

Integrating Medicare and Medicaid: State Experience with Dual Eligible Medicare Advantage Special Needs Plans

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Research Report

The conclusions and recommendations set forth in this paper reflect the views of state officials who participated in interviews with the authors. They do not necessarily reflect AARP policy or the views of the Advisory Committee or the organizations they represent.

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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EXECUTIVE SUMMARY

The dually eligible population—nearly 9 million seniors and younger people with disabilities who are covered by both Medicaid and Medicare—accounts for a disproportionate share of spending in both programs: up to 46 percent of all Medicaid spending and 24 percent of Medicare spending (compared with 18 percent and 16 percent as a share of enrollment in each program, respectively). Dual eligibles often face significant fragmentation in their health care coverage, with Medicare as the primary payer for physician and hospital services, a separate Medicare Part D plan as the primary payer for most prescription drugs, and a state-administered Medicaid program responsible for Medicare copayments, Part B premiums, and a variety of additional services not covered by Medicare. The most significant of these additional services is long-term care. Navigating two systems is challenging for individual beneficiaries and providers and creates financial disincentives for improved quality of care.

Medicare Advantage Special Needs Plans (SNPs) were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to encourage health plans to develop programs to better serve targeted Medicare subpopulations, including dual eligibles. Dual eligible SNPs were intended to provide an option for integrating Medicare and Medicaid services for this vulnerable, high-cost population and to bring long-running demonstrations, including both integration demonstrations and demonstrations about care management in nursing homes, under a single program. By August 2009, almost 944,587 dual eligibles were enrolled in a Medicare dual eligible SNP.¹ However, the majority of SNP plans were providing only Medicare services to dually eligible enrollees; fewer than 20 percent of state Medicaid programs had contracted with a SNP to provide some level of integration across the two programs.

Congress has extended the authority for SNPs through plan year 2010. All SNPs must provide certain care management activities for all members, including the use of evidence-based models of care; annual assessment of physical, psychosocial, and functional needs; and individual care plans. Dual eligible SNPs are now required to contract with state Medicaid programs when they seek to enter a new market or expand within a state.

This report explores the experience of Minnesota, New Mexico, and New York, three states that have contracted with Medicare SNPs to provide integrated Medicare-Medicaid services for dually eligible consumers. The purpose of the study is to better understand the perspective of state Medicaid programs: why they contract with SNPs, what impact SNP enrollment has on beneficiaries, what the barriers are to effective contracting between Medicaid and SNPs, and what federal policy changes might best support better integration of Medicare and Medicaid services for dually eligible consumers.

Each of the case study states provides a SNP model that includes some or all Medicaid long-term care services to dual eligibles.

¹ Centers for Medicare and Medicaid Services. Special Needs Plan Comprehensive Report: [Medicare Advantage/Part D contract and enrollment Data, Special Needs Plans Data](http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1227826&intNumPerPage=10). accessed at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1227826&intNumPerPage=10>

- **Minnesota** offers Minnesota Senior Health Options (MSHO) for seniors who are dual eligibles. MSHO is offered statewide through Medicare SNPs and includes all Medicaid acute care services, home and community long-term care services, and up to 180 days of nursing home care. Enrollment in Medicaid managed care is required for seniors in Minnesota, but seniors can choose to enroll in either a SNP model for Medicare and Medicaid or a health plan that offers Medicaid services only. Minnesota also offers Minnesota Disability Health Options (MDHO) in seven counties for dually eligible adults who have a physical disability; enrollment is voluntary.
- **New Mexico** has implemented the Coordination of Long-Term Services (CoLTS) program, which provides all Medicaid services, including long-term care services and supports, through SNPs. Enrollment in CoLTS is targeted to adults who need long-term care services, including dual eligibles. Enrollment in CoLTS is mandatory for Medicaid beneficiaries needing long-term care, but SNP enrollment for Medicare services is optional.
- **New York** offers Medicaid Advantage Plus (MAP) through SNPs for dually eligible adults with long-term care needs in five counties and New York City. All Medicaid benefits, including acute care and all community and institutional long-term care services and supports, are included. Enrollment in MAP is optional for dual eligibles, but individuals cannot enroll in MAP unless they also enroll in the SNP for Medicare.

New York also offers Medicaid Advantage, a SNP model that provides the “wrap-around” benefits only (no long-term care) to dually eligible adults in 25 counties and New York City. Enrollment is voluntary; this option allows Medicaid managed care enrollees to continue managed care enrollment when they become Medicare eligible.

