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Medicare Advantage

Special Needs Plans

Site Visits

*A study conducted by staff from
Mathematica Policy Research, Inc. for the
Medicare Payment Advisory Commission*

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MATHEMATICA
Policy Research, Inc.

**Medicare Advantage
Special Needs Plans
Site Visits**

Final Report

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Submitted to:

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SPECIAL NEEDS PLANS SITE VISITS: OVERVIEW

Medicare Advantage (MA) Special Needs Plans (SNPs) were established by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which allowed MA managed care plans to specialize in serving Medicare beneficiaries who are dually eligible for Medicare and Medicaid, who are in or eligible to be in nursing facilities or other long-term-care institutions, or who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) approved 276 SNPs for 2006: 226 for dual eligibles, 37 for institutionalized beneficiaries, and 13 for beneficiaries with severe or disabling chronic conditions.

The Medicare Payment Advisory Commission (MedPAC) is interested in an early, descriptive snapshot of how SNPs are developing. To that end, MedPAC contracted with Mathematica Policy Research (MPR) to assist MedPAC staff in site visits to three market areas (Boston, Phoenix, and Miami) with several SNPs and different marketplace characteristics. The site visits included interviews with SNPs, state Medicaid officials, and CMS regional office staff. The accompanying text box provides details on site selection and the methodology we used to collect information from the site visits.

This report includes findings from the three site visits and describes why plans decided to become SNPs; outlines their outreach, marketing, network development, care coordination, and quality improvement strategies; discusses implementation challenges they have encountered; and reviews their suggestions for program improvements. The report also describes SNP relationships with state Medicaid programs, including current or planned inclusion of Medicaid-funded services in the SNP benefit package.

METHODOLOGY

MedPAC staff chose four sites for this early snapshot of SNPs: Baltimore, Maryland; Boston, Massachusetts; Phoenix, Arizona; and Miami, Florida. The site visits were conducted in February and March 2006. MPR staff accompanied MedPAC staff on visits to the last three sites, which are the subject of this report.

MedPAC staff chose the sites based on the following criteria:

- A large number of competing SNPs
- The presence of existing special plans that converted to SNPs
- Passive enrollment of Medicaid managed care enrollees in dual-eligible SNPs
- The presence of organizations that offer several dual-eligible SNPs
- The presence of two or more of the three types of SNPs: dual eligible, institutional, and chronic care

In advance of the site visits, MPR staff prepared (1) background information on each state and its Medicare and Medicaid programs, (2) profiles of each SNP operating in the marketplace we planned to visit, and (3) detailed interview protocols for the interviews with SNPs, state Medicaid agencies, and CMS regional offices.

MPR staff made some recommendations for SNPs to be visited, but the final decision rested with MedPAC staff, affected in some instances by the willingness of SNPs to be interviewed. Table 1 shows the number and types of SNPs in each of the three market areas and the number of plans offering SNPs that we visited in each market. As noted in the table, we visited 5 of 6 plans offering SNPs in Boston, 6 of 10 in Phoenix, and 4 of 11 in Miami. Table 1 also provides background information on the metropolitan area markets and the states that we visited.

Table 2 shows, by SNP type, the names of all the plans operating SNPs in each of the market areas we visited and the geographic regions they cover. The information in Table 2 is taken from the January 2006 CMS report on SNPs, which is publicly available. Because we promised the interviewed SNPs that we would not link particular comments to specific SNPs, this summary report does not use plan names in the text.

Due to time and logistical constraints, we were able to conduct interviews with Medicaid agency officials only in Boston and Phoenix and with CMS regional office officials only in Boston.

We circulated a draft of this report to all the individuals we interviewed, and incorporated corrections and revisions as appropriate in response to their suggestions.

Table 1. SNP Site Visit Facts

	Boston	Phoenix	Miami
Visit Date	2/15/06 – 2/16/06	2/22/06 – 2/23/06	3/16/06
SNP Types in Metropolitan Area Market	Dual Eligible, Institutional, Dual Demo	Dual Eligible, Institutional, Chronic Conditions	Dual Eligible, Institutional
Number of SNPs in Metropolitan Area Market	7	12	11
Number of Plans Offering SNPs ^a	6	10	11
Number of Plans Offering SNPs Visited ^b	5	6	4
Total Metropolitan Area Population (2003)	4,579,137	3,593,408	2,341,167
Total State Population (2003-2004)	6,360,110	5,642,350	17,148,330
State MA Enrollment (2005)	159,034	207,435	574,426
State Medicaid Capitated Managed Care (MC) Enrollment (2004)	908,174	881,741	1,597,215
State Full Dual Eligible Enrollment in Medicaid (2003)	192,000	70,000	380,000
As a % of Total Medicaid (2003)	21%	8%	17%
As a % of Total Medicare (2003)	20%	10%	13%
Percent Autoenrolled in Stand-Alone PDPs (2006) ^c	97%	84%	93%
State Total Dual Enrollment As a % of Total Medicaid MC (2004)	0.1%	8%	0.9%

Sources: Kaiser Family Foundation State Health Facts, www.statehealthfacts.kff.org; HSC, Boston Community Report, December 2005; HSC, Phoenix Community Report, September 2005; HSC, Miami Community Report, December 2005; CMS Medicaid Data Sources and Medicare Enrollment Reports, 2003; CMS Special Needs Plan Report, January 4, 2006

^aPlans with the same or similar contract names but different contract numbers in the CMS Special Needs Plan Report were counted as separate plans (e.g., the two Commonwealth Care Alliance plans); some plans operate multiple SNPs, which accounts for the difference between SNP numbers and plan numbers

^bIf two separate plans fell under the same parent company (e.g., United Healthcare of Florida and United Healthcare Insurance Company) and we spoke with representatives from the parent company, we counted it as if we spoke with both companies

^cThis calculates dual auto-enrollment in PDPs as of May 7, 2006 as a percentage of full dual eligibles in 2003 (the most recent year for which those data are available)

Table 2. SNP Plans in Sites

SNP Type	Boston		Phoenix		Miami	
	Plan Contract Name	Region Covered	Plan Contract Name	Region Covered	Plan Contract Name	Region Covered
Chronic Condition			Sun Health Medisun, Inc.	Maricopa County		
Institutional	United Healthcare Insurance Company (also offers a dual eligible plan)	Boston, Springfield, Worcester Metro Areas	United Healthcare Insurance Company (also offers a dual eligible plan)	Maricopa, Pima, Pinal, and Yuma Counties	CareOne Health Plan, Inc.	Florida
Dual Eligible	Commonwealth Care Alliance ^a	Greater Boston and Springfield Areas	Abrazo Advantage Health Plan	Central Arizona	American Pioneer Life Insurance Company	Florida
	Commonwealth Care Alliance	Greater Boston and Springfield Areas	Arizona Physicians IPA, Inc. (offers 2 dual eligible plans)	Cochise, Maricopa, Mohave, Pima, and Yuma Counties (first dual eligible plan)	Humana Medical Plan, Inc.	Dade County
	Fallon Community Health Plan	WORC, MSEX, FRK, HMD, HPS, NOF Counties	Care 1 st Health Plan	Maricopa Counties	Preferred Care Partners, Inc.	Miami-Dade County
	Senior Whole Health, LLC ^a	Senior Whole Health Areas	Cigna Healthcare of Arizona, Inc.	Maricopa County and City of Apache Junction	Summit Health Plan, Inc.	Dade, Broward and Palm Beach Counties
	United Healthcare Insurance Company ^a	Boston, Springfield, and Worcester Metro Areas	Health Choice Arizona, Inc.	Apache, Coconino, Maricopa, Navajo, Pima and Pinal Counties	United Healthcare Insurance Company	Florida

