approach in its final MA rules [70 FR 4588, 4607 (Jan. 28, 2005) (codified at 42 C.F.R. § 222)], CMS authorized passive enrollment in a subregulatory document that was the annual request for bids or "call letter" to managed care organizations who wanted to be approved for MA contracts for 2006. CTR. FOR MEDICARE & MEDICAID SERV., 2006 CALL LETTER 9-11 (2006), http://www.cms.hhs.gov/BenePriceBidFormPlanPackage/02_Bid2006.asp (follow "Medicare Advantage 2006 Call Letter" hyperlink) (last visited Mar. 14, 2007) [hereinafter 2006 CALL LETTER]. It permitted MA Organizations with SNPs that also had Medicaid managed care plans to passively enroll into their MA-SNPs those dual eligibles already enrolled in their Medicaid managed care plans. *Id.* Several factors differentiate the Pennsylvania dual eligibles from others who were subjected to passive enrollment. Among other things, Pennsylvania's dual eligibles were in mandatory Medicaid managed care, which is prohibited under federal law

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of dual eligibles into drug plans to ensure drug coverage on January 1, 2006, when Medicaid drug coverage for this population would virtually end, it did not authorize the disruption of their original Medicare coverage.⁸

Consumers, advocates, and consumer organizations protested the passive enrollment plan as unlawful and unfair, but CMS refused to dismantle it. In November 2005, the Pennsylvania Health Law Project, the Center for Medicare Advocacy, and Community Legal Services of Philadelphia filed a class action lawsuit in the Eastern District of Pennsylvania on behalf of the 110,000 dual eligibles who were subject to passive enrollment.⁹ *Erb v. McClellan* alleged violations of the MMA, the Medicare Act, the Administrative Procedure Act, and constitutional due process requirements.¹⁰

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.¹¹ 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

absent a waiver assuring that the recipients' Medicare freedom of choice would still be honored. As a result, the dual eligibles in Pennsylvania were nominally, although not functionally, in Medicaid Mandatory Managed Care as they retained the ability to see any and all Medicare providers and were not hamstrung in their healthcare access by any managed care network, referral, or prior authorization issues. Further, starting January 1, 2006, the dual eligibles in Pennsylvania would be returned to Medicaid Fee-For-Service, thereafter having no ongoing connection to the managed care plan. The dual eligibles in the thirteen other states were individuals with Medicare and Medicaid who had elected to be in Medicaid managed care organizations instead of Medicaid Fee-for-Service. *Id.* at 10. Additionally, the dual eligibles in the other thirteen states were to remain with the same managed care organization for both packages of benefits. *Id.* at 10-11.

8. See 42 U.S.C.A. § 1395w-101.

9. *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

10. Compl. at 29-30, *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

11. See *id.*

June 2006.¹²

Unauthorized passive enrollment into SNPs with limited provider networks robbed beneficiaries of their Medicare free-choice-of-provider rights and caused confusion about the source of their health care. The *Erb* settlement sought to remedy those consequences of unauthorized passive enrollment. For dual eligibles, the more significant issue to surface in early 2006 was and remains the capacity and commitment of SNPs to actually meet enrollees' needs.

This article examines the demographic and health care needs of dual eligibles, the history and nature of managed care in Medicare including Medicare SNPs, the premises and past experience underlying SNPs for dual eligibles, and whether SNPs actually meet the needs of that population. This article concludes with recommendations related to SNPs.

WHO ARE DUAL ELIGIBLES?¹³

Dual eligibles are seniors and disabled persons, who are enrolled in both Medicare and Medicaid and have low incomes and few resources.¹⁴ Generally speaking, dual eligibles are poorer, sicker, less educated, more likely to be minorities, and more likely to be alone or in an institution than other Medicare beneficiaries.¹⁵ While dual eligibles comprise a diverse

12. Settlement Agreement at 1-7, *Erb v. McClellan*, No. 2:05-cv-6201 (E.D. Pa. filed Nov. 30, 2005).

13. Creating a demographic profile of dual eligibles is challenging. References cited for various demographic and health status characteristics report data from different years. Each source reports certain characteristics, but no single source, relying on data from a single year, paints the full picture of who comprises the dual eligible population. Even a single source may rely on data from different years. The authors nonetheless rely on these varying sources in the belief that characteristics of the population as a whole are unlikely to change dramatically over a two- or three-year period. Most sources cited rely on data from 2001, 2002, or 2003.

14. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: NEW APPROACHES IN MEDICARE 72 (June 2004), http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch3.pdf (last visited Mar. 20, 2006).

15. See MEDICARE PAYMENT ADVISORY COMM'N, A DATA BOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM 31 fig.3-3, 32 fig.3-4 (2006), http://www.medpac.gov/publications/congressional_reports/Jun06DataBookSec3.pdf (last

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population, they nonetheless share major health and well-being indices.¹⁶

Almost 6.2 million beneficiaries receiving full Medicaid services are dually eligible (full duals).¹⁷ An additional 1.3 million beneficiaries receive limited Medicaid assistance with Medicare cost-sharing through a Medicare Savings Program (partial duals).¹⁸ Nearly five million dual eligibles are sixty-five or older; about 2.5 million are disabled and under sixty-five.¹⁹ Both full and partial duals are eligible for consideration as “special needs populations” for MA SNP purposes. CMS has stated, in guidance, that a SNP could limit its coverage to those dual eligibles entitled to full Medicaid services.²⁰

DEMOGRAPHIC AND HEALTH CHARACTERISTICS COMPARED WITH THOSE OF OTHER MEDICARE BENEFICIARIES.

Demographic and health characteristics of dual eligibles strongly suggest that they are high users of health care services and face challenges navigating complex health care delivery systems.

The Medicare Payment Advisory Commission reported the following statistics, based on data from 2003:

- Nearly eighty percent of dual eligibles had income below 125% of federal poverty levels (\$8825 for people living alone and \$11,133 for married couples in 2003), compared to sixteen

visited Mar. 20, 2007) [hereinafter MEDPAC 2006].

16. *See id.*

17. JOHN HOLAHAN & ARUNABH GHOSH, HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID ENROLLMENT AND SPENDING FOR MEDICARE BENEFICIARIES IN 2003 3 (2005), http://www.kff.org/medicaid/upload/7346%20Dual%20Eligibles_Enrollment%20and%20Spending_Beneficiaries_Final_revised%2007_28.pdf (last visited Mar. 20 2007).

18. *Id.*

19. *Id.* at 3 fig.1.

20. *See* CTR. FOR MEDICARE & MEDICAID SERV., MA SPECIAL NEEDS PLANS GUIDANCE 6 (Jan. 19, 2006), <http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FinalSNPGuidance1-19-06R1.pdf> (last visited Mar. 20, 2007) [hereinafter CMS SNP GUIDANCE].

- percent of other Medicare beneficiaries;²¹
- Dual eligibles lack high school diplomas at a rate more than twice that of other Medicare beneficiaries (fifty-seven percent and twenty-five percent, respectively);²²
- African-Americans and Latinos comprise thirty-eight percent of dual eligibles, compared to thirteen percent of other Medicare beneficiaries;²³
- Twenty-one percent of dual eligibles report poor health status, compared to seven percent of other Medicare beneficiaries;²⁴
- Nearly one-third of dual eligibles have substantial limitations in daily living activities compared to thirteen percent of other Medicare beneficiaries.²⁵
- Nineteen percent of dual eligibles reside in institutions, usually long-term care facilities, compared to two percent of other Medicare beneficiaries.²⁶

2002 data revealed the following health characteristics of dual eligibles:

- Twenty-seven percent have diabetes, compared to eighteen percent of other Medicare beneficiaries;
- Ten percent were diagnosed with Alzheimer's disease, compared to four percent of other Medicare beneficiaries;
- Twice as many had mental disorders compared to other Medicare beneficiaries (thirty-four percent and seventeen percent, respectively).²⁷

These statistics suggest that dual eligibles tend to be in poorer health and in greater need of subsidized healthcare.

21. MEDPAC 2006, *supra* note 15, at 32 fig.3-4.

22. *Id.*

23. *Id.*

24. *Id.* at 31 fig.3-3.

25. *Id.* at 30 fig.3-2.

26. *Id.* at 32 fig.3-4.

27. JULIETTE CUBANSKI ET AL., HENRY J. KAISER FAMILY FOUND., MEDICARE CHARTBOOK 8 fig.1.12 (3rd ed. 2005), <http://www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Report.pdf> (last visited Mar. 19, 2007).

SPENDING ON HEALTH CARE FOR DUAL ELIGIBLES

Medicaid and Medicare spending for dual eligibles provides evidence confirming their high use of health care services.

MEDICAID SPENDING

In 2003, dual eligibles represented 13.6 percent of the Medicaid population (or 7.5 million enrollees)²⁸ but forty percent of total Medicaid spending (or \$105.4 billion).²⁹ The previous year, this spending disparity translated into average payments for a dual eligible of nearly four times more than those for a non-dual enrollee: \$11,352 and \$2891, respectively.³⁰ In 2003, approximate Medicaid expenditures nationwide for dual eligibles were as follows: sixty-six percent for long-term care services; fourteen percent for prescription drugs; fourteen percent for other acute care services and to supplement Medicare; and five percent for Medicare premiums.³¹

MEDICARE SPENDING

Dual eligibles also consume a disproportionate share of Medicare dollars. While dual eligibles comprised only sixteen percent of the Medicare population in 2003 (forty-two million total), they used twenty-four percent of the dollars (\$271 billion total).³² Average Medicare payments for duals and non-duals are not as disparate as those for Medicaid but are nonetheless remarkable: 2003, Medicare spent \$9,595 per dual eligible and

28. HOLAHAN & GHOSH, *supra* note 17, at 3 fig.1.

29. *Id.* at 8 fig.2.