KEY FINDINGS FROM CASE STUDY STATES

Case Study States identified several potential advantages of contracting with Medicare SNPs to offer integrated Medicare-Medicaid products for dual eligibles, as well as barriers regarding the use of SNPs. These include the following:

Advantages

- **Integrated plans have the potential to provide more cost-effective care for dually eligible beneficiaries, including improved access to community long-term care services.** State goals for integrated products include improved integration between Medicare and Medicaid services, enhanced care management services, and improved consumer access to community-based long-term care services.
- **Integrated Medicare-Medicaid products can improve the total range of benefits available to dually eligible enrollees.** All SNPs offer enhanced care management services, and states have worked to provide improved community-based services. New York established a uniform Medicare Advantage benefit package for participating plans to offer some supplemental services not usually covered by Medicare. Some states, including New Mexico, have also targeted improved community system capacity through integrated managed care strategies.

- **States have the capacity and experience to manage SNPs to achieve specific objectives for dually eligible enrollees.** States are able to build on their long-standing experience with managed care oversight to achieve the following objectives for duals: ensure adequate consumer protections, monitor plan performance (including service utilization and quality measures), and monitor consumer satisfaction and grievances. Some states use performance-based incentive payments to influence plan behavior.

Barriers

- **Engaging stakeholders in the design of an integrated product helps overcome resistance to managed long-term care and improves consumer protections.** States noted that support for managed long-term care increased as advocates came to see these arrangements as key to increasing access to community-based long-term care options and as specific concerns, especially around consumer protections and provider access, were explicitly addressed in program design.
- **The process for a state to obtain federal authorization for an integrated Medicare-Medicaid managed care product is lengthy and has changed over time.** Each of the case study states operates its integrated managed care product under a distinct set of federal authorizations, and some states described multiyear negotiations to gain federal approval.
- **It is challenging to fully integrate administrative activities between Medicare-Medicaid SNPs due to differences in state and federal program regulations.** States report that it is particularly difficult to integrate administrative functions for SNP enrollees, including enrollment and grievance and appeals processes, due to differing federal requirements for Medicare and Medicaid programs.
- **Start-up for a state requires significant time and effort, including resources to hire actuaries, while Medicaid savings take time to accrue.** Contracting with a SNP model required considerable state resources to negotiate federal approvals, develop and administer health plan procurements and contracts, establish actuarially sound rates, modify state regulations to support the new product offering, and conduct outreach to dual eligibles and other stakeholders. Analysis suggests that Medicare savings can accrue relatively quickly from care management strategies for the dually eligible population, for example, from avoiding preventable hospitalizations with improved primary care. However, Medicaid savings rely on reducing the demand for long-term care services (through better primary and preventive care) and on offering individuals more cost-effective options as the need for long-term care arises. Medicaid savings do occur, but they are likely to accrue over a longer period of time.² Delayed savings, coupled with the administrative costs associated with developing and implementing an integrated managed care product, might discourage more states from responding to SNP contracting opportunities.

² The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities* (Falls Church, VA: The Lewin Group, November 2008).

- **Voluntary enrollment for Medicare can be a significant barrier to achieving full integration.** While states can require enrollment in managed care for Medicaid services, states cannot require dual eligibles to enroll in a Medicare SNP; encouraging voluntary dual enrollment is time consuming for SNPs and states. States may lack incentives to conduct outreach activities designed to get Medicaid beneficiaries to voluntarily enroll in SNPs. It may also be hard for SNPs to achieve sufficient enrollment to effectively cover start-up costs.
- **Federal policy raises questions about the future of SNPs, which may discourage states from pursuing new contracts or undermine existing arrangements.** SNPs are currently federally authorized only through 2010, which may discourage some states from investing in the development of a SNP contract. Some officials raised concerns that evolving federal policies on Medicare Advantage plan rates may reduce the viability of SNPs. In addition, some officials are concerned that new administrative and operational requirements for Medicare SNPs may make it more difficult to offer an integrated product for dual eligibles.

RECOMMENDATIONS

State officials recommended specific federal policy reforms to better support integrated products:

1. **The Centers for Medicare and Medicaid Services (CMS) should form a dedicated unit to support Medicare-Medicaid integration models.** This would increase reliability and predictability of federal guidance and facilitate sharing best practices among states. It would also help to coordinate and integrate Medicare and Medicaid policies and identify inconsistencies between the two programs that pose barriers to effective integration.
2. **CMS should formalize policy guidance and clarify effective state options for offering integrated products to streamline the approval process.** Without promulgated regulations or other formal guidance, federal auditors may not understand integrated features; states will face ever-changing advice from federal regulators; and states will be reluctant to pursue burdensome, multiyear approval processes.
3. **CMS should allow more flexibility in Medicare regulations to support effective integration with Medicaid.** Increased flexibility regarding Medicare administrative requirements would make it easier to fully integrate the managed care experience for enrollees and reduce the start-up costs for states. A “PACE-like” approach, where a single, fully integrated program is created, would be ideal. In particular, CMS should work with states to create a streamlined, fully integrated process to manage consumer notifications and respond to consumer grievances and appeals. In addition, CMS should work with states to create strategies that encourage enrollment for both Medicare and Medicaid to increase the number of dual eligibles who are fully enrolled in integrated plans. One idea is an “opt-out” approach, in which enrollment is presumed unless dual eligibles explicitly choose Medicare fee-for-service. Another is to allow states to create a single point of enrollment for both health plans.