Table 2 (continued)

SNP Type	Boston		Phoenix		Miami	
	Plan Contract Name	Region Covered	Plan Contract Name	Region Covered	Plan Contract Name	Region Covered
Dual Eligible (continued)	United Healthcare Insurance Company (also offers an institutional plan)	Boston, Springfield, and Worcester Metro Areas	Health Net of Arizona, Inc.	Maricopa, Pinal, Pima, Santa Cruz Counties	United Healthcare of Florida, Inc.	Miami-Dade County
			PacificCare of Arizona, Inc.	Maricopa, Pima, and Apache Junction Counties	Vista Healthplan, Inc.	Dade, Broward and Palm Beach Counties
			Southwest Catholic Health Network Corporation (Mercy Care)	Maricopa, Pima, and Santa Cruz Counties	Vista Healthplan of South Florida, Inc.	Dade, Broward, Martin and St. Lucie Counties
			United Healthcare Insurance Company (also offers an institutional plan)	Maricopa and Pima Counties	WellCare of Florida, Inc.	Miami-Dade County

Source: CMS Special Needs Plan Report, January 4, 2006

^aSenior Care Options (SCO) Dual Demo Plan

The next section provides a summary of the major themes and issues that emerged from the three site visits. It is followed by a short section summarizing some of the challenges and opportunities faced by SNPs. Detailed summaries of each site visit follow this overview.

MAJOR SITE VISIT THEMES AND ISSUES

Considerable diversity was evident among even the small number of SNPs and three market areas we visited. We expect the variation to be even greater among SNPs that have less experience than those we visited and that are operating in states and market areas in which managed care is less well established than in Boston, Phoenix, and Miami.

Market Environment and SNP Goals and Strategy

Plan goals and strategies reflected differences in the Boston, Phoenix, and Miami marketplaces, in plan relationships to Medicaid, and in plan histories in Medicare and Medicaid:

- The Boston SNP marketplace is dominated by Senior Care Options (SCO), the Medicare-Medicaid dual-eligible demonstration program that has been under development for many years and that began enrolling members in 2004. All but one plan that offers SNPs participates in SCO, and the one non-SCO plan that operates a SNP also operates a PACE program¹ and is a Medicaid contractor. The plans we visited all view the SNP program as a way of continuing to expand incrementally the programs they currently operate. Some noted that more non-SCO SNPs may enter the Boston market in 2007 and 2008, potentially changing the market's competitive dynamics.
- The Phoenix SNP marketplace is dominated by well-established Medicaid managed care plans that have become SNPs and have "passively enrolled" their existing Medicaid members.² These SNPs that include Medicaid have a primary goal of preserving their existing membership but also see SNPs as a way of incrementally expanding their membership. Thus far, the SNPs that do not include Medicaid appear to lack a strategy for obtaining significant enrollment.

¹ The Program of All-Inclusive Care for the Elderly (PACE) is a program operating in several parts of the country that provides integrated Medicare and Medicaid services in the community to beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility.

² Passive enrollment refers to a one-time process authorized by CMS in 2005 that permitted SNPs that applied to and were approved by CMS to enroll dual-eligible beneficiaries who were already enrolled in Medicaid managed care plans owned by the same company in the same geographic area for all their Medicare benefits, including the new Part D drug benefit. Passive enrollment thus permitted beneficiaries to continue to receive their drug benefit from the same organization after January 2006, although it also limited their choice of Medicare providers once they enrolled in the SNP. Passively enrolled dual-eligible beneficiaries are allowed to disenroll from the SNP at any time.

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- The Miami SNP marketplace is characterized by a very high percentage of dual eligibles and Hispanics in the Medicare population, making the south Florida region attractive to dual-eligible SNPs that can market effectively to that population and obtain the higher MA capitation rates paid for duals. The interviewed plans characterized the south Florida market as highly competitive for all MA plans, given the area's high MA capitated payments.

Relationships with the State

SNP relationships with state Medicaid programs are likely to be a key factor in SNPs' prospects for success, since adding Medicaid benefits to the SNP benefit package can enable SNPs to distinguish themselves from other MA plans and demonstrate more clearly the care coordination value they can add.

Most SNPs in Boston and Phoenix have worked closely with the state for many years, reflecting special efforts in both states to establish integrated managed care programs. The Miami SNPs have worked less closely with the state but some expect greater opportunities to do so in the future:

- In Boston, the SCO SNPs enjoy particularly close and well-established relationships with the state because of their work together in developing the SCO program, while the non-SCO SNP's relationship with state officials is focused more on its PACE and Medicaid-only products.
 - The SCO SNPs include Medicaid benefits in their capitated benefit package; the non-SCO SNP does not.
- In Phoenix, the SNPs that include Medicaid worked closely with the state and CMS to develop the passive enrollment approach to SNP enrollment, with Arizona appearing to provide a major impetus for national CMS decision making on passive enrollment.
 - The state began discussing options for SNPs with health plans in late 2004 and commissioned the state's actuaries to develop detailed comparisons of Medicare and state managed care requirements to provide background for the discussions.
 - All Medicaid acute care services are included in the SNP benefit package in the SNPs that include Medicaid, and two of those SNPs in the Phoenix area also include Medicaid-funded long-term-care services in their benefit package.
 - The SNPs that do not include Medicaid include only Medicare services in their SNP benefit package.
- In Miami, SNP relationships with the state have been more distant. The state Medicaid agency does not currently contract with SNPs for Medicaid services

and does not coordinate with MA plans for payment of Medicare cost sharing for dual eligibles, leaving MA providers to seek payment directly from the state.

- The plans we spoke with were enthusiastic about the potential opportunities for SNPs in the new Florida Senior Care program, a managed integrated long-term-care program currently being developed by the state.

Similarities and Differences Among SNPs

While we were able to visit only a relatively small number of SNPs of different types in the three market areas, we were able to see differences in the approach of different types of SNPs to outreach and enrollment, care coordination and management, nursing facility services, and quality monitoring and improvement. It was generally too early to tell how organizational, infrastructure, and payment issues are likely to play out among different types of SNPs.

Outreach and Enrollment. SNP approaches to outreach and enrollment differed significantly, depending on target populations (dual eligibles age 65 and over, disabled duals under age 65, institutionalized, or chronically ill) and whether SNPs benefited from passive enrollment:

- Dual-eligible SNPs relied on the broadest marketing strategies, aiming at physicians, hospitals, community organizations, and beneficiary advocacy groups.
- Institutional SNPs marketed primarily to nursing facilities and families of residents.
- Chronic condition SNPs focused primarily on physicians and other chronic care providers.
- SNPs with passive enrollment focused heavily on keeping their current enrollees, with little emphasis so far on broader marketing.
- Few SNPs believed that television, newspapers, or other media would be effective in reaching potential members, although most thought that direct mailings would be if contact information could be obtained.
- The Miami SNPs emphasized strongly the importance of community-based and personalized marketing to south Florida's dual-eligible and heavily Hispanic population.
- Few SNPs in Boston, Phoenix, or Miami have a well-developed strategy for marketing to the very large portion of dual eligibles who are already auto-enrolled in stand-alone prescription drug plans (PDPs).

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- SNPs have found it difficult (some said impossible) to take advantage of the CMS Web-based plan finder tool since their specialized focus and broader benefits do not fit well into the current plan finder format.

Care Coordination and Management. The SCO SNPs in Boston and the SNPs that include Medicaid in Arizona have well-developed care coordination and management programs they can build on, but the other SNPs in those areas appear to be in the relatively early stages of developing care coordination programs for the SNP population. One plan in Miami has a care coordination program based on the efforts of its Miami-area community services partner, and another plan uses the same care coordination model in Miami that it uses elsewhere in the nation.