30. See Terry R. Lied, *Dually Eligible Enrollees: 2002*, 27 HEALTH CARE FINANCING REV. 138 tbl. 1 (2006) (reporting 2002 Medicaid statistical information system data).

31. HOLAHAN & GHOSH, *supra* note 17, at 8 fig.3.

32. MEDICARE PAYMENT ADVISORY COMM'N, A DATABOOK: HEALTHCARE SPENDING AND THE MEDICARE PROGRAM 29 CHART 3-1 (JUNE 2006), http://www.medpac.gov/publications/congressional_reports/Jun06DataBookSec3.pdf (last visited Mar. 15, 2006).

\$6,023 for other Medicare beneficiaries.³³ In 2003, total per person spending for dual eligibles, including Medicaid, Medicare, supplemental insurance, and out-of-pocket payments, was \$20,941, almost twice the amount for other beneficiaries.³⁴

DETAILS OF MEDICAID AND MEDICARE SPENDING FOR DUAL ELIGIBLES

MEDICAID SPENDING

Medicaid spending for dual eligibles is distributed between the elderly and disabled populations in proportion to their presence in the population.³⁵ Thus, elderly persons comprise about two-thirds of all dual eligibles³⁶ and use about two-thirds of all Medicaid dollars spent for dual eligibles.³⁷

A more nuanced picture reveals that Medicaid spending for dual eligibles is concentrated between disabled beneficiaries under sixty-five and beneficiaries over seventy-five.³⁸ In 2001, data from Medicaid Statistical Information System (MSIS) outlined spending for dual eligibles by age and service as follows:

- For disabled dual eligibles under sixty-five, spending was \$28.3 billion. Long-term care services, the largest expense, comprised 61.5% of that amount, nearly half of which was for non-institutional services. About one-third of long-term care expenditures were for Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). The next single largest expense was for prescription drugs which

33. *Id.*

34. *Id.*

35. HOLAHAN & GHOSH, *supra* note 17, at 7 tbl. 3, 9 fig.4.

36. *Id.* at 7 tbl. 3.

37. *Id.* at 9 fig.4. Total Medicaid expenditures for dual eligibles for federal fiscal year 2003, as projected from 2001 data, were estimated to be \$105.4 billion, of which \$69.8 billion was estimated to be for aged beneficiaries and \$35.6 billion for people with disabilities. *Id.*

38. *See id.* at 12 tbl. 6.

- comprised 15.8% of spending for dual eligibles under age sixty-five.³⁹
- For dual eligibles between sixty-five and seventy-five, expenditures were \$13.6 billion. While spending on long-term care overall was proportionally similar to that for disabled beneficiaries under sixty-five, the breakdown is noticeably different. Overall, 37.5% of spending for this group was for nursing facility care, contrasted with 12.6% for the younger population. This group had insignificant spending on ICFs-MR (3.8% of total expenditures) and less spending on community-based long-term care services than the younger group (16.3% and 28.2%, respectively). As with the younger group, the next largest category of spending was for prescription drugs, comprising 17% of total expenditures.⁴⁰
 - For dual eligibles seventy-five and older, spending was \$43 billion dollars, more than half of all spending on dual eligibles. An astounding 81.6% of spending was for long-term care, of which over 80% was for nursing facility services and approximately 14% for home and community-based care.⁴¹ Prescription drug spending for this group comprised only 8.3% of overall expenditures, nearly half the rate for the other two groups.⁴²

MEDICARE SPENDING

Although a breakdown of Medicare spending by age group is not available, average per dual eligible spending by service

39. HOLAHAN & GHOSH, *supra* note 17, at 12 tbl. 6.

40. *Id.*

41. The high amount of Medicaid spending for dual eligibles in long-term care is of great concern to Medicaid directors and state governors, and it makes them interested in systems that “integrate” coverage (Medicare provides most of dual eligibles’ acute care and Medicaid provides most of their long-term care) and payment so that cost-shifting between programs is reduced or eliminated. *See, e.g.*, Nat’l Governors Ass’n, Policy Position: HHS-28 Long-Term Care § 28.5.1, <http://www.nga.org/portal/site/nga/menuitem.8358ec82f5b198d18a278110501010a0/?vgnnextoid=47a0d3add6da2010VgnVCM1000001a01010aRCRD> (last visited Mar. 19, 2007).

42. HOLAHAN & GHOSH, *supra* note 17, at 12 tbl. 6.

was reported for 2003.⁴³ These data demonstrate that forty-four percent of Medicare spending for dual eligibles is for inpatient hospital services, twenty-eight percent for physician services, and thirteen percent for skilled long-term care services, split evenly between skilled nursing facility services and home health services.⁴⁴

Because these Medicare and Medicaid data are for 2003, they show all prescription drug costs as costs to Medicaid; however, after December 31, 2005, prescription drug coverage for dual eligibles is provided under Medicare Part D.⁴⁵ In 2003, Medicare paid roughly thirty-eight percent of all Medicare/Medicaid expenditures for dual eligibles.⁴⁶ The prescription drug coverage shift under Medicare Part D may increase that proportion to about forty-two percent.⁴⁷

The demographic and spending data discussed above demonstrate that a huge portion of the cost of caring for dual eligibles is due to their need for long-term care services. Nothing in the statutory language creating SNPs for dual eligibles requires such plans to provide long-term care services, despite these being potentially the most universal "special need"

43. MEDPAC 2006, *supra* note 15, at 33 fig.3-5.

44. *Id.*

45. 42 U.S.C.A. § 1396u-5(d)(1) (Westlaw current through Mar. 21 2007). The loss of Medicaid coverage for prescription drugs was not total; categories of drugs used by a significant number of dual eligibles were excluded by statute from Medicare Part D coverage; coverage of those drugs remained an option for states. Most states continued to cover at least some of the Part D excluded drugs. The excluded categories include benzodiazepines (used heavily in nursing facilities), barbiturates, weight loss and weight gain drugs, prescription vitamins, and over the counter drugs, among others. 42 U.S.C.A. §§ 1395w-102(e), 1396r-8(d)(2), 1396u-5(d)(2).

46. See Fact Sheet: Medicare at a Glance, Kaiser Family Foundation, April 2003; Medicaid Facts: Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries, Kaiser Commission on Medicaid and the Uninsured, July 2005; MEDPAC 2006, *supra* note 15, at 29 fig. 3-1.

47. Medicaid prescription drug expenditures in 2001 for dual eligibles were \$10.3 billion. HOLAHAN & GHOSH, *supra* note 17, at 12 tbl. 6. Adding this full amount to Medicare expenditures for 2003 and deducting it from Medicaid expenditures increases the Medicare portion of costs to forty-four percent of total Medicare/Medicaid expenditures. However, this is a crude measure that does not account for continued Medicaid coverage of certain drugs that are important to dual eligibles.

of this population. Furthermore, Medicare's coverage of long-term care services is more limited than Medicaid's coverage (for example, Medicare pays a maximum of one hundred days of skilled care in a skilled nursing facility and does not pay for any long-term care services that are not incident to skilled services).⁴⁸ This is why most long-term care services are paid for by Medicaid.⁴⁹ Perhaps significantly, the market for SNPs for institutionalized individuals, another category of persons with special needs identified in the statute, has not developed nearly to the extent of the market for SNPs for dual eligibles.⁵⁰

WHAT IS A MEDICARE ADVANTAGE (MA) PLAN?

Medicare Part C⁵¹ defines MA plans, and this part differs from Medicare Parts A,⁵² B,⁵³ and D.⁵⁴ Instead of identifying benefits to be covered by Medicare, Part C establishes a different delivery mechanism for the benefits identified in Parts A, B, and D.⁵⁵ Since the Part C delivery model utilizes a variety of private

48. See KAREN TRITZ, INTEGRATING MEDICARE AND MEDICAID SERVICES THROUGH MANAGED CARE 2-4 tbl. 1 (Congressional Research Serv. ed., June 27, 2006), available at http://www.nhpg.org/content/pdfcontent/crs_report-mm_i_via_snps.pdf (last visited Jan. 29, 2007) (comparing services covered by Medicare and Medicaid).

49. See *id.*

50. MARSHA GOLD, SC. D., HENRY J. KAISER FAMILY FOUND., "THE GROWTH OF PRIVATE PLANS IN MEDICARE, 2006" 18 (March 2006), <http://www.allhealth.org/BriefingMaterials/Kaiser-rowthofPrivatePlansinMedicare-255.pdf> (last visited Mar. 24 2007); see also MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 251 tbl. 4-4 (Mar. 2007), http://medpac.gov/publications/congressional_reports/Mar07_Ch04.pdf (last visited Mar. 24, 2007) [hereinafter MEDPAC CONGRESSIONAL REPORT 2007].

51. 42 U.S.C.A. § 1395w-21 (Westlaw current through Dec. 22, 2006).

52. 42 U.S.C.A. § 1395c (Westlaw current through Dec. 22, 2006). Medicare Part A covers hospital care, skilled nursing facility care, hospice care, and some home healthcare services provided after an inpatient hospital stay. *Id.*

53. 42 U.S.C.A. § 1395j (Westlaw current through Dec. 22, 2006). Medicare Part B, referred to in the statute as "Supplementary Medical Benefits for Aged and Disabled," provides coverage for doctor visits, durable medical equipment, some home healthcare coverage, and other coverage provided on an outpatient basis. 42 U.S.C.A. § 1395k (Westlaw current through Dec. 22, 2006).