- 4. Federal policy should identify ways in which Medicaid programs can realize early savings by offering integrated products.** States must make a significant administrative investment in creating and implementing an integrated product, but may realize only modest savings or break-even results for Medicaid over the near term. Federal policy could encourage more states to develop integrated initiatives by identifying options that give states a share of any early Medicare savings, allowing states to count Medicare savings toward waiver budget neutrality tests, or by providing funding to offset up-front state administrative costs.

INTRODUCTION

As states and the federal government attempt to ensure more clinically effective and financially sustainable Medicaid programs, attention is turning to the subset of beneficiaries who are covered by both Medicaid and Medicare. In 2005, this so-called “dually eligible” population made up 18 percent of Medicaid enrollment but accounted for approximately 46 percent of the nation’s total Medicaid spending.³ Dual eligibles are a high-cost subpopulation within Medicare as well, representing 16 percent of Medicare beneficiaries, but accounting for 24 percent of total Medicare spending in 2006.⁴ Approximately 5.6 million people ages 65 and older and 3.2 million people younger than 65 who have disabling conditions were covered by both Medicare and Medicaid in 2005.⁵ Total state and federal spending on duals is projected to grow to more than \$775 billion by 2024, with average annual costs potentially approaching \$80,000 per person.⁶

Dual eligibles typically have multiple chronic conditions. When compared with other Medicare beneficiaries, dual eligibles are 100 percent more likely to be in poor health, 50 percent more likely to have diabetes, 600 percent more likely to live in a nursing home, and 250 percent more likely to have Alzheimer’s disease.⁷

Most policymakers agree that this is a population that could benefit from an integrated, coordinated approach to health and social service delivery. Instead, these beneficiaries generally face significant fragmentation in their health care coverage. Medicare is the primary payer for physician and hospital services, and often a separate Medicare Part D plan is the primary payer for most prescription drugs. A state-administered Medicaid program is responsible for Medicare Part B premiums, copayments, and—for those who also qualify for full Medicaid coverage—a variety of services not covered by Medicare (vision, sometimes dental, certain drugs, and therapies and behavioral health services in excess of Medicare coverage). Most significantly, Medicaid provides this population with coverage for long-term services and supports in both institutional and home and community settings. (See the figure, “Medicaid Expenditures for Dual Eligibles, FFY 2005.”) Only 6 percent of Medicaid dual eligibles’ spending was paid through capitation in 2005,⁸ as most states exclude duals from enrollment in Medicaid managed care arrangements, and less than 15

³ J. Holahan, D. Miller, and D. Rousseau, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, February 2009).

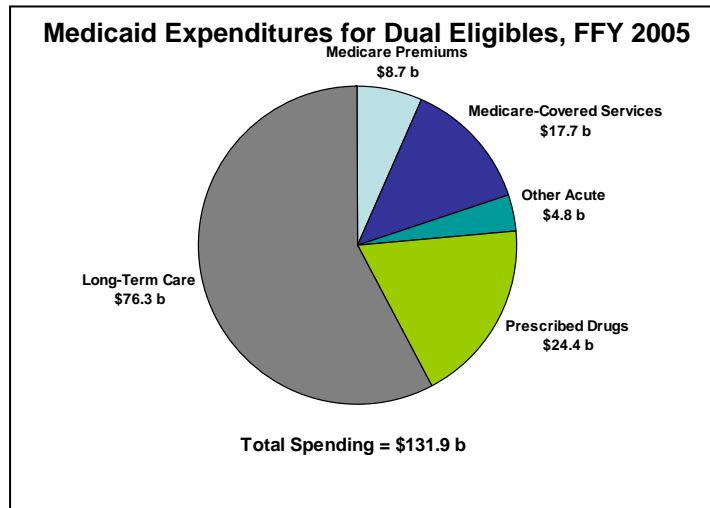
⁴ Medicare Payment Advisory Commission (Medpac), “Section 3: Dual Eligibles,” in *A Data Book: Healthcare Spending and the Medicare Program* (Washington, DC: Medpac, June 2009).

⁵ J. Holahan, D. Miller, and D. Rousseau, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, February 2009).

⁶ The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities* (Falls Church, VA: The Lewin Group, November 2008).

⁷ The Henry J. Kaiser Family Foundation, *Medicare Chartbook* 3rd ed. (Washington, DC: The Henry J. Kaiser Family Foundation, Summer 2005).

⁸ Capitation is a payment method for health care services in which a managed care plan is paid a contracted rate for each member assigned, referred to as “per-member-per-month” rate, regardless of the number or nature of services provided. The contractual rates are usually adjusted for age, gender, illness, and regional differences. The Free Dictionary by Farlex, accessed at <http://medical-dictionary.thefreedictionary.com>.



percent of Medicare's spending for dual eligibles was paid through capitated managed care arrangements.⁹ Most dual eligibles have had little incentive to voluntarily enroll in Medicare Advantage (MA) plans because they have access to the Medicaid benefit package as well as Medicaid assistance with cost sharing.