Nursing Facility Services. Providing prescription drug services to enrollees in nursing facilities is likely to present significant challenges for SNPs that have not previously been at risk for drug use in these settings. With the exception of institutional SNPs and one dual-eligible SNP in Phoenix that also participates in Arizona's Medicaid managed long-term-care program, the SNPs we visited had little experience in dealing with enrollees in nursing facilities.

The SNPs with experience serving enrollees in nursing facilities said that good relationships with nursing facilities were crucial to their success. Their care model relies heavily on stationing their own nurse practitioners on site in the nursing facilities to help manage enrollees' care. They indicated that it was less crucial to deploy their own consultant pharmacist to the facilities because nurse practitioners could help assure appropriate drug prescribing and utilization.

The SNPs that include Medicaid in Arizona that have been participating in the state's Medicaid managed long-term-care program have been at financial risk for prescription drugs in nursing facilities for many years, and the SCO SNPs in Boston have also been at risk for drugs in nursing facilities. A closer look at their experience could be useful for SNPs that are new to prescription drug responsibility in these settings.

Quality Monitoring and Improvement. The SCO SNPs in Boston and the SNPs that include Medicaid in Phoenix have already put in place substantial quality monitoring and reporting systems because of dual-eligible demonstration requirements in Boston and state Medicaid requirements in Arizona. The other SNPs do not appear to have any special quality monitoring efforts underway at this point, beyond CMS requirements.

The SNPs in all three areas underscored the importance of developing quality monitoring and performance reporting systems to enable SNPs to demonstrate that they are adding value beyond what a standard MA with prescription drug benefits (MA-PD) or PDP might offer. Several plans noted that a CMS evaluation of SNPs is due to Congress at the end of 2007 and that Congress must act to extend the SNP authorization beyond 2008. This means that SNPs will need to demonstrate their value within a relatively short time.

Organization and Infrastructure. Most SNPs in Boston, Phoenix, and Miami have so far not made major changes to their SNP organization or infrastructure, such as adding new

departments, staff, or data systems. The SNPs we visited plan to build incrementally on the plans' existing infrastructure.

Financing and Payment. The SNPs in all three areas expect that MA capitated payments will be adequate to cover their costs, especially with the full phase-in of the CMS Hierarchical Condition Category (CMS-HCC) risk-adjusted capitated payment system in 2007. The SCO SNPs in Boston expressed some concern that payment would not be adequate in future years without a frailty adjuster (which they now have), but SNPs in Phoenix expressed less concern, perhaps because they do not currently rely on a frailty adjuster.³

The Boston SCO SNPs and state officials indicated that requiring SNPs to keep separate track of Medicare and Medicaid funding streams was somewhat burdensome for plans, but the SNPs that include Medicaid in Phoenix reported that it was not a problem for them, probably reflecting their longer experience with the process. The SNPs in both areas indicated that these financial and accounting requirements did not affect their relationships with providers or their clinical care coordination efforts. The separate accounting could be handled as a "back office" matter that providers and clinicians do not have to deal with.

Contracting with CMS and Implementation Challenges

SNPs in all three market areas described the process of contracting with CMS as somewhat unpredictable and filled with last-minute changes in signals. The CMS central office rather than regional offices handled nearly the entire SNP contracting process, making it difficult for CMS to account adequately for unique state and local circumstances.

The SNPs in Boston and Phoenix noted significant difficulties in obtaining correct enrollment information from CMS for the January 1, 2006, start-up of Part D.

SNPs that also contracted for Medicaid services all noted the many conflicts between Medicare and Medicaid rules dealing with bidding, contracting, enrollment, marketing, complaints and grievances, reporting, monitoring, and rate setting, and urged CMS and states to work to reduce these administrative barriers in order to facilitate better integration of the two programs. Those we interviewed in Boston noted that a three-way agreement among the state, CMS, and SNPs that was developed as part of the SCO program deals effectively with many of these issues.

³ The frailty adjuster is a provision in PACE programs and CMS dual-eligible demonstration programs under which CMS makes higher per-enrollee payments for enrollees with significant limitations on activities of daily living. It is scheduled to be phased out for the dual-eligible demonstration programs and will not be available to them after 2007. CMS is considering applying a frailty adjustment broadly across all MA plans. The earliest that could take effect would be 2008.

The SNPs in Boston and Phoenix noted few difficulties with provider or beneficiary advocacy groups during SNP implementation, stressing that Medicaid managed care was well established in both areas, although more so in Phoenix.

MAJOR CHALLENGES AND OPPORTUNITIES FOR SNPs

While the site visits provided only limited initial snapshots of three market areas, they and other early developments around the country helped to identify some key emerging opportunities and challenges for SNPs:

- One of the biggest challenges for SNPs over the next year will be to obtain sufficient enrollment to support the managed care infrastructure needed to serve beneficiaries with special needs.⁴ Most of the plans we visited had an enrollment base either from passive enrollment or in other plan offerings that they considered sufficient to get them started, experience in dealing with special needs populations, and the provider networks, staff experience, and information systems needed to serve their current enrollees and the incremental growth they project over the next year. Nationwide, however, CMS has auto-enrolled over 90 percent of dual-eligible beneficiaries in stand-alone PDPs for their Part D drug benefit. As SNPs and other MA plans seek more growth in future years, they face the challenge of marketing to a dual eligible population that is already receiving a full array of Medicare benefits in fee-for-service (FFS) settings. Even in Arizona, where an unusually large percentage of dual eligibles was “passively enrolled” in SNPs, about 84 percent of dual eligibles are in PDPs.
- SNPs with significant relationships with states that are actively seeking to work with SNPs to better integrate Medicare and Medicaid acute and long-term-care services in managed care organizations appear to have better prospects for expanding enrollment and improving beneficiary care than SNPs that are planning to offer only Medicare benefits. It is not clear that SNPs providing only Medicare benefits will be able to offer dual-eligible beneficiaries enough added value to persuade them to leave the FFS Medicare system. Since dual-eligible beneficiaries’ responsibility for Medicare FFS cost sharing is already quite limited, SNPs generally cannot use lower cost sharing as an enticement for dual eligibles to enroll. In addition, most regular MA-PD plans have experience in coordinating Medicare acute care benefits, so Medicare-only SNPs may not be able to distinguish themselves clearly from other Medicare-only managed care options. In Boston and Phoenix, many SNPs have worked closely with state and CMS officials to develop managed care programs that integrate Medicare and Medicaid services. Florida has six years of experience with a pilot managed care program aimed at better integration of Medicaid

⁴ As of early June, 2006, CMS had not released any information on SNP enrollment.

acute and long-term care services for frail elderly dual eligibles (the Nursing Home Diversion Program), and is developing a new managed care pilot program for Medicaid beneficiaries age 60 and older in two areas of the state (Florida Senior Care) that is expected to provide opportunities for SNPs to contract with the state to cover Medicaid services. About ten other states either have or are developing ways of better integrating Medicaid and Medicare services, but most states have no current plans to do so, which could limit SNP opportunities in those states.