54. 42 U.S.C.A. § 1395w-101 (Westlaw current through Dec. 22, 2006). Medicare Part D provides coverage for outpatient prescription drugs. *Id.*

55. 42 U.S.C.A. § 1395w-21.

health insurance arrangements, many observers view the MA plans described in Part C as a move away from the universal nature of original Medicare and towards the privatization of health insurance for older people and people with disabilities.⁵⁶

Some form of private delivery model has been available almost since the beginning of the Medicare program.⁵⁷ Although Congress allowed health maintenance organizations (HMOs) to contract with Medicare starting as early as 1972, HMOs did not really begin participating in Medicare until the early 1980s after Congress made the first of many changes to encourage HMOs to participate.⁵⁸ By making managed care available to Medicare beneficiaries, Congress hoped to control Medicare costs while providing more coordinated medical services to a population that requires and uses a large amount of health care.⁵⁹

The HMO model was not widely adopted; HMOs simply were not available in most parts of the country.⁶⁰ By 1995, only about eight percent of Medicare beneficiaries had enrolled in a HMO.⁶¹ Furthermore, studies suggested that HMOs might not be accomplishing the goals intended by Congress.⁶² They attracted healthier beneficiaries who were less likely to require

56. See, e.g., Robert A. Berenson, *Medicare Disadvantaged and the Search for the Elusive "Level Playing Field": What the Changes to Medicare Really Mean for Competition and the Future of the Program*, HEALTH AFF., Dec. 15, 2004, at W4-573, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.572v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=berenson&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> (last visited Mar. 20, 2007); Trudy Lieberman, *Privatizing Medicare*, THE NATION, July 7, 2003, at 24, available at <http://www.thenation.com/doc/20030707/lieberman> (last visited Mar. 20, 2007).

57. Reginald D. Williams II, *Payment and Participation: A Renaissance for Medicare's Private Health Plans?*, MEDICARE BRIEF, May 2005, at 1, available at http://www.nasi.org/usr_doc/medicare_brief_12.pdf (last visited Mar. 20, 2007).

58. Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 § 114, 42 U.S.C.A. § 1395mm (Westlaw current through Dec. 22, 2006).

59. See Williams, *supra* note 57, at 5.

60. MARILYN MOON, *MEDICARE: A POLICY PRIMER* 69 (2006). California, Florida, and New York were among the states with the largest concentration of HMOs. *Id.*

61. MICHAEL E. GLUCK & KRISTINA W. HANSON, HENRY J. KAISER FAMILY FOUND., *MEDICARE CHARTBOOK* 51 fig.41 (2nd ed. 2001), <http://www.kff.org/mediare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13598> (last visited Mar. 19, 2007).

62. Williams, *supra* note 57, at 2.

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the care coordination promised by managed care.⁶³ Additionally, and possibly as a result of the healthier populations they served, HMOs were paid at a rate higher than their expenses; therefore they were likely costing, and not saving, money for the Medicare program.⁶⁴

Nevertheless, Congress decided in 1997 to expand the managed care model and the use of private health insurance plans as part of its effort to balance the federal budget.⁶⁵ The Balanced Budget Act of 1997⁶⁶ (BBA) created a new Medicare Part C to emphasize the importance of the private insurance delivery mechanism.⁶⁷ The new program was called Medicare+Choice and expanded the type of private insurance plans that could contract with Medicare beyond HMOs.⁶⁸ These plans included coordinated care plans such as HMOs and preferred provider organizations (PPOs),⁶⁹ private fee-for-service plans,⁷⁰ and a demonstration for high deductible plans with medical savings accounts.⁷¹ Medicare+Choice plans were required to cover the same services as covered under the original Medicare program.⁷² Any savings they achieved through effective administration were to be passed on to beneficiaries in the form of additional benefits.⁷³

63. *Id.*

64. MOON, *supra* note 60, at 69.

65. *Id.* at 69-70; Williams, *supra* note 57, at 2 (both agreeing that the federal budget was balanced in large part due to Medicare changes and cuts).

66. Pub. L. 105-33, 111 Stat. 251 (1997).

67. 42 U.S.C.A. § 1395w-21 (Westlaw current through Dec. 22, 2006).

68. Williams, *supra* note 57, at 2.

69. 42 U.S.C.A. § 1395w-21(a)(2)(A).

70. 42 U.S.C.A. § 1395w-21(a)(2)(C).

71. 42 U.S.C.A. § 1395w-21(a)(2)(B).

72. 42 U.S.C.A. § 1395w-22(a)(1)(A) (Westlaw current through Dec. 22, 2006).

73. *Id.*; 42 C.F.R. §§ 422.100-422.102 (2005). Plans satisfy this requirement as long as the total value of their benefit package is the same as under original Medicare. 42 U.S.C.A. § 1395w-22(a)(2). As a result, some plans reduce cost sharing for doctors' services while imposing higher cost sharing than original Medicare requires for services such as home health that are generally used by enrollees with greater healthcare needs. See Brian Biles et al., *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?*, COMMONWEALTH FUND ISSUE BRIEF, May 2006, at 9, [hereinafter *Medicare Beneficiary Out-of-Pocket Costs*].

Congress also changed the payment mechanism for HMOs and the other new Medicare+Choice plans. HMOs previously received a set amount for each enrollee that was ninety-five percent of the amount Medicare paid, on average, for an original Medicare beneficiary.⁷⁴ Under the BBA, payments to Medicare+Choice plans remained capped, so that plans continued to receive a set payment amount for each plan enrollee, regardless of the services provided to the enrollee.⁷⁵ However, the new payment structure set a floor payment to encourage growth of Medicare+Choice plans in rural and other underserved areas and guaranteed a minimum annual two percent rate increase.⁷⁶ It also accounted for geographic differences and established a risk-adjustment factor to account for the characteristics and health status of the Medicare beneficiaries enrolled in each particular Medicare+Choice plan.⁷⁷

The number of Medicare+Choice plans (still primarily HMOs) expanded, and by 1999, 6.2 million beneficiaries, or sixteen percent of the Medicare population, were enrolled in a private plan.⁷⁸ Enrollment began to decline, however, as private insurance companies withdrew from the Medicare market, alleging that the changes to the payment structure made their Medicare participation no longer viable.⁷⁹ Beneficiaries who were enrolled in plans became disillusioned when their HMOs reduced benefits and/or increased charges to offset what the plans considered reduced Medicare payments.⁸⁰

74. See, e.g., Berenson, *supra* note 56, at W4-773.

75. See *id.* at W4-573-W4-574.

76. Williams, *supra* note 57, at 2.

77. 42 U.S.C.A. § 1395w-23(a)(1)(C) (Westlaw current through Dec. 22, 2006).

78. MOON, *supra* note 60, at 69.

79. Marsha Gold, *Can Managed Care and Competition Control Medicare Costs?: It Will Take More Than Managed Care and Competitive Options to Ensure that Medicare Can Meet Its Obligations in the Future*, HEALTH AFF., Apr. 2, 2003, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.176v1> (last visited Jan. 13, 2007).

80. See Marsha Gold & Lori Achman, *Shifting Medicare Choices, 1999-2003*, MONITORING MEDICARE+CHOICE: FAST FACTS, Dec. 2003 No. 8, available at <http://www.mathematica-mpr.com/publications/PDFs/fastfacts8.pdf> (last visited Mar. 24, 2007).

Despite claims by private health plans that they were underpaid by Medicare, government analysts continued to assert that Medicare+Choice plans, on average, received more for their enrollees than Medicare would have paid had the enrollees remained in the fee-for-service program.⁸¹ Additionally, Medicare+Choice plans continued to attract beneficiaries who on average were healthier than the general Medicare population.⁸² In a 2004 analysis of payment rates to private plans, the Medicare Payment Advisory Commission (MedPAC), a quasi-governmental entity charged by Medicare to analyze and report on the Medicare program, reported that CMS found Medicare+Choice “plans enroll a less costly population than would be accounted for by demographics.”⁸³

In 2003, Congress enacted changes to Medicare Part C as part of the sweeping Medicare reforms included in the MMA, many of which were designed to promote the privatization of Medicare.⁸⁴ As noted earlier, the statute changed the name of the program from Medicare+Choice to Medicare Advantage. Other changes included making the Medicare Medical Savings Account (MSA) demonstration permanent⁸⁵ and creating

81. See, e.g., U.S. GEN. ACCT'G OFFICE, MEDICARE+CHOICE: PAYMENTS EXCEED COSTS OF FEE-FOR-SERVICE BENEFITS, ADDING BILLIONS TO SPENDING, GAO No. HEHS-00-161, at 5-6 (Aug. 2000), available at <http://frwebgate.access.gpo.gov/cgi-bin/useftpl.cgi?IPaddress=162.140.64.21&filename=he00161.pdf&directory=/diskb/wais/data/gao> (last visited Mar. 20, 2007) [hereinafter GAO MEDICARE+CHOICE]; MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 210 (Mar. 2004), http://www.medpac.gov/publications/congressional_reports/Mar04_Ch4.pdf (last visited Mar. 20, 2007) [hereinafter MEDPAC REPORT TO CONGRESS].

82. GAO MEDICARE+CHOICE, *supra* note 81, at 8 tbl. 1.

83. MEDICARE PAYMENT ADVISORY COMM'N, M+C PAYMENT RATES COMPARED WITH COUNTY MEDICARE PER CAPITA FEE-FOR-SERVICE SPENDING 2 (REVISED) (Apr. 8, 2004), http://www.medpac.gov/publications/other_reports/April04_PostMMA_MplusC_2pgrSH.pdf (last visited Mar. 24, 2007).