This fragmentation across two programs can be challenging for beneficiaries and providers to navigate. Worse, it creates financial disincentives for improved quality of care. For example, poor quality nursing home care funded by Medicaid may result in an individual being hospitalized—a cost shift to Medicare. Likewise, inadequate Medicare-funded chronic care coordination in the community may result in the premature need for long-term care services—imposing new costs on Medicaid. Unfortunately, this also means that investments in improved care by one program may accrue savings to the other program, rather than the savings being realized by the program making the investment.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)¹⁰ created Medicare Advantage Special Needs Plans (SNP),¹¹ which are authorized to target enrollment of dual eligibles.¹² Federal policymakers hoped that this option would create a vehicle to promote improved integration of services for dual eligibles and would put the previously existing federal demonstrations, as well as the EverCare demonstration of managed care in nursing homes,¹³ under a single federal

⁹ The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities* (Falls Church, VA: The Lewin Group, November 2008).

¹⁰ Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173).

¹¹ MA plans are plans offered by private companies that contract with Medicare to provide Medicare Part A and Part B benefits. HHS.Gov. Medicare Glossary, accessed at <http://www.medicare.gov/Glossary/search.asp?Language=English&SelectAlphabet=M>.

¹² MA plans could always enroll dual eligibles, but SNPs are the first MA plans allowed to market exclusively to duals. Some states have worked out financial arrangements for the states to pay MA plans for duals.

¹³ EverCare's federal demonstration was designed to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. EverCare received a fixed capitated payment for all nursing home resident Medicare enrollees. This demonstration transitioned to an MA Institutional SNP model.

authority. The goal is both improved service delivery and outcomes for this population and a reduction in the overall costs of care.

MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR DUAL ELIGIBLES

FEDERAL AUTHORITY

The MMA created a new type of MA plan, the SNP, to encourage health plans to develop targeted programs to more effectively care for high-risk beneficiaries and provide incentives to better integrate the provision of care.¹⁴ This new MA option was a response to the rapid increase in Medicare costs and the general lack of coordinated care for high-cost populations. SNPs also were intended to be used to better integrate Medicare and Medicaid services. The law creating SNPs represents the first time Congress has permitted private plans to limit enrollment to specific types of Medicare beneficiaries.¹⁵

The federal Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services must approve the offer of specific SNPs by MA organizations. An individual MA organization can offer multiple SNPs, even within a single state. SNPs must target one of three special needs populations:

- **Dual eligible SNPs** are designed for Medicare beneficiaries who are also enrolled in their state's Medicaid program. Dual eligible SNPs were designed to accommodate existing state waiver demonstration projects to integrate Medicare and Medicaid in Massachusetts, Minnesota, and Wisconsin and to allow additional states to implement integration strategies. However, under the initial authorizing legislation, dual eligible SNPs were not required to have contracts with state Medicaid programs. Most dual eligible SNPs today provide only Medicare-related benefits to enrollees.
- **Institutional SNPs** may enroll Medicare beneficiaries who live or are expected to live for 90 days or longer in a long-term care facility, including skilled nursing facilities, nursing homes, nursing facilities, intermediate-care facilities for persons with developmental disabilities, and inpatient psychiatric facilities. They may also enroll beneficiaries living in the community who require a level of care equivalent to that of beneficiaries in these facilities. Plans may limit enrollment and market only to selected facilities within their geographic area, with CMS approval.
- **Chronic disease SNPs** are designed for Medicare beneficiaries with "severe or disabling chronic conditions." The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) required CMS to convene a panel of clinical advisers to identify the chronic conditions that meet the MIPPA-clarified definition of "severe or disabling." Fifteen SNP-specific chronic conditions were approved for 2010: (1) chronic alcohol and other drug dependence, (2) certain autoimmune disorders, (3)

¹⁴ Ellen Lukens et al., *Medicare Advantage Special Needs Plans* (Washington, DC: Avalere/ACAP, November 2007).

¹⁵ J. Verdier, M. Gold, and S. Davis, *Do We Know If Medicare Advantage Special Needs Plans Are Special?* Prepared for The Henry J. Kaiser Family Foundation, January 2008.

cancer (excluding precancer conditions), (4) certain cardiovascular disorders, (5) chronic heart failure, (6) dementia, (7) diabetes mellitus, (8) end-stage liver disease, (9) end-stage renal disease requiring dialysis, (10) certain hematologic disorders, (11) HIV/AIDS, (12) certain chronic lung disorders, (13) certain mental health disorders, (14) certain neurologic disorders, and (15) stroke.¹⁶ Institutional and chronic disease SNPs can serve both dually eligible and non-dually eligible beneficiaries.