- SNPs and states committed to better coordination of Medicare and Medicaid services must deal with numerous differences between Medicare and Medicaid rules for bidding, contracting, enrollment, marketing, complaints and grievances, reporting, monitoring, and rate setting, although CMS and some states with integration experience have been making progress in reducing some obstacles to integration. States such as Massachusetts, in which dual-eligible managed care demonstration programs have been developed with CMS assistance, have devised effective solutions for many of the problems within the context of the demonstration, but the problems remain substantial for SNPs that are not part of the demonstration. Reducing the many administrative barriers to integration of Medicare and Medicaid managed care will likely require continuing top-level attention by CMS, states, and SNPs.
- Assessing and demonstrating the value added by SNPs in the short term presents major challenges for CMS and SNPs, given the time needed to establish effective organizations, the relative lack of performance measures for the care coordination and other extra services SNPs are expected to provide, and the current limited availability of data on Part D drugs and MA plan services. The congressionally mandated evaluation of SNPs, which is due at the end of 2007, may not be sufficient to provide a full assessment of SNPs before the current authorization for SNPs expires at the end of 2008.

SPECIAL NEEDS PLANS SITE VISIT SUMMARIES

BOSTON, MASSACHUSETTS

We interviewed five of the six plans offering SNPs in the Boston area on February 15–16, 2006 (and received information on six SNPs because one of the plans offers more than one SNP). One of the interviewed SNPs is an institutional SNP while the other five are dual-eligible SNPs. Two of the interviewed dual-eligible SNPs participate in the Senior Care Options (SCO) program. SCO is a CMS dual-eligible demonstration program that was created in 2002 when the Medicaid agency entered into an agreement with CMS to provide integrated and coordinated care for the dual-eligible population age 65 and older; it began enrolling members in early 2004. We also interviewed several CMS regional office staff as well as a Medicaid agency official who has been extensively involved in the development of the SCO program.

Market Environment and SNP Goals and Strategy

Most of the plans we spoke with in the Boston marketplace entered into SNPs as a natural extension of the services they were already providing for special needs populations. Many of the plans offering SNPs in the Boston area have a history with the SCO program. When SNPs became an option, both CMS and the state Medicaid agency saw the SNP program as an opportunity to bring the SCO demonstration project under the Medicare Advantage umbrella. The SNP authority also presented an opportunity for plans to extend services to populations not covered under the SCO program (the dual-eligible disabled population under age 65) through institutional and dual-eligible SNPs, thus enabling the plans to expand their membership. However, plans wanting to cover these non-SCO populations were required to establish separate SNPs to do so.

The one plan we spoke with that was not affiliated with the SCO program appears to have established its SNP as a way of filling out its portfolio of MA options for current members and did not have an immediate goal of using its SNP to expand membership. Rather, in providing the new MA option, the plan primarily hoped to retain the large number

of dual eligibles already in its membership and would consider incremental membership growth to be an additional benefit.

The SCO plans have been able to build on the pre-existing dual-eligible demonstration program to dominate the Boston-area SNP market. Only one non-SCO plan came forward with a SNP for 2006. State officials suggested that barriers to new plan entrants for SNPs included the short time frame CMS provided for setting up SNPs, the established presence of the Program of All-Inclusive Care for the Elderly (PACE) in the state, and providers' reluctance to contract with new plans. However, respondents said that new entrants, especially from national plans, are likely in the Boston market in upcoming years, as are expansions of existing SNP programs. One plan suggested that the planned SCO re-procurement in 2008 will prompt the national plans to enter the market soon.⁵ The same plan expressed some concern that the larger plans with their greater resources will define the SNP market before smaller, local plans have a chance to build relationships with community advocates and state agencies to demonstrate what a good SNP organization should look like.

Relationships with the State

The plans with SCO SNPs enjoy close and well-established relationships with the state because of their many years of work together in developing the SCO program. The non-SCO plan's relationships with the state revolve primarily around its PACE plan and its regular Medicaid managed care plan. As noted above, plans that are in the SCO program must set up separate SNPs to cover the non-SCO dual eligible population (disabled duals under age 65). There is less support from the state for these separate non-SCO SNPs. Some non-SCO plans told us that they would like to coordinate more fully with Medicaid to enrich their SNP services by including Medicaid benefits in the SNP benefit package.

Similarities and Differences Among SNPs

Outreach and Enrollment. Most of the SNPs in Boston benefited from some level of passive enrollment, whether it was retaining their members from the SCO program as the plan transitioned to SCO SNP status or passively enrolling a small number of voluntarily enrolled dual eligibles already in their non-SCO Medicaid plans.⁶ Beyond the initial enrollment, it is unclear how the plans will enroll additional members in their SNPs. While all the SNPs stated that the large number of dual eligibles in the market represents a major membership opportunity, especially those enrolled in stand-alone prescription drug plans (PDPs), none of the plans appeared to have a well-developed strategy for marketing to the

⁵ The state's Medicaid agency will allow plans to submit bids in 2008 to participate in SCO plans in 2009.

⁶ Massachusetts does not mandate enrollment of dual eligibles in Medicaid managed care, and voluntary enrollment outside SCO plans is small.

dual eligibles who were auto-enrolled in PDPs.⁷ Aside from the passive enrollment, enrollment numbers for new members are still relatively small.

Most of the plans recognize that standard marketing tools (e.g., television, newspaper, or other media) and outreach approaches are not effective with the SNP population. Rather, marketing to this population requires collaboration with people or organizations involved with their care to help foster awareness of SNP options. SNPs reaching out to institutionalized individuals could market primarily to the “captive audiences” in nursing facilities and the families of residents, assuming the plans already have relationships with the nursing facilities. Plans reaching out to dual eligibles in the community could use “targeted marketing,” which involves coordination with physicians, hospitals, senior centers, houses of worship, and beneficiary advocacy groups to reach out to the dual population. Several plans indicated that maintaining good relationships with primary care physicians (PCPs) in particular is a key strategy for future enrollment.

Targeted marketing, however, especially through physicians, raises some issues with CMS’s MA marketing guidelines, which state that physicians are not permitted to steer patients to one plan or another. Physicians can declare their affiliation with a specific plan they are contracted with through a one-time direct mail or e-mail announcement, but they must include in any future affiliation announcements all other MA plans, and all affiliation communication materials that describe MA plans in any way must be approved by CMS. Providers offering informational pamphlets on one plan must also provide information on all other available plans they contract with. For the plans relying on community providers to refer patients to SNPs, the CMS restrictions may prove problematic. One plan indicated that the standard MA marketing guidelines do not sufficiently address the unique challenges of the dual population. As the SNP model moves forward, CMS’s rules and prohibitions on primary care physicians and the type of role they can play in guiding patients could undermine efforts to serve the dual-eligible population.

Plans looking to differentiate their SNPs from other plans (standard MA plans and other SNPs) have also run into difficulty with the CMS Web-based plan finder tool in that its current format does not fit well with the SNPs’ specialized focus and broader benefits. The SNP information on the plan finder is “misleading and useless,” one respondent told us.

Care Coordination and Management. The SCO SNPs have put in place well-developed care coordination and management programs that can provide the foundation for better serving the SNP population. The non-SCO SNP does not have SNP-specific care coordination and management programs, and is using the programs that service all its members, including those in other Medicare Advantage plans. The non-SCO SNP has a unique integration-of-care model in its PACE plan that is not easily translated for broader SNP use because it includes plan-owned day centers with salaried physicians and staff teams that coordinate member care. The PACE integration-of-care model is expensive to operate,

⁷As of May 7, 2006, about 97 percent of the 192,000 full dual eligibles in Massachusetts had been auto-enrolled in stand-alone PDPs (Kaiser Family Foundation, statehealthfacts.org).

we were told, and therefore may be difficult to use more broadly under a SNP. At present, the extent of care coordination for the non-SCO SNP is limited primarily to disease management and medication management.