84. MOON, *supra* note 60, at 99; Brian Biles et al., *The Cost of Privatization: Extra Payments to Medicare Advantage Plans – Updated and Revised*, COMMONWEALTH FUND ISSUE BRIEF, Nov. 2006, at 1, available at http://www.cmwf.org/usr_doc/Biles_cost_privatizationextrapayMAplans_970_ib.pdf (last visited Mar. 24, 2007) [hereinafter *Cost of Privatization*].

85. 42 U.S.C.A. § 1395w-21(a)(2)(B) (Westlaw current through Dec. 22, 2006). The first Medicare MSAs will be offered in 2007, ten years after the delivery mechanism was added to Medicare.

regional Preferred Plan Providers (PPOs) with a different deductible structure and with an initial stabilization fund to encourage their development.⁸⁶ Congress once again changed the reimbursement mechanism to promote broader distribution of MA plans throughout the country.⁸⁷ The change most relevant to this article, however, was the creation of Medicare Advantage SNPs.

WHAT IS AN MA SPECIAL NEEDS PLAN (SNP)?

Prior to the MMA, a MA plan (then known as a Medicare+Choice plan) could not limit enrollment to subgroups of the Medicare population.⁸⁸ Medicare+Choice plans were required to enroll any eligible individuals during their available enrollment periods, unless CMS had permitted the plan to limit enrollments through a capacity waiver.⁸⁹

The MMA permits MA plans to establish and offer special MA plans that exclusively or disproportionately enroll "special needs" populations.⁹⁰ These are called "specialized MA plans for special needs individuals" or, more commonly, SNPs.⁹¹ The statute defines a "specialized MA plan for special needs individuals" as a "MA plan that exclusively serves special needs individuals."⁹² The statute defines a "special needs individual" as a:

MA eligible individual who— (i) is institutionalized . .

86. 42 U.S.C.A. § 1395w-21(a)(2)(A)(i).

87. 42 U.S.C.A. § 1395w-23 (Westlaw current through Dec. 22, 2006). Analysts project that the changes will increase Medicare costs through 2013. See *Cost of Privatization*, *supra* note 84, at 1. See also *infra* notes 122-30 and accompanying text (discussing payment rates).

88. 42 U.S.C.A. § 1395w-22(b) (Westlaw current through Dec. 22, 2006) (prohibiting discrimination against any eligible individual).

89. 42 C.F.R. § 422.60 (2005). However, in limited circumstances, an MA plan may seek to cap or close enrollment. *Id.*

90. 42 U.S.C.A. § 1395w-28(f) (Westlaw current through Dec. 22, 2006) ("In the case of a specialized MA plan for special needs individuals . . . , the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.").

91. 42 U.S.C.A. § 1395w-28(b)(6).

92. *Id.*

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.; (ii) is entitled to medical assistance under a State plan . . . ; or (iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan . . . for individuals with severe or disabling chronic conditions.⁹³

The Secretary of Health and Human Services has exercised the authority given to him by the MMA and, by guidance, has designated disease-specific chronic conditions groups as “special needs groups” for which MA plans can design SNPs.⁹⁴ For example, a SNP could be offered solely for serving the special needs of individuals with Medicare Parts A and B who have HIV or AIDS. The MMA’s authorization for SNPs will cease at the end of 2008 unless Congress reauthorizes the Special Needs Plan provision.⁹⁵

SNPs can be designed to serve people who (1) are institutionalized; (2) are entitled to state medical assistance; or (3) have a severe or disabling chronic condition.⁹⁶ However, most SNPs approved by Medicare have focused on the dual eligible population.⁹⁷ For 2006, CMS had approved 276 plans to be Medicare Advantage SNPs.⁹⁸ Of those plans, thirty-seven are

93. *Id.* Congress advised: “In promulgating regulations to carry out section [42 U.S.C.A. § 1395w-28(b)(6)], the Secretary may provide . . . for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals.” MMA § 231(d), Pub. L. No. 108-173, 117 Stat. 2066, 2208 (2003).

94. See CMS SNP GUIDANCE, *supra* note 20, at 1.

95. 42 U.S.C.A. § 1395w-28(f) (Westlaw current through Dec. 22, 2006). Congress requires: “Not later than December 31, 2007, the Secretary shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the [M]edicare program as a result of [adding 42 U.S.C.A. §§ 1395w-21(a)(2)(A)(ii), 1395w-28(b)(6), 1395w-28(f)].” MMA § 231(e), Pub. L. No. 108-173, 117 Stat. 2066, 2208 (2003). Mathematica Research Group will generate this report. CTR. FOR MEDICARE & MEDICAID SERV., SPECIAL NEEDS PLAN – FACT SHEET & DATA SUMMARY, <http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/finalSNPfactsheetsum2-14-06.pdf> (last visited Mar. 14, 2007) [hereinafter SNP FACT SHEET].

96. CMS SNP GUIDANCE, *supra* note 20, at 1.

97. Christie Provost Peters, *Medicare Advantage SNPs: A New Opportunity for Integrated Care?*, NAT’L HEALTH POL’Y F. ISSUE BRIEF, Nov. 11, 2005, at 3, http://www.nhpf.org/pdfs_ib/IB808_SNP_11-11-05.pdf (last visited Mar. 13, 2007).

98. See CTR. FOR MEDICARE & MEDICAID SERV., SPECIAL NEEDS PLAN REPORT 2006, <http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/SNPReport200601>.

designed to serve institutionalized individuals, 226 are designed to serve dual eligibles, and thirteen are designed to serve individuals with other chronic diseases or conditions.⁹⁹ The arrival of SNPs on the market since the MMA has been swift, and their numbers substantial.¹⁰⁰ A number of insurance companies that have SNPs in a service area also hold a Medicaid managed care contract in that service area. Therefore, these insurance companies could already be managing the dual eligibles' Medicaid care.¹⁰¹ These SNPs are, arguably, already at risk for the cost of all care. This, however, is not uniformly the case, and while CMS publicly encourages these arrangements, SNPs are not required to be Medicaid managed care contractors serving the population in the area.¹⁰² Those not at risk for the Medicaid care costs may be more likely to shift costs to the Medicaid wraparound benefit.¹⁰³

HOW DOES AN MA PLAN BECOME A SNP?

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 Medicare Part D prescription drug benefits to all enrollees; and (3) satisfy all SNP requirements specified by CMS.¹⁰⁴

zip (last visited Mar. 25, 2007) (listing all approved plans).

99. *Id.*

100. See SNP FACT SHEET, *supra* note 95. CMS approved eleven MA SNPs in 2004, 125 in 2005, and 276 in 2006. *Id.*

101. The Congressional Research Service notes that it is unclear how many SNPs have contracts to provide Medicaid managed care and the extent to which those with both contracts are delivering Medicare and Medicaid services in an integrated manner. TRITZ, *supra* note 48, at 11.

102. Peters, *supra* note 97, at 2.

103. See *id.*

104. 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

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To date, however, CMS has promulgated neither regulations delineating standards that a MA plan must meet for approval as a SNP nor any requirements for approved SNPs to follow in meeting the special needs of its enrollees.¹⁰⁵ The MMA itself requires implementing regulations.¹⁰⁶ CMS even mentioned that in early 2005 formal rulemaking would be forthcoming.¹⁰⁷ Yet, to date, no substantive regulations have been promulgated.

CMS has issued a few SNP guidance documents, but these largely relate to enrollment and marketing issues.¹⁰⁸ CMS has most recently published several documents offering

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.”).

105. 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. *See, e.g.*, 42 CFR § 422.2 (2005) (definitions); § 422.4 (2005) (types of MA plans); § 422.50 (2005) (eligibility to elect MA plan); § 422.52 (2005) (eligibility to elect MA plan for special needs individuals); § 422.74 (2005) (disenrollment by the MA organization); § 422.254 (2005) (submission of bids); § 423.279 (2005) (national average monthly bid amount); § 423.855 (2005) (definitions for fallback prescription drug plans).

106. MMA § 223(b), Pub. L. No. 108-173, 117 Stat. 2066, 2207 (2003) (“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.A. § 1395w-21 (2006)] to carry out the provisions of this Act.”); MMA § 231(f)(2), 117 Stat. 2066, 2208 (“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.”).

107. CTR. FOR MEDICARE & MEDICAID SERV., RENEWAL AND NONRENEWAL INSTRUCTIONS FOR CONTRACT YEAR 2005 (CALL LETTER) 8 <http://www.cms.hhs.gov/ACR/Downloads/CallLetter.pdf> (last visited Mar. 20, 2007) (subregulatory document stating “CMS intends to solicit comments on this provision of the MMA through rulemaking. Therefore, this interim guidance is subject to change in the future.”).

108. *See, e.g.*, CTR. FOR MEDICARE & MEDICAID SERV., 2006 SPECIAL NEEDS PLAN (SNP) ENROLLMENT REPORT BY SNP TYPE, http://www.cms.hhs.gov/SpecialNeedsPlans/Downloads/06SNP_Enrollment_by_Type11-9-06.pdf (last visited Mar. 23, 2007); 2005 SPECIAL NEEDS PLANS REPORTS, available for download on the CMS website at <http://www.cms.hhs.gov/SpecialNeedsPlans> (follow “2005 Special Needs Plans Reports” hyperlink) (last visited Mar. 14, 2007); JANUARY 2006 SPECIAL NEEDS PLAN REPORT; 2007 SPECIAL NEEDS PLANS REPORTS, available for download on the CMS website at <http://www.cms.hhs.gov/SpecialNeedsPlans> (last visited Mar. 14, 2007) (follow “2007 Special Needs Plans Reports” hyperlink).

recommendations, suggestions, or encouragement for what a plan could do to work with the states to integrate Medicare and Medicaid services to meet the enrollees' special needs.¹⁰⁹ These documents, while providing parameters for SNP marketing activities and other aspects of program administration, offer little guidance in establishing minimum standards for the steps SNPs must take to coordinate care and benefits or to meet special needs.