After enactment of the MMA, the number of Medicare-approved SNPs grew rapidly, from 11 in 2004 to 787 by January 2008. By March 2009, the number of SNPs had dropped to 698, but dual eligible SNPs remained the most common plan type, with 406.¹⁷ Enrollment in dual eligible SNPs also grew rapidly in early 2006. The rapid growth in the number of SNPs and in the enrollment in SNPs was driven by a one-time option that enabled Medicare SNPs that were also contractors for Medicaid managed care to “passively enroll” their dually eligible Medicaid enrollees into their SNP product. This option was allowed by CMS to facilitate enrollment of dually eligible Medicaid beneficiaries in Medicare Part D,¹⁸ and it had a significant impact in the small number of states that had already enrolled dual eligibles into Medicaid managed care. By August 2009, there were almost 944,587 dual eligibles enrolled in Medicare SNPs.¹⁹

While enrollment in dual eligible SNPs for Medicare services grew rapidly, state contracting with SNPs to integrate some or all Medicaid services has grown much more slowly. In 2007 and 2008, fewer than 20 percent of states reported having some form of Medicaid contract arrangement with a Medicare SNP. As a result, most dual eligibles enrolled in SNPs do not receive integrated services across both Medicare and Medicaid.^{20,21}

2008 SNP REFORMS

The authority for SNPs to limit enrollment to the specified subgroups was scheduled to expire at the end of 2008. Congress extended that authority for an additional year, to December 31, 2009, under the Medicare, Medicaid, and SCHIP Extension Act of 2007, but placed a moratorium on CMS authority to approve any new plan or plan service area expansions after January 1, 2008.²² MIPPA, enacted in mid-2008, extended federal authority for all SNPs through plan year 2010. During the federal debate over the SNP extension, advocates and others expressed concerns about whether all SNPs offered

¹⁶ Medicare Improvement for Patients and Providers Act of 2008, Public Law No. 110-275.

¹⁷ MedPac, *A Data Book: Health Care Spending and the Medicare Program* (Washington, DC: Medicare Payment Advisor Commission, June 2009).

¹⁸ There were more than 40 dual eligible SNPs approved for 2006 that were owned by managed care organizations with existing Medicaid managed care contracts. Beneficiaries were notified in advance of passive enrollment and were allowed to opt out.

¹⁹ Centers for Medicare and Medicaid Services. *Special Needs Plan Comprehensive Report: Medicare Advantage/Part D contract and enrollment Data, Special Needs Plans Data*. accessed at <http://www.cms.hhs.gov/MCRAdvPartDEnrollData/SNP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1227826&intNumPerPage=10>

²⁰ J. Verdier, M. Gold, and S. Davis, *Do We Know If Medicare Advantage Special Needs Plans Are Special?* Prepared for The Henry J. Kaiser Family Foundation, January 2008.

²¹ R. Schmitz, A. Merrill, J. Schore, R. Shapiro, and J. Verdier, *Evaluation of Medicare Advantage Special Needs Plans: Summary Report*. Prepared for Centers for Medicare and Medicaid Services, September 30, 2008.

²² Medicare, Medicaid and SCHIP Extension Act of 2007, Public Law No. 110-173.

sufficient value-added services, and over the fact that so few SNPs had contracts with states to integrate Medicare and Medicaid services for dual eligibles more fully.²³ Congress responded to these concerns and included in MIPPA several provisions to improve the quality of MA-SNPs:

- All SNPs must provide certain care management activities for all members. These include evidence-based models of care; appropriate networks of providers and specialists; initial and annual assessment of physical, psychosocial, and functional needs; and individual care plans that identify goals, objectives, measurable outcomes, and specific benefits. The plans must also provide certain data to measure health outcomes and other quality measures at the plan level.
- Dual eligible SNPs must give all prospective enrollees a comprehensive, written statement that describes the benefits and cost-sharing protections provided under Medicaid as well as the Medicare benefits that the plans provide.
- Dual eligible plans are required to contract with the state to provide for some coordination with Medicaid benefits in order to enter the market. SNPs that are already in operation are not required to contract with the state Medicaid programs unless they want to expand into new service areas. State Medicaid programs are not required to contract with SNPs.
- SNPs may not impose cost sharing on full dual eligibles and qualified Medicare beneficiaries that exceeds the amount permitted under federal Medicaid law.²⁴

METHODOLOGY

The AARP Public Policy Institute contracted with Health Management Associates (HMA) to explore the experience of state Medicaid programs that have contracted with dual eligible SNPs. The purpose of the study is to better understand, from the perspective of state Medicaid programs, why some states chose to contract with SNPs, what impact SNP enrollment has on beneficiaries, what barriers prevent effective contracting, and what federal policy changes might best support effective integration of Medicare and Medicaid services for dually eligible consumers.