Nursing Facility Services. Aside from the institutional SNP in the Boston market, most SNPs in Massachusetts have little experience in dealing with enrollees in nursing facilities. The plan with a long history of serving institutionalized members credits its success to good relationships with nursing facilities as well as to a care model based heavily on salaried, on-site nurse practitioners who manage patient care. On-site nurse practitioners hold graduate degrees, are trained in geriatrics, and can act as medical diagnosticians by providing a level of assessment and medical management that nursing facility staff do not normally provide. The nurse practitioners not only assist with managing care, but they also help ensure appropriate drug prescribing and utilization.

The SNP with a background in institutional care also maintains on-site consultant pharmacists who advise nurse practitioners on drug utilization. The consultant pharmacists' primary role is to manage acute drug utilization for the purpose of benefiting medical outcomes rather than containing costs.

Another SNP we spoke with indicated that it is working to adopt a similar nurse practitioner model, even though staffing challenges may slow the process. A third SNP relied on contracting with nursing facilities to provide management along with skilled care.

Quality Monitoring and Improvement. The SCO SNPs have put in place substantial quality monitoring and reporting systems in response to the dual-eligible demonstration requirements. The SCO program has many requirements for guidelines of care for the elderly population, report cards and measurement for PCPs dealing with this population, and strategies to improve delivered care. For example, the SCO program has developed sets of requirements for conditions such as diabetes and congestive heart failure that plans now use for the dual SNP program. One plan relies on a multi-pronged approach to quality monitoring, which includes using CMS's regulatory requirements as well as reports provided to plan PCPs on utilization and cost measures. The true challenge for the SCO SNPs is in determining how to measure and monitor care for very frail institutional SNP patients since HEDIS measures do not work well for this population.

The one non-SCO SNP we spoke with has not established quality monitoring and reporting systems specific to its SNP and is planning to use the same reporting methods required by CMS for the broader MA population, which is consistent with current CMS SNP requirements. However, the plan expects changes in the HEDIS data requirements as well as new measures from CMS for different types of SNPs.

Organization and Infrastructure. The SCO SNPs in Boston have not had to make major changes to their organization or infrastructure because they have been building incrementally on the plans' existing infrastructure. This may prove to be less true for the non-SCO SNP. The one plan that is expanding its care model to include nurses and nurse practitioners indicated that the greatest impediment is recruitment of nursing personnel to staff the model.

Financing and Payment to Providers. Most SNPs in Boston expect that the MA payments will be adequate to cover their costs, especially with the full phase-in of the CMS-HCC risk-adjusted capitated payment system in 2007. While one SCO SNP expressed some concern that payment would not be adequate in future years without a frailty adjuster (which is now in place but will be phased out after 2007), another SCO SNP remained unconcerned after its analysis of the Medicare payment with and without the frailty adjuster showed the payments to be roughly comparable. The SCO SNPs were more apprehensive about the adequacy of the Medicaid payment, noting that Medicaid fee-for-service rates are so far below the Medicare rates that Medicaid is not covering the 20 percent Medicare co-insurance payments for dual-eligible beneficiaries.

One SCO SNP that receives both Medicare and Medicaid capitated payments indicated that the requirement to keep separate track of both funding streams has not been particularly burdensome. Although the plan had to divide the Medicare and Medicaid funding streams for accounting purposes during the bid process, it did not have to keep precise track on a day-to-day basis of which services are paid for from which funding stream. Tracking of the dual funding stream is a “back office” matter, and the plan stated that financial and accounting requirements do not affect its relationships with providers or its clinical care coordination efforts.

SNPs pay physicians and hospitals in a variety of ways, ranging from fee-for-service to different degrees of capitation, with individual SNPs sometimes constructing varying payment arrangements for different providers within their networks. One SNP indicated that its payment models for contracted physician practices include (1) paying a “sub-cap” (percentage share) of the plan’s per-member per-month capitated payment to physician practices that have salaried doctors and (2) setting up provider risk-sharing agreements that take administrative costs for both the plan and provider off the top. Another SNP said that its strategy is to contract with providers initially through a relatively standard payment arrangement (percent-of-premium or fee-for-service) with the intent of eventually moving those providers into risk-sharing arrangements.

Contracting with CMS and Implementation Challenges

The bidding process with CMS appeared to be more difficult for some plans than for others, depending on the complexity of what needed to be done (i.e., whether a redesignation of a SCO plan was required) and the plans’ experience with MA procedures. One plan in particular described the CMS bidding process as onerous, partly because of the necessity of transforming its SCO into a SNP, which another respondent described as trying to “fit a round peg into a square hole.” Adding to the difficulty was the fact that plans had to deal primarily with the CMS central office rather than with the Boston regional office. The central office was sometimes slow to respond to questions and provide information, we were told, and SCO plans were much more accustomed to dealing with the Boston office. Even the plan that had a long history with MA plans found some materials required by CMS to be challenging to produce (e.g., evidence of coverage documents).

One organization that was not a pre-existing licensed insurance company ran into difficulty when applying for SNP status because there was no state agency with authority to certify and regulate them as a risk-bearing entity. Legislation needed to be drafted to grant the Executive Office of Human Services the authority to regulate free-standing SNP applicants (i.e., those not part of a licensed insurance company). The SNP that experienced the problem noted that it knew of at least one other SNP in another state that experienced similar difficulties with certification.

While most plans found the implementation of SNPs to have been “surprisingly clean,” one plan did experience difficulty in transforming its SCO plan into a SNP because some aspects of the MA framework did not fit well with the special needs of the dual population.

The SNPs noted few difficulties with beneficiary advocacy groups during SNP implementation. One plan stated that the advocacy groups on aging fully support them and their care model. Another plan indicated that it experienced some difficulty with provider and service organizations such as the Area Agencies on Aging and Aging Service Access Points, which they perceive as generally biased against managed care.

Lessons Learned

It is still too early for most SNP programs to derive any firm lessons for the future, we were told. Most plans stated that they simply want to see how the SNPs’ first year unfolds before developing extensive plans. One plan, however, did note that it has learned from its mistake of not taking advantage of targeted marketing opportunities when it was setting up the SNP, commenting that the experience will serve the plan well “year round” as SNP members can switch plans at any time during the year.

PHOENIX, ARIZONA

We interviewed 6 of the 10 plans operating SNPs in the Phoenix area on February 22–23, 2006 (and received information on a total of 7 SNPs as 1 plan offers more than 1 SNP). One of the interviewed SNPs is a chronic care SNP, 1 is an institutional SNP, and 5 are dual-eligible SNPs. We also interviewed a Medicaid agency official who has been extensively involved with the development of SNPs in Arizona. We did not interview officials from the CMS regional office in San Francisco.

Market Environment and SNP Goals and Strategy

Since the 1980s, Arizona has required almost all Medicaid beneficiaries to enroll in capitated managed care plans. The Medicaid managed care plans in Phoenix, some of which have served the Medicaid population for up to 20 years, dominated the SNP marketplace as the plans transitioned into SNPs and benefited from the “passive enrollment” of existing Medicaid members. Individual plans were able to passively enroll anywhere from 1,700 to 14,500 SNP members. Although the SNPs that include Medicaid said that their primary goal was preservation of their existing membership, they also see SNPs as a way of expanding their membership incrementally. Several Phoenix-area SNPs that do not include Medicaid entered the SNP market to provide existing or future members with more choice, although their strategy for obtaining and retaining enrollment is unclear.