Similarly, since the MMA's authorization of SNPs, there have been no discrete requirements for SNPs included within the MA Coordinated Care Plan application. Any MA coordinated care plan that either exclusively enrolls special needs individuals or enrolls a disproportionate percentage of special needs individuals can apply for approval as a SNP.¹¹⁰ To become a SNP, an insurer not already approved to be a MA plan must submit a MA Coordinated Care Plan application, as is required by all other MA applicants.¹¹¹ An existing MA plan that wants approval to offer a SNP need only submit a service area expansion application.¹¹² No special or additional application form is required for a plan to be approved as a SNP, and the additional information that a MA plan requesting SNP approval must include has been de minimus.¹¹³ For the 2007 contract year, for example, the application to be a MA plan had a small handful of pages that were specific to plans applying to be SNPs,¹¹⁴ several of which were expressly for the purposes of

109. See CMS SNP GUIDANCE, *supra* note 20, at 6-7.

110. See MEDICARE MANAGED CARE MANUAL, *supra* note 104, at ch. 1 § 20.

111. See CMS SNP GUIDANCE, *supra* note 20, at 1-2.

112. See *id.*

113. See *id.*

114. See DEP'T OF HEALTH & HUMAN SERV., MEDICARE ADVANTAGE INITIAL APPLICATION FOR COORDINATED CARE PLANS (CCPs) 2007 27-30 (on file with MARQUETTE ELDER'S ADVISOR) [hereinafter 2007 MA APPLICATION]. For the 2008 application, CMS has articulated more detail that each SNP applicant must submit. DEP'T OF HEALTH & HUMAN SERV., MEDICARE ADVANTAGE INITIAL APPLICATION FOR COORDINATED CARE PLANS (CCPs) 2008, available at http://www.cms.hhs.gov/MedicareAdvantageApps/02_Final%202008%20Applications.asp (follow "Initial Application for Coordinated Care Plans" hyperlink) (last visited Mar. 14, 2007) [hereinafter 2008 MA APPLICATION].

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describing and defining SNPs and special needs populations, as articulated in the statute and regulations.¹¹⁵ The applicant was asked to provide CMS with the key components of the SNP's "marketing, enrollment, clinical expertise and experience, benefits that are unique to the SNP population including an explanation of why those benefits were chosen and how the specified benefits are meaningful to the target population."¹¹⁶ The SNP also had to state its target population, including how the SNP planned to identify and market to its target population and how its network would be comprised.¹¹⁷ Lastly, SNPs applying to serve dual eligibles in 2007 were asked to "[i]dentify any contracts between the applicant and the State to provide Medicaid services; [and] [i]f the applicant organization has a contract to serve Medicaid beneficiaries, indicate whether the contract excludes any subset(s) of beneficiaries."¹¹⁸ Nothing more was required.

For all practical purposes, SNPs needed not articulate any plan, policies, or practices explaining how they would coordinate care or benefits or manage care needs to meet the special needs of their special needs population. They needed not articulate any past experience or special expertise relevant to meeting the needs of potential enrollees. They needed not articulate any specific mechanisms or methods for ensuring that needs are met. As for the handful of items CMS asked the plans to recite, there was no reason to believe the items they were required to articulate hold any significance to CMS. And while the application for obtaining a new SNP contract for the 2008 contract year requires more information to be provided by the applicant,¹¹⁹ CMS continues to have no written standards for determining whether a SNP proposal is worthy of approval. CMS still has not created any guidelines for evaluating the

115. *See id.* at 26-31.

116. *Id.* at 28.

117. *Id.* at 28.

118. *Id.* at 29.

119. 2008 MA APPLICATION, *supra* note 114, at 26-61.

information sought or any enforceable conditions of participation to assess plans' performance after contract approval. CMS reportedly determines whether a MA plan has met the requirements to become a SNP on a case-by-case basis, taking into account the following factors: appropriateness of the target population, special expertise to serve this target population,¹²⁰ and whether the proposed plan discriminates against the sicker members of the target population.¹²¹

WHY OFFER AN SNP?

SNPs are paid on the same basis as other MA plans.¹²² Until 2007, this payment system had been one of fixed capitated payments based on the age and sex of the enrollee, although an additional amount was paid to plans for each dual eligible enrolled.¹²³ For 2007, however, the capitated payments will be risk-adjusted based primarily on the health status and to a lesser extent on the demographics of the enrollees.¹²⁴ Although Congress intended that payments shift swiftly from a fixed capitated rate to a risk-adjusted rate based on health status, the

120. However, it is unclear what weight, if any, is given to special expertise during the approval process. Existing MA plans did not have to show any special expertise to serve dual eligibles during their initial approval process, and the information they have to submit to convert to a SNP is minimal. See 2007 MA APPLICATION, *supra* note 114, at 28-30.

121. See SNP Fact Sheet, *supra* note 95, at 1; 42 C.F.R. § 422.2 (2005).

122. See MEDICARE MANAGED CARE MANUAL, *supra* note 104, at ch. 1 § 30.2.5.

123. See *supra* notes 65-87 and accompanying text (discussing history of MA plans). Under the fixed capitated rate system, however, the fixed rate reimbursement was set higher for Medicare beneficiaries that were dually enrolled in Medicare and Medicaid than it was for those who are only enrolled in Medicare. 42 U.S.C.A. § 1395w-23 (Westlaw current through Dec. 22, 2006); MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 245 (March 2007), http://www.medpac.gov/publications/congressional_reports/Mar07_EntireReport.pdf (last visited Mar. 24, 2007).

124. 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 8 (Ctr. for Health Care Strategies, Inc. ed., Oct. 2006), available at http://www.chcs.org/usr_doc/Medicare_Advantage_State_Primer.pdf (last visited Mar. 24, 2007); Sarah Lueck & Jane Zhang, *Give Us Your Sick...Thanks to a Shift in Medicare Policies, Insurers Are Seeking Out Those They Once Avoided*, WALL ST.J., Oct. 21-22, 2006, at R5.

change to a risk-adjusted rate has been slower than anticipated and is not expected to be in full effect for 2007.¹²⁵ Because not all the data have been collected to adjust the rates, some plans will receive higher payments than their enrollees' care would call for under the new risk-adjusted payment system.

Risk-adjusted rates alone do not offend. However, risk-adjusted rates are based on diagnoses, chronic conditions, and care needed.¹²⁶ They are not based on care delivered. Some researchers note that capitated rate payment systems create "incentives to stint on health care and avoid enrollees who are in poor health and represent a greater risk of high costs."¹²⁷ Further, where the SNP managed care plans are at risk only for the dual eligibles' Medicare covered services, denied care may result either in cost shifting to the Medicaid program or in health status decline.¹²⁸

The increased capitation is a financial incentive for plans to become SNPs.¹²⁹ For those SNPs without a Medicaid managed care product filling the Medicare gaps, the financial incentive exists without financial risk for undelivered care to the extent that care is covered under a state's Medicaid program. Those MA organizations that hold both the Medicare SNP contract and the Medicaid managed care contract to serve dual eligibles are receiving two monthly capitated rates both of which may be

125. *Medicare Beneficiary Out-of-Pocket Costs*, *supra* note 73, at 5. SNPs are subject to the risk-adjusted payment formula for Medicare Advantage plans, which included an immediate payment increase for 2004 and 2005. *Id.* Payments to these plans are adjusted for the expected costs of the enrollees, based on health condition and not demographic factors. *Id.* at 4. In 2007, demographic factors will have no bearing on payment. *Id.* at 5. Plans whose clients are generally healthy may see higher payment levels or even overpayment. *Id.*

126. MEDPAC REPORT TO CONGRESS, *supra* note 81, at 212.

127. *Medicare Beneficiary Out-of-Pocket Costs*, *supra* note 73, at 8. Dual eligibles themselves may shy away from SNPs out of "concern that the [plan's] financial incentives for savings will ultimately result in limiting services and quality." TRITZ, *supra* note 48, at 24.

128. TRITZ, *supra* note 48, at 18-19. Cost savings are more likely to be realized to the SNP because of the lower utilization of primarily Medicare-funded services with an accompanying increase in utilization of Medicaid-funded services. *Id.*

129. Lueck & Zhang, *supra* note 124, at R5 (quoting John Gorman, president and CEO of Gorman Health Group LLC, "The people these plans were running from five years ago now become the desirables.").

risk-adjusted, permitting any financial risk of serving this high-needs population to be spread across two programs.¹³⁰

WHY JOIN AN SNP?

Generally speaking, dual eligibles have no incentive to join a MA plan. Medicaid "provides wraparound coverage for services Medicare does not cover, such as long-term care, dental, and eye coverage."¹³¹ SNPs do not appear to offer that additional coverage, which would benefit consumers by filling in the gaps in Medicare coverage.¹³² In states such as Pennsylvania, where Medicaid provides dual eligibles a comprehensive benefits package, enrolling in a MA plan usually represents a reduction in benefits, as access to providers for dual eligibles is limited without a measurable benefit in return.¹³³ Thus, it is not surprising that most dual eligibles choose original Medicare for their Medicare benefit package, as it offers a wider array of provider options and an easier means of accessing covered services.¹³⁴ Only if the mythic promise of coordinated, integrated care, discussed below, were to become a CMS commitment, would a dual eligible benefit from enrolling in a SNP.