HMA conducted in-depth telephone interviews in late 2008 and early 2009 with state Medicaid officials (appendix A) in three states—Minnesota, New Mexico, and New York—that currently contract with dual eligible SNPs to promote integration of Medicare and Medicaid services. Each of these states offers at least one SNP product that includes Medicaid long-term care as part of the benefit package. Telephone interviews were also conducted with officials in Alabama and Washington to explore relevant experience in these states with contracting with Medicare SNPs for Medicaid dual eligibles. The AARP Public Policy Institute invited a panel of national experts to

²³ C. Milligan and C. Woodcock, *Issue Brief I, Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer* (Washington, DC: Center for Medicare Advocacy, October 2007).

²⁴ Center for Health Care Strategies, *Medicare Improvements for Patients and Providers Act of 2008, Policy Update* (Hamilton, NJ: Center for Health Care Strategies, October 2008).

assist in the selection of case study states and in the development of the interview survey instrument (appendix B). The panel sought to identify a set of case study states that had demonstrated a thoughtful policy commitment to service integration for the dually eligible population, included at least some significant length of experience with contracting for Medicare and Medicaid service integration, and represented a range of contracting approaches (including both acute care wrap-around as well as full long-term care service integration models). Advisory panel members also were asked to review and comment on the final report.

HMA and the AARP Public Policy Institute used a variety of additional information-gathering methods to develop this report, including review of federal guidelines and recent national and federal reports regarding MA-SNPs; a facilitated Breakfast Roundtable discussion of Medicare-Medicaid service integration among interested state officials, health plan representatives, and industry experts at the 2008 National Academy for State Health Policy Annual Conference in Tampa, Florida; and telephone interviews (conducted in February and July 2009) with selected additional state and federal Medicaid officials, as recommended by the advisory panel.

STATE EXPERIENCE WITH DUAL ELIGIBLE SNPS

STATE CONTRACTING OPTIONS

State Medicaid contracts with Medicare SNPs generally involve one of two approaches to benefit design:

- **Contracting with a Medicare SNP to provide all Medicaid services, including both Medicaid acute care services that “wrap around” Medicare and Medicaid long-term care services. This is known as “full integration.”**

Most observers believe that the greatest benefit for state Medicaid programs—and dually eligible beneficiaries—results when Medicaid long-term care services are included in the state’s contract with a Medicare SNP. This is because a significant portion of Medicaid spending for dual eligibles is for long-term care, with Medicare the primary payer for primary, acute, and pharmacy services; therefore, savings from improved long-term care service management are the primary source of eventual state savings.²⁵ However, as of January 2009, only ten states had implemented any form of managed care strategy for Medicaid long-term care, which means the opportunities for SNPs to enter into full integration contracts with state Medicaid programs remain limited (see Appendix C).

The number of states with some form of Medicaid managed long-term care is likely to continue to grow, suggesting increased opportunities for states to explore the use of full Medicare-Medicaid integration models. As of January 2009, five additional states had proposed but not yet implemented managed long-term care. Three of these states—Pennsylvania, Virginia, and Vermont—were proposing a Medicare-Medicaid integrated

²⁵ The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities* (Falls Church, VA: The Lewin Group, November 2008).

product, although Virginia has since put its proposal on hold. Because states that introduce managed long-term care for the first time generally face significant initial opposition from providers and advocates, even states that are interested in full-integration options may not be able to adopt a managed long-term care strategy quickly. The CMS-sponsored evaluation of SNPs concluded that it may take several years for state Medicaid programs to fully engage SNPs in integration strategies.²⁶

Appendix C lists states with Medicaid managed long-term care models (implemented and proposed).

- **Contracting for the SNP to provide only the Medicaid acute care benefits that “wrap around” Medicare services. This is known as “partial integration.”**

It is common for states to exclude dual eligibles from Medicaid managed care options, generally because Medicare is the primary payer of hospital, physician, pharmacy, and other services for this population, so there is little for the Medicaid plan to manage if long-term care is not included. However, some states find value in encouraging integration of Medicare and Medicaid services, even if long-term care is not included. These states may contract with a SNP, for example, to allow people who become eligible for Medicare after being covered by a Medicaid managed care plan to continue their enrollment in managed care. These states believe that dually eligible individuals can benefit from Medicare care management for their chronic or disabling conditions or from the enhanced Medicare services often offered by a SNP to encourage Medicare beneficiaries to enroll.

In 2007, at least 10 states had some form of acute-care only benefit available to dual eligibles through a contract with a Medicare SNP in at least some geographic areas, even if only for Medicaid’s coverage of Medicare cost sharing.²⁷ With the enactment of the MIPPA requirement for dual eligible SNPs to contract with states in order to expand to new markets, it is likely that more states will be asked by SNPs to consider some type of contractual arrangement, even if it is limited to cost sharing or acute services.

Alabama is an example of a state that contracts with MA and MA-SNPs to pay Medicare cost sharing for its Medicaid beneficiaries who voluntarily enroll in MA or MA-SNPs. The state does not contract with plans to provide the full or partial Medicaid benefit package.