Medicaid plans also noted that they decided to offer SNPs in order to provide members with the improved care coordination made possible by one plan offering both Medicare and Medicaid services. One plan that was striving to create a one-stop shop for members expressed interest in bidding for a contract with the state’s Medicaid managed long-term-care program (ALTCS), which would allow the plan to provide members with an entire continuum of care if needed.⁸

With most Medicaid plans deciding to enter the market, the SNP environment in Phoenix is highly competitive. We were told that even plans that did not have the benefit of passive enrollment chose to offer a SNP, partly because they recognized the opportunity for growth in membership and earnings. One plan indicated, however, that while there are many local players in the SNP market, most are comfortable with relatively low enrollment. The result is no major pressure for enrollment growth in the near future because “presumably with risk-adjusted payment, you don’t have to be God’s gift to management to make ends meet.”

⁸ The Arizona Long Term Care System (ALTCS), which provides capitated managed care for persons who are age 65 and older, blind, or disabled and need ongoing services at a nursing home–facility level of care, was soliciting proposals for the next contract period at the time of the site visit. Responses to the request for proposals (RFP) were due on March 31, 2006. The RFP stated that, in order to improve care coordination for dual-eligible members in the future, program contractors must either become a SNP or develop “formal relationships” with a SNP.

Relationships with the State

The SNPs that include Medicaid appear to enjoy a close working relationship with the state Medicaid agency (the Arizona Health Care Cost Containment System, or AHCCCS). In fact, AHCCCS approached the Medicaid plans in 2004 about applying for SNPs and worked to pass legislation that allowed the agency to certify the plans in accordance with Medicare requirements so that the plans would not have to deal with the Department of Insurance. The Medicaid agency worked with Medicaid plans to develop the passive enrollment approach and provided help when implementation issues arose. AHCCCS has been enthusiastic about the SNP model, even contracting with Mercer (the state's long-time outside actuaries) in late 2004 to identify the barriers to better Medicaid and Medicare collaboration in the SNP model and then reaching out to plans for their recommendations on what the agency could do to remove or reduce barriers.

All Medicaid acute care services are included in the SNP benefit packages offered by the SNPs that include Medicaid, and two of those SNPs in the Phoenix area also include Medicaid-funded long-term-care services in their benefit packages. The SNPs that do not include Medicaid provide only Medicare services in their SNP benefit packages; one of these plans indicated that it would be helpful to add Medicaid services to its SNP benefits.

Similarities and Differences Among SNPs

Outreach and Enrollment. The Medicaid managed care plans in the Phoenix market benefited from their ability to passively enroll Medicaid members into their new SNPs. At least two respondents suggested that health plan leaders in Arizona played a significant role in persuading CMS to allow for passive enrollment of Medicaid members. As it turned out, the implementation of passive enrollment gave rise to significant administrative problems largely attributable to CMS's inability to provide plans with an accurate roster of their passive enrollees in the first month of Part D implementation, placing some beneficiaries at risk of losing their drug coverage. These administrative problems are discussed further below.

The SNPs that include Medicaid see their Medicaid members as a built-in enrollment base for the SNP. Two of the plans indicated that their strategy for expanding SNP enrollment would focus on their current Medicaid population and people aging into Medicare because the two groups are already in the plans' systems. Most plans expressed little interest in spending funds on traditional marketing tools (television advertisements, newspapers, and so forth) to boost enrollment. They do not believe these marketing techniques reach the SNP population effectively. Rather, most plans rely on marketing through word of mouth and outreach based on plan participation in community activities, distribution of informational brochures in hospitals and physician offices, and marketing through physicians.

Retention of existing members seems to be a principal goal in several plan strategies for enrollment. Recognizing that dual eligibles can exercise the option to change SNPs at any time, one Medicaid plan noted that its strategy for enrollment will focus first on retention and management of disenrollment and then on the identification of pockets where SNP populations reside in order to recruit new members. Another plan emphasized the

importance of a retention plan, especially given that stand-alone PDPs appear to be actively recruiting members from plans with passive SNP enrollees.⁹ While active recruitment by PDPs has led to some member disenrollment from this plan, the plan noted that it has saved a few disenrollments by having member services staff contact members to explain the effects of their decision. For the most part, Medicaid plans have not put together a comprehensive strategy for recruiting members not already on their Medicaid rolls, partly because so many Medicaid contractors have entered the SNP market. It would be “an uphill battle” to take members from other plans that offer the same benefits (or more benefits, in the case of plans with ALTCS contracts) and with which members are already familiar and comfortable.

Several plans believe that they will be able attract new SNP members through the supplemental benefits they make available in the SNP (e.g., dental, vision, transportation, free blood pressure cuffs). Many plans understand that members talk to each other about their benefits, and one respondent indicated that the market will first see a shift in members from non-SNPs to SNPs and then a shift from SNP to SNP based on what supplemental benefits are offered.

As would be expected, most enrollment numbers for the SNPs that did not include Medicaid are small since they did not benefit from passive enrollment. One non-Medicaid plan suggested that the Part D rollout was so complicated that it had to concentrate primarily on making sure that its existing MA plans ran smoothly rather than focusing on building membership for new programs such as the SNP.

Care Coordination and Management. The SNPs in Phoenix that include Medicaid have been able to build on existing, well-developed care coordination and management programs that were initially put in place to coordinate care for Medicaid members whose Medicare benefit came from another source. The plans with both Medicaid and Medicare expect that care coordination will be easier now that members can receive both their Medicare and Medicaid benefits under one plan. One plan even suggested that care coordination will be extremely helpful in retaining SNP members who will come to understand that it is worthwhile remaining with the SNP that manages their Medicaid benefit as well. Currently, plans are working to educate recipients, providers, and hospitals about the new SNPs and how coordination will work. The state is attempting to do its part in helping to encourage coordination of care, especially for the members in the state’s ALTCS program. As noted, the state has indicated in its recent RFP for the ALTCS reprocurement that all ALTCS contractors will either have to become a SNP or develop a formal relationship with a SNP.

⁹ In large measure because of the significant passive enrollment of dual eligibles into SNPs in Arizona, a smaller share of dual eligibles was auto-enrolled into stand-alone PDPs in Arizona than in the nation as a whole: about 84 percent in Arizona as compared with about 92 percent nationally (Kaiser Family Foundation, statehealthfacts.org).

Care coordination in one SNP we interviewed that does not include Medicaid is in its early stages and currently extends to case management and disease management programs, which are high-touch plan programs that augment care delivered in physician offices.

Nursing Facility Services. Aside from the plans that have contracted with the state's ALTCS program, most SNPs had little experience with enrollees in nursing facilities. One plan with expertise in serving the institutionalized population credits its success to a nursing home service model that employs nurse practitioners who have the education and training to manage care and write prescriptions. Another plan with experience serving people in long-term care uses a similar nurse practitioner model for some but not all members.

Although the plans not involved in ALTCS are less experienced in serving institutionalized enrollees, at least some expressed interest in moving into this area. One plan indicated that it currently has relationships with skilled nursing facilities and home health facilities, using them as step-down facilities from acute care to long-term care and from nursing facility care to home health. The plan expressed interest in participating in ALTCS and would not hesitate to build additional relationships with nursing facilities as a first step in the direction of providing full service for the institutionalized population.

The SNPs in Arizona that have been participating in the state's ALTCS program have been at financial risk for prescription drugs in nursing facilities for many years, and SNPs new to the responsibility for prescriptions (in Arizona and elsewhere) could probably benefit from a closer look at the ALTCS experience. One ALTCS plan said it depends on nurse practitioners to drive prescription practice patterns with doctors and to help manage the drug benefit.