WHAT OVERSIGHT IS NEEDED TO ENSURE THAT SNPs ARE MEETING ENROLLEES SPECIAL NEEDS?

Not only has CMS failed to articulate the standards or criteria a MA plan must meet before it can be an approved SNP, CMS has yet to articulate any requirements for how a plan must

130. TRITZ, *supra* note 48, at 4.

131. Peters, *supra* note 97, at 13.

132. *See id.*

133. *Id.*

134. HENRY J. KAISER FAMILY FOUNDATION, MEDICARE ADVANTAGE PLAN PENETRATION: 2006, <http://www.kff.org/medicare/healthplantracker/topicresults.jsp?i=8&rt=1&ctot=&sr=2&ss=> (last visited Mar. 20, 2007) (reporting only 16.3% of Medicare beneficiaries participate in MA plans). The Congressional Research Service reports that less than two percent of dual eligibles were enrolled in Medicare Advantage plans in April 2006. TRITZ, *supra* note 48, at 9.

perform after approval. Regulations that articulate CMS's expectations for SNPs' performance and that are enforced would go a long way in ensuring that individuals with special healthcare needs actually receive the healthcare they need.

PREMISE BEHIND SNPs

Congress included the provisions for SNPs as part of its effort to increase plan and beneficiary participation in managed care.¹³⁵ In particular, SNPs serve populations (for example, dual eligibles, long-term care residents, people with chronic conditions) that generally are not enrolled in Medicare managed care plans.¹³⁶ In an ideal world, these populations would seem to benefit most from managed care since they tend to be the highest users of healthcare.¹³⁷

However, one of the premises behind the initiative, the coordination of care in a cost-effective way, also creates a barrier for serving these populations, particularly for dual eligibles.¹³⁸ Managing care for dual eligibles involves managing and coordinating benefits available under two separate programs, Medicare and Medicaid.¹³⁹ Differences in the Medicare and Medicaid benefit structures, and in the beneficiary protections they provide, have made the integration of services for this population difficult.¹⁴⁰ Earlier attempts to combine the programs

135. Peters, *supra* note 97, at 2.

136. *Id.* In fact, beneficiaries with end-stage renal disease (ESRD) are not eligible to enroll in a Medicare Advantage plan in most circumstances. 42 U.S.C.A. § 1395w-21(a)(3)(B) (Westlaw current through Dec. 22, 2006). Dual eligibles are ineligible to enroll in Medicare Advantage MSAs. 42 U.S.C.A. § 1395w-21(b)(3). Residents of long-term care facilities have greater flexibility to enroll in and disenroll from MA plans than other Medicare beneficiaries. 42 C.F.R. § 422.62(a)(6).

137. See Peters, *supra* note 97, at 4.

138. *Id.* at 5.

139. TRITZ, *supra* note 48, at 1.

140. *Id.* CMS identifies Medicare and Medicaid contractual arrangements, integrating benefits under both programs, accounting and tracking funding sources, managing data reporting requirements, coordinating Medicare and Medicaid appeals processes, and coordinating quality oversight requirements among the issues to be considered when developing an integrated program for dual eligibles. CTR. FOR MEDICARE & MEDICAID SERV., STATE GUIDE TO INTEGRATED MEDICARE & MEDICAID MODELS 19-20 tbl. 4, (Mar. 2006), <http://www.cms.hhs.gov/Du>

and integrate covered services have not always been successful.¹⁴¹

MEDICARE AS SOCIAL INSURANCE

It is important to note at the outset that high-cost Medicare beneficiaries, including dual eligibles, benefit most from the concept of Medicare as a social insurance program. Medicare was enacted to provide healthcare to all people over sixty-five, regardless of income or health status, at a time when private health insurance companies were unwilling to offer them insurance coverage.¹⁴² High-cost beneficiaries continue to receive Medicare benefits through the Medicare program, regardless of where they live, their income, the services they require, or their health condition when they first become eligible for Medicare.¹⁴³ Partially due to the implementation of Medicare, the poverty rate among older people has decreased, bringing Medicare beneficiaries and their families health and economic security.¹⁴⁴

There is a concern that turning to private markets to deliver Medicare benefits will undermine the security provided by Medicare.¹⁴⁵ As noted earlier, private plans move in and out of the Medicare program, disrupting enrollee relationships with their healthcare providers and their access to healthcare in general. Unlike original Medicare, private plans offer different additional benefits and cost sharing and serve only limited areas, factors that also have implications for those most in need of health services.¹⁴⁶ The inequity in benefits may result in uneven care, threatening the reliability of the health insurance

alEligible/Downloads/StateGuide.pdf (last visited Mar. 24, 2007) [hereinafter CMS STATE GUIDE].

141. TRITZ, *supra* note 48, at 17-18.

142. MOON, *supra* note 60, at 2.

143. *Id.* at 26.

144. *See id.* at 2.

145. *Id.* at 123.

146. *Id.* at 73-74.

program.¹⁴⁷

Therefore, if SNPs are to accomplish their goal, they must provide the stability, financial protections, and universality that original Medicare provided to beneficiaries in 1966 and continues to provide today.

FEDERAL PACE MODELS

SNPs for dual eligibles are not a new concept. For decades, healthcare providers, states, and policymakers have tried to develop sufficient coordinated care mechanisms to serve dual eligibles.¹⁴⁸ SNP providers would be well-advised to study the successes and failures of these efforts.

On Lok¹⁴⁹ Senior Health Services, the first program to combine health and social services effectively, was established in San Francisco to meet the needs of older immigrants and their families.¹⁵⁰ Medicaid began funding On Lok's adult day care program in 1974.¹⁵¹ Throughout the rest of the decade, On Lok expanded the services it provided, adding a social day-care center, in-home care, home-delivered meals, housing assistance, and complete medical and social support services for older people otherwise eligible for nursing home care.¹⁵² By 1979, On Lok had received a grant from the Department of Health and Human Services to develop an integrated healthcare delivery model for older people who required long-term care services.¹⁵³ In 1983, On Lok worked with the Medicare agency, then known as the Health Care Financing Administration, to develop a risk-

147. NAT'L ACAD. OF SOC. INS., THE ROLE OF PRIVATE INSURANCE IN MEDICARE: LESSONS FROM THE PAST, LOOKING TO THE FUTURE 1 (2003); http://www.nasi.org/usr_doc/Medicare_and_Markets_Exec_Sum.pdf (last visited Mar. 24, 2007).

148. See Peters, *supra* note 97, at 7-9.

149. On Lok means "peaceful, happy abode" in Cantonese. On Lok SeniorHealth, What is PACE?, <http://www.onlok.org/SeniorHealth/content.asp?catid=240000177&scatid=240000200> (last visited Mar. 24, 2007).

150. National PACE Association, What Is PACE?, <http://www.npaonline.org/website/article.asp?id=12#History> (last visited Mar. 24, 2007).

151. *Id.*

152. *Id.*

153. *Id.*

adjusted capitated payment rate for each enrollee.¹⁵⁴

Drawing on the success of On Lok, Congress in 1983, and again in 1986, authorized a demonstration program that would provide intensive acute and long-term care management services to help frail older people remain in the community.¹⁵⁵ The Program for All-Inclusive Care for the Elderly (PACE) was made a permanent part of both the Medicare and Medicaid statutes by the Balanced Budget Act of 1997.¹⁵⁶ PACE providers generally are non-profit organizations¹⁵⁷ that enter into a contract with CMS and/or a state Medicaid agency to provide comprehensive services to PACE-eligible individuals.¹⁵⁸ They operate under the federal statute and regulations as well as under a PACE Protocol published by On Lok.¹⁵⁹

Individuals at least fifty-five years old, who live in the area covered by the PACE program, and who generally need a skilled level of care, are eligible to enroll in a PACE program.¹⁶⁰ Enrollment and disenrollment are voluntary and are not subject to the enrollment lock-in periods as is the case with enrollment in MA plans.¹⁶¹ Enrollment is effective the first day of the month

154. U.S. GEN. ACCT'G OFFICE, MEDICARE AND MEDICAID: IMPLEMENTING STATE DEMONSTRATIONS FOR DUAL ELIGIBLES HAS PROVEN CHALLENGING, GAO No. HEHS-00-94, at 22 (Aug. 2000), *available at* <http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.21&filename=he00094.pdf&directory=/diskb/wais/data/gao> (last visited Mar. 20, 2007) [hereinafter GAO IMPLEMENTING STATE DEMONSTRATIONS].

155. Social Security Act of 1983 § 603(c)(1), Pub. L. No. 98-21, 97 Stat. 65 (codified at 42 U.S.C.A. §§ 1395eee, 1396u-4); Consolidated Omnibus Budget Reconciliation Act of 1985 § 9220, Pub. L. No. 99-272, 100 Stat. 82 (1986); Omnibus Budget Reconciliation Act of 1986 § 9412(b), Pub. L. No. 99-509, 100 Stat. 1874.

156. Balanced Budget Act of 1997 § 4803, 42 U.S.C.A. § 1395eee (Westlaw current through Dec. 22, 2006).

157. 42 U.S.C.A. §§ 1395eee(a)(3), 1396u-4(a)(3). The BBA also established certain conditions under which the Secretary of Health and Human Services has discretion to contract with private entities to serve as PACE providers. 42 U.S.C.A. §§ 1395eee(a)(3)(B), 1396u-4(a)(3)(B).