²⁶ Ibid.

²⁷ Ibid.

The Alabama Experience: Contracting with MA and MA-SNPs for Medicare Cost Sharing

Since 1998, Alabama Medicaid has been contracting with Medicare Advantage plans to provide Medicare cost sharing for its dually eligible population. If a dually eligible Medicaid beneficiary (including persons who receive only limited Medicaid benefits through the Medicare Savings Program) *voluntarily* enrolls in a contracted plan for his or her Medicare services, the state pays the plan a capitated premium to provide any required Medicaid reimbursement for Medicare copays, deductibles, and coinsurance. The capitation amount is based on historical fee-for-service coinsurance payments. The contractual relationship that the state has with these plans is not exclusive to MA-SNPs, but is available to any MA plan that enrolls dual eligibles. Currently, the five MA plans that the state contracts with offer some degree of a dual SNP.

The Medicaid agency finds that it is cost effective to have the Medicare health plan administer cost sharing, citing average per capita savings of \$45 to \$65 per month for every \$15 per member per month (PMPM) payment. Beginning January 2010, the PMPM is scheduled to double to \$30. Savings are realized because the state does not have to meet its full cost-sharing obligation and because the state is relieved of the costs associated with administering Medicare cost sharing.

Out of a total population of 190,000 dual eligibles enrolled in the state's Medicaid program, about 23,000 are enrolled in one of the contracted MA plans for their Medicare cost sharing. According to the state, the plans like the arrangement because the money they save by managing care allows them to offer extra services to their members that are either not currently covered by Medicare or Medicaid or are covered on a limited basis by Medicaid. Examples of these types of services include extra hospital days, healthy lifestyle services and discounts, enhanced vision and hearing exams, and assistance with transportation to medical appointments beyond the Medicaid benefit.

STATE ENROLLMENT OPTIONS

With either of these models, states can take one of two approaches to beneficiary enrollment in a SNP:

- **Voluntary Enrollment in Medicare SNP to Receive Medicaid Benefits**

In some states, beneficiaries are offered a choice between enrolling in a managed care plan that offers Medicaid benefits only or a plan that also offers a Medicare SNP. The state may require that individuals choose the SNP for Medicaid benefits only if they are also enrolled in the SNP for Medicare benefits. As a result, this approach may result in “full integration” for enrollees, but total enrollment in the SNP for Medicaid may be lower, especially in markets where enrollment in managed care for Medicare is not common.

- **Mandatory Enrollment in Medicare SNP to Receive Medicaid Benefits**

In other states, enrollment in a managed health plan that offers a Medicare SNP might be mandatory to receive Medicaid services. This increases total SNP enrollment, but, *because enrollment in a SNP to receive Medicare benefits remains voluntary*, this

approach may result in a situation where a health plan that offers a Medicare SNP is providing managed Medicaid services to a dual eligible, but the dual eligible has not chosen to enroll in the SNP for Medicare services. (The individual may have enrolled in a different MA plan for Medicare benefits, or may be receiving Medicare through the fee-for-service option.) In states with a Medicaid mandatory enrollment option, a relatively small number of dual eligibles may actually benefit from true integration of services across the two programs, at least initially. SNPs have an increased opportunity to market Medicare options to Medicaid SNP enrollees, so dual enrollment could increase over time.

DESCRIPTION OF INTEGRATED SNP PRODUCTS: MINNESOTA, NEW MEXICO, AND NEW YORK

All three of the case study states offer a SNP for dual eligibles that integrates Medicaid acute and some or all long-term care services with the Medicare offering. New York also offers a Medicaid primary-and-acute-care-services-only option, as a wrap-around to Medicare, through a SNP arrangement. Each of the case study states had considerable experience with Medicaid managed care programs, including promoting managed care arrangements for some or all elderly or disabled populations, prior to introducing an integrated Medicare-Medicaid option for dually eligible enrollees.

MINNESOTA

Minnesota's Medicaid program has been a national leader in pursuing care management and service integration for dually eligible populations. Enrollment in managed care for primary and acute care Medicaid services has been mandatory for all seniors covered by Medicaid since 1983. Today, seniors in Minnesota must choose from one of two managed care products: Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO). MSC+ provides Medicaid-covered services only; MSHO integrates both Medicare and Medicaid services, including some long-term care services. The state also offers an integrated product for younger persons with disabilities, called Minnesota Disability Health Options Program (MDHO).

Minnesota Senior Health Options (MSHO) has a history that predates SNPs. In 1995, the state negotiated waivers with the CMS to allow the development of a demonstration project that was designed to integrate Medicare and Medicaid services. Seniors in Minnesota Medicaid were already required to enroll in managed plans for acute care services, and the state was seeking to use the waiver to improve care coordination across Medicare and Medicaid for dual eligibles. The state's goal was to make it easier for beneficiaries to navigate the health care system by creating one linked system to improve access and quality. The state did not explicitly target budget savings as a program goal, but did intend for the reformed program to be at least budget neutral.