Quality Monitoring and Improvement. The SNPs in Phoenix that include Medicaid have substantial quality monitoring and reporting systems already in place in response to state Medicaid requirements. AHCCCS requires its Medicaid plans to submit extensive encounter data by service and to report on performance indicators. However, since the encounter data that plans have to submit to Medicaid differ from what must be submitted to CMS—which mainly requires diagnoses for CMS-HCC risk adjustment—plans are struggling with the extra burden of submitting two sets of data. One plan respondent suggested that the SNP model provides the opportunity for Medicare and Medicaid to coordinate and jointly determine the appropriate measures needed to monitor quality and improve the care received by beneficiaries. Plans dealing with institutionalized individuals, for example, have found that CMS's HEDIS measures do not work for this population. While determining replacement measures is a difficult task, the process would benefit from discussions among Medicare, Medicaid, and plans.

At least two plans offering SNPs expressed the view that the bar for quality and improvement should be set especially high for SNPs so that organizations do not enter the SNP market simply to give sales associates something to do outside MA open enrollment periods. "We want to keep SNPs special," one respondent said.

Organization and Infrastructure. Most Medicaid plans experienced only incremental costs in setting up SNPs because they built on existing plan infrastructure, keeping

administrative teams and even provider networks largely intact. However, one Medicaid plan noted that it has increased staff for medical management programs and has been recruiting for a Medicare expert, and another Medicaid plan indicated that it has invested \$600,000 in preparations for SNP, adding 22 new staff positions (case managers, pharmacy technicians, member and provider services representatives).

Although payers worked to keep the SNP provider networks the same as those for existing plans (MA or Medicaid), two plans did experience a slight change in their networks for the SNP as some physicians decided not to participate in the SNP because they were either unwilling to accept the Medicare payment or did not fully understand how participation could benefit them.

Financing and Payment. Plans appeared confident that the MA payment will adequately cover their SNP costs, especially with the complete phase-in of CMS-HCC risk adjustment in 2007. The plans voiced no concern over the adequacy of the Medicaid payment.

The plans operating SNPs in Phoenix did not experience much difficulty in keeping the Medicaid and Medicare funding streams separate, which may reflect the long history of some of the plans in dealing with both Medicare and Medicaid. Most plans were confident that the management of the separate funding streams could remain in the background and not affect clinical coordination for members or plan relationships with providers.

The interviewed plans pay their physicians in a variety of ways under the SNP. One plan pays physicians fee-for-service and uses the Medicare DRG system for hospital payment. It is experimenting with a per-diem hospital payment system with a stop-loss to see how it compares to the DRG payment. Another plan pays providers a percentage of the AHCCCS fee schedule for Medicaid and a percentage of the Medicare fee schedule for non-physician services. We were told that Medicaid health plans regularly pay physicians 95 percent of the AHCCCS rate, which is higher than Medicare and high even by commercial plan standards.

Contracting with CMS and Implementation Challenges

While some plans operating SNPs in Phoenix found that the CMS application and bidding process was easy, other plans described it as somewhat unpredictable and susceptible to last-minute changes. Several respondents noted that CMS did not appear to have fully thought through all the implications for dual eligibles and plans and seemed to be “making it up as they went along,” resulting in a somewhat unpredictable process. Changes to CMS requirements often occurred at the last minute, with information and clarification from the agency slow in coming. One plan expressed some frustration with the process of creating a drug formulary for the bid when, on several occasions, CMS requested the addition of several drugs to the formulary after submission of the bid. The plan was not given the opportunity to re-price the formulary to include the drugs added after the bid submission and therefore will have to bear the expenses for those drugs for 2006.

Plans noted that they had to deal primarily with the CMS central office for the SNP application and bidding process. Communication with the central office was often slow, causing problems.

The issue of greatest significance associated with SNP implementation was the breakdown of the passive enrollment and auto-enrollment process and the delays experienced by plans in awaiting correct enrollment information from CMS. About 20,000 people were not assigned to any plan or PDP by the end of December 2005, and so were not covered for their medications. CMS issued general guidance to plans, indicating that they should treat the people they had expected to enroll passively as enrollees and continue paying for their medications. AHCCCS worked closely with the affected Medicaid plans to figure out how to deal with these individuals, coordinating calls with CMS and raising the issue with the governor's office. In the end, the SNPs that included Medicaid decided to treat the 20,000 people as if they were already enrolled even though CMS had not confirmed enrollment. One plan noted that it has accrued \$190,000 in costs from covering these individuals. The governor authorized \$500,000 in emergency funds to pay plans caring for unassigned members and will seek reimbursement from CMS at a later time. Some Medicaid plans that expected passive enrollment in the thousands received initial enrollment tapes that showed no enrollment or enrollment in the hundreds. By the time of our site visit in late February, one of the SNPs that includes Medicaid was still waiting to receive its passive enrollment file.

SNPs that have contracted for Medicaid services noted several conflicts between Medicare and Medicaid rules dealing with bidding, contracting, enrollment, marketing, complaints and grievances, denial processes, reporting, monitoring, and rate setting and urged CMS and states to work to reduce these administrative barriers to better integration of the two programs. One respondent understood that it would be difficult for states to agree with CMS on everything since the states want to maintain a level of independence, but the respondent noted that areas such as HEDIS measures and grievances/appeals and notifications would benefit from standardization and coordination between Medicare and Medicaid. Several plans also said that they should be able to waive copayments for dual eligibles in the community, as the small copayments do not offset the cost of Medicare members' failure to take their medications because of their inability to pay copayments.

Plans have experienced few difficulties with providers or beneficiary advocacy groups during SNP implementation, partly because Medicaid managed care has been well established in Phoenix for many years.

Lessons Learned

Most plans indicated that it was still too early to derive any firm lessons learned or to set forth any definitive future plans for their SNPs. However, plans did hope that CMS learned that future endeavors would benefit from more forethought and planning. Several interviewed plans indicated that many of the challenges associated with SNP implementation occurred because CMS failed to think through the process thoroughly or to seek input from plans about the operational impact of decisions. One plan suggested that CMS should

identify clearer goals for SNPs, study the lessons learned from the problems in 2005–2006, and then hold forums to discuss and formulate the policies that would support those goals.

MIAMI, FLORIDA

We interviewed 4 of the 11 plans operating SNPs in the Miami area on March 16, 2006 (and received information on a total of 4 SNPs). One of the interviewed SNPs is an institutional SNP, and the other 3 are dual-eligible SNPs. Of the 11 Miami-area SNPs, 2 are institutional and 9 are dual eligible. There are no chronic-condition SNPs in Florida. We sought to interview several of the other SNPs in the Miami area but were unable to schedule interviews with them.

Market Environment and SNP Goals and Strategy

Miami is a highly competitive Medicare managed care marketplace characterized by a high percentage of dual eligibles and Hispanics in the Medicare population, making south Florida attractive to dual-eligible SNPs that can market effectively to the population and obtain the higher risk-adjusted rates paid for duals. The plans we spoke with highlighted three reasons why they established SNPs in Miami. First, the cultural aspect of the area's large Hispanic community lends itself to SNPs because adult children in the community prefer caring for aging parents and grandparents in home environments rather than in nursing homes. Second, in addition to filling a service need in the community, plans noted that the SNPs made good business sense because of the CMS-HCC risk adjustment, which pays plans more for sicker individuals. The basic MA capitation rates are particularly high in the Miami area, allowing plans to offer supplemental benefits if they can keep utilization below the high fee-for-service base levels. Third, as Medicaid becomes an ever-larger line item in state budgets and states look for more savings from the Medicaid population, plans with SNPs will be well positioned to take on the dual eligible membership and care for individuals at lower cost.