158. 42 U.S.C.A. §§ 1395eee(a)(2), 1396u-4(a).

159. 42 U.S.C.A. §§ 1395eee(a)(4), (6), 1396u-6(a)(4), (6).

160. 42 U.S.C.A. §§ 1395eee(a)(5), (c)(2), 1396u-4(a)(5), (c)(2); 42 C.F.R. § 460.150(b) (2005). Potential PACE enrollees do not have to be Medicare beneficiaries or Medicaid recipients. 42 C.F.R. § 460.150. They may, but are not required to, be entitled to Medicare Part A, enrolled in Medicare Part B, or eligible for Medicaid. 42 C.F.R. § 460.150(d).

161. 42 C.F.R. §§ 460.154, 460.162 (2005). Enrollment involves an extensive

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after the month in which the PACE program receives the signed PACE agreement.¹⁶² Enrollment continues, regardless of the beneficiary's health status, until the beneficiary dies or disenrolls.¹⁶³ The beneficiary may voluntarily disenroll from the program at any time.¹⁶⁴ Each beneficiary must be re-evaluated on a yearly basis, however, to determine whether he or she still meets the skilled level of care requirements under the state Medicaid program.¹⁶⁵

PACE programs provide all Medicare and Medicaid covered services without imposition of any cost sharing by PACE beneficiaries.¹⁶⁶ Dual eligibles are not charged a premium to enroll in a PACE program.¹⁶⁷ The comprehensive, multidisciplinary services are available twenty-four hours a day, seven days a week.¹⁶⁸ Like HMO enrollees, PACE enrollees are restricted to using PACE providers.¹⁶⁹

According to the National PACE Association, the average PACE enrollee is female, eighty years old, limited in three activities of daily living, and has about eight medical

intake process whereby potential enrollees are evaluated to determine whether they meet eligibility criteria. 42 C.F.R. § 460.152 (2005). The PACE program, including beneficiary rights, is also described to the potential enrollee during the intake process. *Id.*

162. 42 C.F.R. § 460.158 (2005). Medicare beneficiaries may only enroll in, disenroll from, or change Medicare Advantage plans at certain specified time periods, but they may not change at will. 42 C.F.R. § 422.62 (2005).

163. CTR. FOR MEDICARE & MEDICAID SERV., PACE FACT SHEET, <http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf> (last visited Mar. 14, 2007).

164. CTR. FOR MEDICARE & MEDICAID, STATE GUIDE TO INTEGRATED MEDICARE & MEDICAID MODELS 22 (March 2006), <http://www.cms.hhs.gov/DualEligible/Downloads/StateGuide.pdf> (last visited Mar. 23, 2007) [hereinafter CMS STATE GUIDE 2006].

165. 42 C.F.R. § 460.160(b). A beneficiary may be involuntarily disenrolled for failing to pay any premium that is required or for disruptive behavior. 42 C.F.R. § 460.164(a) (2005).

166. 42 U.S.C.A. §§ 1395eee(b)(1)(A), 1396u-4(b)(1)(A).

167. 42 C.F.R. § 460.186(d) (2005). PACE enrollees who are eligible for only Medicaid pay no premiums. *Id.* Premiums for Medicare beneficiaries who are not eligible for Medicaid vary, depending on whether they are enrolled in Medicare Part A, Medicare Part B, or both Medicare Part A and Part B. 42 C.F.R. § 460.186(a)-(c).

168. 42 U.S.C.A. §§ 1395eee(b)(1), 1396u-4(b)(1).

169. 42 U.S.C.A. §§ 1395eee(a), 1396u-4(a).

conditions.¹⁷⁰ Although approximately half of PACE enrollees have dementia, over ninety percent live at home.¹⁷¹ In March 2006, there were thirty-seven PACE programs around the country,¹⁷² up from thirty-one programs in 2000.¹⁷³ PACE sites have been described as resembling “small staff-model HMOs – with interdisciplinary teams . . . – designed with the goal of treating the whole person” and treating a small number of enrollees.¹⁷⁴

Crucial differences between PACE and SNPs raise red flags about the potential for SNPs to meet the needs of elderly or disabled dual eligibles.¹⁷⁵ Issues encountered by dual eligibles in PACE programs are addressed in advance by the statute and regulations.¹⁷⁶ Indeed, the effectiveness of the PACE program in serving dual eligibles rests in part on its statutory and regulatory integration of Medicare and Medicaid. Both the enabling statute and regulations apply to Medicare and Medicaid services.¹⁷⁷ Regulations address some of the difficult issues in coordination between Medicare and Medicaid, including payment under both programs,¹⁷⁸ co-payment issues,¹⁷⁹ and the differences in appeal rights available under both programs.¹⁸⁰ Because dual-eligible PACE enrollees are entitled to services available under Medicare

170. National PACE Association, *Who Does Pace Serve?*, <http://www.npaonline.org/website/article.asp?id=50> (last visited Mar. 14, 2007).

171. *Id.*

172. National PACE Association, *PACE and Pre-PACE Providers*, <http://www.npaonline.org/website/download.asp?id=1740> (last visited Mar. 20, 2007). However, not all are operating to their fullest capacity. *Id.* (referring to these as pre-PACE).

173. Peters, *supra* note 97, at 7.

174. *Id.*

175. PACE regulations articulate clear standards of performance and monitoring that are applicable only to PACE models. 42 C.F.R. §§ 460.30, 460.32, 460.34, 460.40 (2005). Additionally, the PACE protocol is based on the On Lok model, which has proven successful in providing integrated Medicare and Medicaid services for over thirty years. TRITZ, *supra* note 48, at 12.

176. See TRITZ, *supra* note 48, at 12.

177. 42 U.S.C.A. §§ 1395eee, 1396u-4 (Westlaw current through Dec. 22, 2006); 42 C.F.R. § 460.

178. 42 C.F.R. §§ 460.180, 460.182 (2005).

179. 42 C.F.R. § 460.90 (2005).

180. 42 C.F.R. §§ 460.122, 460.124 (2005).

and Medicaid,¹⁸¹ they do not encounter the problem, experienced by SNP enrollees, of PACE providers who do not contract with their state Medicaid program.¹⁸²

The On Lok program and the PACE programs that have followed successfully assist dual eligibles with substantial health care and social service needs.¹⁸³ SNP providers and health policymakers may do well to review lessons learned from PACE programs.

DEMONSTRATION PROJECTS ON COMBINING MEDICARE AND MEDICAID

Other demonstration projects to combine Medicare and Medicaid services for dual eligibles are based on state initiatives. Federal law allows states to seek a waiver of federal Medicare and/or Medicaid requirements in order to demonstrate that alternative delivery models are effective while remaining budget neutral (in other words, they create no additional cost to the federal government).¹⁸⁴

Only two states, Minnesota and Wisconsin, have used the waiver process successfully to develop their own managed care programs that integrate acute and long-term care services under Medicare and Medicaid. Minnesota was the first state to seek, and then to receive, approval to establish demonstration waiver

181. 42 C.F.R. §§ 460.92, 460.94 (2005). All participants, regardless of their source of payment, are entitled to Medicaid services, but only Medicare participants are entitled to Medicare services. *Id.* The distinction is primarily relevant for payment purposes. With the exception of long-term care, Medicaid generally covers the services covered by Medicare.

182. *See infra* Part "How Are SNPs Actually Meeting Dual Eligibles' Needs?"

183. Peters, *supra* note 97, at 8. Evercare Health Care, a provider of health care services, developed its own model in the late 1980s to serve nursing home residents. *Id.* The Evercare program, which is based on the On Lok and PACE models, expanded to include dual eligibles living in the community. *Id.* Evercare currently contracts with CMS to provide SNPs for institutionalized beneficiaries. *Id.*

184. Social Security Act § 1915, 42 U.S.C.A. § 1396n(b) (Westlaw current through Dec. 22, 2006), Social Security Act § 1115, 42 U.S.C.A. § 1315(a) (Westlaw current through Dec. 22, 2006); Social Security Amendments of 1972 § 222, 42 U.S.C.A. § 1395b-1(b) (Westlaw current through Dec. 22, 2006). Waivers generally are referred to by their Social Security Act section, § 1915, § 1115, or § 222.

programs in 1995.¹⁸⁵ Minnesota Senior Health Options (MSHO) provides integrated Medicare and Medicaid services to elderly dual eligibles.¹⁸⁶ MSHO is a managed care model, and participants are required to limit their choice of providers.¹⁸⁷ Because it is a demonstration program, MSHO is permitted to serve the limited geographic area of Minneapolis-St. Paul and within that area to limit its enrollment.¹⁸⁸ The Wisconsin Partnership Program provides services to dual eligibles who live at home but require a skilled level of care.¹⁸⁹ As part of the demonstration, Wisconsin includes younger people with physical disabilities who are either dual eligibles or Medicaid recipients.¹⁹⁰

Several other states considered, but were unable to develop, waiver programs that integrate Medicare and Medicaid benefits and services for dual eligibles. Texas originally developed its STAR+PLUS waiver program as a mandatory program to integrate Medicare and Medicaid acute and long-term care services, but the program was approved only as a Medicaid waiver program.¹⁹¹ Massachusetts originally concluded that the

185. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 11.

186. Minnesota Senior Health Options, What is the Minnesota Senior Health Options Program?, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYN_AMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271#P9_236 (last visited Mar. 23, 2007).