One interviewed plan has developed a national SNP strategy based on extending services it already provides to the special needs population, and it appears to be playing out in Miami in much the same way as in other areas of the country. Another interviewed plan has a much more limited SNP strategy and, in the Miami area, is relying on a key partnership with a contractor with extensive experience in the Florida Medicaid program and the provision of community-based services in the Miami area. The latter plan's SNP ambitions beyond Florida are limited to areas in which the plan has existing MA-PD plans and conditions are otherwise favorable, such as areas with a large share of dual eligibles in the Medicaid population and the state's potential interest in better integrating Medicare and Medicaid services through managed care.

The plans we spoke with emphasized the highly competitive nature of the south Florida SNP market, given the financial attractiveness of dual eligibles and the high rates of MA capitation payments. According to one plan, dual-eligible SNPs dominate the marketplace because the additional revenue on the dual-eligible side allows plans to spend dollars on the provision of extra services.

Plans are also interested in dual eligibles because after mid-May 2006, when the initial Part D enrollment period ends, dual eligibles “are the only game in the county” until the 2007 enrollment period opens in November (dual eligibles can change plans every month).

Relationships with the State

In Miami, SNP relationships with the state have been more distant than in Boston and Phoenix. The state Medicaid agency does not currently contract with SNPs for Medicaid services and does not coordinate with MA plans for payment of Medicare cost sharing for dual eligibles, thus requiring MA network providers to seek payment for cost sharing directly from the state.¹⁰

Plans believe that it would be helpful if they had the opportunity to work more closely with the state and expressed enthusiasm about the potential opportunities for SNPs in the new Florida Senior Care program, a managed integrated long-term-care program currently under development by the state.¹¹

One plan indicated that it would like to see the state become more involved in providing the entire dual-eligible population with general SNP information, though without recommending any one particular plan. Without the state’s help, finding a dual eligible is like “looking for a needle in a haystack.”

Similarities and Differences Among SNPs

Outreach and Enrollment. One Miami plan strongly emphasized the importance of community-based and personalized marketing to the dual-eligible and heavily Hispanic population in south Florida. The plan officials we spoke with who had experience with the special needs population emphasized that this population is not receptive to traditional marketing and advertising methods (television commercials, direct mail, or print media) and noted that the way to connect with the group is through grassroots approaches and through community organizations that individuals trust or rely on for services. The plan indicated that a good deal of its marketing is network-based, especially through care providers in nursing homes where patients are a captive audience. Another plan relies on more “passive marketing,” using general, global educational pieces or member orientations that educate people on available products. This soft marketing focuses on providing general information, followed by more detailed information if and when consumers contact the plan with questions.

¹⁰ Medicaid is required to pay Medicare cost sharing (deductibles and coinsurance) for dual eligibles up to the amount that Medicaid would pay for the service. In some states, the Medicaid agency allows MA plans to submit claims for Medicare cost sharing to the state on behalf of the plans’ network providers. In some other states, the Medicaid agency makes monthly capitated payments to MA plans for their dual-eligible enrollees’ cost sharing based on actuarial estimates of what per-enrollee cost sharing will be.

¹¹ Details on the Florida Senior Care program are available on the program’s Web site at http://www.fdhc.state.fl.us/Medicaid/long_term_care/index.shtml.

Most of the duals in Miami were auto-enrolled in stand-alone PDPs, we were told, and the plans we spoke with did not have a comprehensive strategy for marketing to this large population.¹² One plan noted that marketing to the duals is not easy because of the Health Insurance Portability and Accountability Act privacy guidelines and Medicare marketing rules.

Care Coordination and Management. One plan has a continuum of care structured around fairly centralized coordination so that an individual entering the plan as a dual eligible who is neither institutionalized nor frail can be moved along the continuum and into the institutional SNP if needed. The plan uses front-end health risk assessments (HRAs) to determine members' conditions and then relies on a software system to follow members from the day they entered the plan, looking at their needs, medical conditions, and psychosocial conditions. All the information from the HRA and the software system is entered into a clinical care management model that drives the services needed by members.

Another plan we spoke with has a care coordination program based on the efforts of its Miami-based community services partner.

Nursing Facility Services. One plan we spoke with in Miami has been at risk for all nursing facility services in the state's Medicaid Nursing Home Diversion Program (for Medicaid dual eligibles over age 65),¹³ and its experience with prescription drugs in that setting is similar to its approach in other SNP sites. The plan charges nurse practitioners in nursing facilities with responsibility for helping to review prescribing protocols and manage utilization. In addition, the plan places plan pharmacy consultants in the nursing homes to assist the nurse practitioners. Another plan we spoke with did not have much experience with institutionalized individuals but expressed interest in entering into the Diversion Program as well.

Quality Monitoring and Improvement. The Miami SNPs have put in place quality monitoring and performance reporting systems for their own internal management and measurement purposes and are looking for ways of better measuring the impact of their efforts to improve care coordination and communication with their members.

One plan said that its reporting for the SNP is currently the same as the standard reporting for its other MA plans, but it is working with the Florida Medicare Quality Improvement Organization to develop quality improvement initiatives for the broader senior population (not just for SNPs) that include HEDIS indicators as well as other measures.

¹² Approximately 93 percent of Florida's 380,000 dual eligibles were auto-enrolled in stand-alone PDPs in May 2006, about the same as the national average (Kaiser Family Foundation, statehealthfacts.org).

¹³ The Diversion Program pays participating managed care organizations a monthly capitation rate to provide, manage, and coordinate long-term-care services and medical services for persons who are dually eligible and over 65 years of age. The managed care organization is at risk for unlimited nursing home payments as long as the individual remains enrolled in the program (CMS, Promising Practices, 12/16/04, www.cms.hhs.gov/PromisingPractices/Downloads/flpmco.pdf).

Organization and Infrastructure. While the plan with extensive special needs experience did not appear to have changed its infrastructure to any great extent, another plan that was newer to SNPs enhanced its infrastructure, particularly its staffing, to administer the extra benefits provided by the SNP.

Financing and Payment. One plan suggested that the new Medicare risk adjustment made it feasible to develop special needs plans. The plans seemed to believe that the MA payment would be adequate.

Contracting with CMS and Implementation Challenges

The Miami interviewees described the CMS contracting process as relatively straightforward, although they reported bumps along the road related to timelines and sporadic internal CMS communications. One plan had a product in the Miami market for the special needs population that needed to be redesignated as a SNP, and though the process seemed generally uncomplicated, it took much longer than the plan expected. Another plan ran into difficulty because the CMS central office and regional office were apparently not communicating. The plan had been in talks with the CMS central office regarding its SNP plan and appeared to be following the CMS regulations but then was contacted by the CMS regional office, which raised issues that had seemingly been settled at an earlier point with the central office. The process of aligning the regional and central offices was time-consuming, we were told.

When asked about implementation challenges, plans mentioned an issue that is not specifically related to SNPs but certainly affects them. Plans noted that as Medicaid-enrolled members age into Medicare, a delay occurs and CMS does not immediately receive information from the state on the member's continuing Medicaid eligibility. The lag between members gaining Medicare eligibility and CMS obtaining Medicaid eligibility information has always been a problem and could result in a temporary loss of drug coverage. Respondents in Phoenix raised the same issue.

Lessons Learned

One plan emphasized the importance of developing relationships with the state. The plan suggested that it would be helpful to streamline and simplify how it works with state partners in order to provide the dual-eligible population with access to information about SNP services.

Another plan we spoke with expressed some concern over CMS's seemingly narrow perspective in looking at SNP benefits to determine which services should be disallowed because they are not considered medical benefits. The plan indicated that if CMS is looking for alternative settings of care, it needs to be more flexible so that plans can offer members benefits that may not at first glance appear to be medical benefits but that will help accomplish the goal of avoiding higher health costs and improving health.