187. *Id.*

188. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 11. MSHO had 4620 enrollees in January 2002, sixty-eight percent of whom resided in nursing homes. PAMELA PARKER, MSHO/MNDHO STATUS REPORT IN PUSHING THE BOUNDARIES BEYOND DEMONSTRATION 3 (Nat'l Chronic Care Consortium ed., 2002), <http://www.nccconline.org/products/M03002.pdf> (last visited Mar. 13, 2007).

189. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 12-13 tbl. 1. In December 2005, approximately eighty percent of participants in the Wisconsin Partnership Program lived at home. WISCONSIN PARTNERSHIP PROGRAM, SEMI ANNUAL NARRATIVE REPORT: WISCONSIN PARTNERSHIP PROGRAM: JULY-DECEMBER 2005 2 (2005), <http://dhfs.wisconsin.gov/WIpartnership/pdf-wpp/SemiAnnual05-2.pdf> (last visited Mar. 20, 2007).

190. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 12-13 tbl. 1. The total Partnership and PACE census as of September 30, 2006 was 2894. Wis. Dep't of Health & Family Serv., 2006 Census Spreadsheet, <http://dhfs.wisconsin.gov/WIpartnership/census-2006spreadsheet.htm> (last visited Mar. 20, 2007).

191. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 15-16. Texas could not use waiver authority to mandate enrollment of a Medicare beneficiary into an HMO. *Id.* Thus, the Texas program mandates Medicaid

risk-adjustment factor to be used in determining capitated payments would be insufficient, given the high cost of providing care to dual eligibles.¹⁹² More recently Massachusetts created a voluntary managed care program for dual eligibles aged sixty-five and older that combines Medicare and Medicaid benefits and that allows Medicare payments to be made using a payment methodology that is similar to the PACE payment methodology.¹⁹³ Florida modified its initial request for both Medicare and Medicaid waivers and sought only a Medicaid waiver based on the difficulties other states experienced in seeking waivers from Medicare.¹⁹⁴

Minnesota may have succeeded where other states failed because of the substantial amount of time the state invested to develop its program. Minnesota officials took twenty-six months to plan before submitting the waiver.¹⁹⁵ Federal review of the waiver application lasted an additional sixteen months.¹⁹⁶ Minnesota then spent another twenty-one months after the waiver was approved to fully develop the program before it felt comfortable to initiate enrollment.¹⁹⁷ Such time was needed for the state to resolve complicated funding and beneficiary protection issues.¹⁹⁸

HOW ARE SNPs ACTUALLY MEETING DUAL ELIGIBLES' NEEDS?

SNPs certainly present the opportunity for better care through coordinated care, integrating all benefits. Yet, while plans may choose to coordinate the care of their special needs members, the decision is entirely theirs to make. CMS imposes no formal coordination of care requirements. Consequently, the "promise"

managed care enrollment while keeping enrollment in the Medicare portion voluntary. TRITZ, *supra* note 48, at 15-16.

192. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 24-25.

193. TRITZ, *supra* note 48, at 14.

194. GAO IMPLEMENTING STATE DEMONSTRATIONS, *supra* note 154, at 39-40.

195. *Id.* at 18 tbl. 2.

196. *Id.*

197. *Id.*

198. *Id.* at 18-19.

of better care may be meaningless to most dual eligibles. If SNPs were required to follow certain guidelines in coordinating care, noticeable benefits might, in fact, inure to dual eligible enrollees.

The experience in Pennsylvania reveals how far short the promises fall. For the over 100,000 dual eligibles who were, in the end, passively enrolled into SNPs, the most critical issue is the extent to which these SNPs, in fact, coordinate their care and benefits. Members of the *Erb* class action lawsuit have called class counsel for individual assistance:¹⁹⁹

- My special needs plan has providers that refuse to take Medicaid. What do I do?
- My SNP has providers who are balance billing people enrolled in Medicaid [in violation of state and federal law]. What can be done?
- The SNPs deny services as not covered (because not covered by Medicare) and do not state or even hint when the item is covered by Medicaid. Is this right?

At first blush, these and other inquiries suggested that the SNPs had to be in noncompliance with requirements for SNPs. This quickly raised the question of what SNPs are required to do to set them apart from "regular" MA Coordinated Care plans.

However, inquiries made by the Pennsylvania Health Law Project revealed:

- SNPs for dual eligibles are not required to admit into their networks only those providers that are willing to accept and bill Medicaid for any amounts unpaid by Medicare.
- SNPs are not required to inform participating providers to comply with state and federal provisions prohibiting them from billing Medicaid recipients for balances unpaid by Medicare.
- SNPs are not required to educate or maintain any

199. Members of the *Erb* class action lawsuit have called the Pennsylvania Health Law Project hotline for assistance. The following statements are representative of calls received.

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accessible system for their participating providers to inquire whether those required services that are not covered by the SNP are covered by Medicaid.

- SNPs are not required to inform their pharmacies of or to require their pharmacies to bill Medicaid programs for Part D excluded drugs that the state has elected to continue to cover under the state Medicaid plan.
- SNPs are not required to inform their enrollees that Medicaid may cover services or prescriptions not included in their SNP benefits and they are not required to assist the enrollees in actually accessing these services.

WHAT IS NEXT FOR SPECIAL NEEDS PLANS?

With the insurance industry and CMS both strenuously supporting the growth of SNPs and their penetration into the market, the recent wave of conferences, discussions and policy briefings about how to further expand this promised integration and coordination of care is not surprising. CMS fully supports the growth and spread of SNPs; the approval of some two hundred new SNPs for 2007 is just one indication of this.²⁰⁰ CMS believes that SNPs can remedy the lack of care coordination historically faced by dual eligibles. Both the policy decision to permit SNPs to target subsets of the statutorily approved categories of special needs individuals so as to match the state Medicaid population and to be better positioned for a state Medicaid contract, and the *State Guide to Integrated Medicare and Medicaid* released by CMS in July 2006 are evidence of this.²⁰¹

The *State Guide*, intended to present options states could

200. MEDPAC CONGRESSIONAL REPORT 2007, *supra* note 50, at 251 tbl. 4-4 (reporting that 424 SNPs were approved for 2007 and 276 SNPs were approved for 2006).

201. See CMS STATE GUIDE, *supra* note 140, at 1-2 (“This guide was developed to address some of the difficulties States face in attempting to integrate Medicare and Medicaid coverage and to help plans and States develop more integrated models, such as through the use of SNPs, for dual eligible beneficiaries.”).

pursue to better structure their Medicaid programs around existing Medicare programs, places considerable focus on the new SNPs (over PACE and waiver options) and on how Medicaid programs should endeavor to wrap benefits around the SNPs.²⁰² Although the *State Guide* suggests that states could wrap their Medicaid around Medicare benefits in several ways, CMS appears to favor using a SNP and having the state contract with the same private insurance company to also deliver the Medicaid healthcare services.²⁰³ The *State Guide* and accompanying documents focus on how marketing and enrollments could then be streamlined, how Medicaid agencies could help with oversight by evaluating Medicaid contract compliance, and how much better off dual eligibles could be because all their care would be delivered by one entity.²⁰⁴

Throughout the *State Guide* and accompanying documents, CMS places great weight on the potential for improved coordination and integration of Medicare and Medicaid.²⁰⁵ Although there may be potential for integration, the experience of consumers demonstrates that improved coordination and integration do not exist; CMS's promises are not coming to fruition.

CONCLUSIONS AND RECOMMENDATIONS

Many special needs individuals have been passively enrolled into SNPs in violation of Medicare's promise of free choice of provider. The enrollment guidance issued with the *State Guide* in July 2006 suggests that many more special needs individuals could find themselves passively enrolled into SNPs by their state Medicaid agency.²⁰⁶ SNPs, particularly SNPs that have contracts with the state Medicaid agencies and the incentives that arise from that relationship, may provide improved care for dual

202. *See id.*

203. *Id.* at 12.

204. *See id.* at 19 Tbl. 4.

205. *Id.* at 1.

206. *Id.* at 21.

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eligibles. However, significant concern exists about the freedom these plans have to decide whether, how, and when to integrate or coordinate care. 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 should follow through on its statutory mandate to promulgate substantive regulations to establish minimum standards for what SNPs must do effectively to meet their enrollees' 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 responsible for covering the service.

At a minimum, SNPs serving dual eligibles must be required to

- 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.
- Include in 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.
- Include in SNP benefits services involved in coordination and integrating the two benefits. Failure to provide these coordination and integration services should trigger beneficiary appeal rights through the Part C appeals process.
- Include in SNP marketing materials explanations of the coordination of care benefits included in addition to Parts C and D covered benefits that dual eligibles obtain from their SNP.
- Arrange for an evaluation of Medicaid coverage

when a prescription is denied at the pharmacy, and, where applicable, direct the pharmacist to bill Medicaid. In the event that some drugs may be covered in some circumstances, denials should come up with a message to the pharmacist that "if this member also has Medicaid, try billing Medicaid." All SNPs should program their systems with medications Medicaid will and will not cover.

- Require network providers to participate in Medicaid or accept the SNP's payment as payment in full.
- Instruct all network providers on applicable state and federal prohibitions to billing Medicaid consumers for Medicare cost sharing that should be covered by Medicaid.
- 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."
- Train member services personnel regarding details of what Medicaid benefits are available and how to obtain them.
- 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.

SNPs in name only are not a magic elixir to resolve the challenges dual eligibles face in accessing their Medicare and Medicaid healthcare benefits. CMS must take steps to ensure a meaningful benefit. Until that time, consumers and their advocates should be cautious and extremely inquisitive as they consider their options for Medicare coverage.