Launched in 1997, MSHO integrates Medicare and Medicaid financing for both acute and some long-term care service delivery for dual eligibles who are 65 and older. MSHO enrolls people in all settings; about one third of enrollees reside in nursing homes. Health plans are responsible for all Medicare-covered services as well as most Medicaid-covered services (not covered by Medicare), including home and community-based waiver services for the elderly

and up to 180 days of care in a nursing facility. Nursing home days beyond 180 are covered by Medicaid under a fee-for-service system, but residents remain enrolled.

Today, MSHO is available in all but four Minnesota counties through contracts with nine managed care organizations that are also Medicare SNPs. As of August 2009, there were 36,929 individuals enrolled in the program. The state reports that enrollment in MSHO is generally the preferred choice for seniors because Medicare services, including pharmacy, are included.

Minnesota Disability Health Options Program (MDHO) was implemented in 2001 and is offered as an option in seven counties and the Twin Cities metro area to residents who are eligible for Medicaid only or who are eligible for both Medicare and Medicaid due to a physical disability. Minnesota Medicaid contracts with a health maintenance organization that offers a Medicare SNP to provide Medicaid services to this population.

To be eligible for MDHO, an individual must meet all of the following:

- Have a physical disability;
- Be at least 18 years of age and under the age of 65;
- Live in a participating county; and
- Be enrolled in Medicaid. Enrollees who are also enrolled in Medicare may receive both Medicaid and Medicare services through MDHO.

Enrollment in MDHO is voluntary. As of August 2009, there were approximately 1,300 enrollees.

Eligible health plans for MSHO and MDHO are licensed health maintenance organizations (HMOs) in Minnesota (HMOs in Minnesota must be nonprofit organizations) or county-based purchasing organizations; must be authorized to operate as Medicare SNPs; offer a product that qualifies for the low-income subsidy under Medicare Part D (the pharmacy benefit); and participate in Medicaid managed care, including (for MSHO) MSC+.

NEW MEXICO

New Mexico has had a statewide commitment to managed care for acute care services since the introduction of its Medicaid managed care program, called Salud! (“To your health!”) in 1997. In 2008, the state created a new program to include Medicaid long-term care services through an initiative called ***Coordination of Long-Term Services (CoLTS)*** program. The integration of Medicare and Medicaid services for dual eligibles is also part of the program design. CoLTS covers primary, acute, and long-term services in one coordinated and integrated program that incorporates Medicare and Medicaid funding and services into a single approach that is seamless to the beneficiary.²⁸ CoLTS, which is jointly managed by the New Mexico’s Human Services Department and the

²⁸ New Mexico Aging and Long-Term Services Department, “Coordination of Long-Term Services: New CoLTS Program in Progress.” Accessed at http://www.nmaging.state.nm.us/CoLTS_overview.html.

Aging and Long-Term Services Department, is designed to improve coordination across the currently fragmented mix of institutional, state plan, and home and community-based services in Medicaid.

Enrollment in CoLTS is mandatory for targeted Medicaid populations, including:

- Dual eligibles (individuals with both Medicare and Medicaid coverage);
- Individuals currently enrolled in New Mexico's Disabled and Elderly waiver program;
- Adults receiving personal care services from the Medicaid Personal Care Option program; and
- Residents of nursing facilities.

Enrollees in section 1915(c) waivers for populations with developmental disabilities, HIV/AIDS, and medically fragile conditions are excluded from enrollment in CoLTS.

The state Medicaid agency has contracts with two vendors, selected through a competitive procurement, to provide the Medicaid benefit package, including long-term care; vendors are required to be a Medicare SNP and/or offer Medicare products statewide. CoLTS is being phased in by geographic area over a one-year period. The first region, which includes Albuquerque and surrounding areas, began operating on August 1, 2008, and is now fully implemented. Total enrollment is projected to reach 38,000.

NEW YORK

Interest in managed long-term care and Medicare-Medicaid integration has deep roots in New York: The state has offered a Medicaid Managed Long-Term Care Plan (MLTCP) option for many years and had two of the nation's original Program for All-Inclusive Care for the Elderly (PACE) sites.²⁹ The New York State Department of Health has developed two Medicare-Medicaid integrated products for dual eligibles:

In ***Medicaid Advantage***, adults 18 years of age and older who are dually eligible may voluntarily enroll in one plan that is approved as both a Medicare SNP and a Medicaid managed care plan to receive their Medicare and Medicaid primary and acute care benefits. Enrollment in the Medicare SNP to receive Medicare benefits is a prerequisite for enrollment in the Medicaid Advantage plan. The Medicare SNP therefore integrates primary, preventive, and acute care across the two payer sources. New York created Medicaid Advantage in part to allow Medicaid enrollees who become eligible for Medicare to be able to continue their managed care enrollment. (The state had previously required individuals to disenroll from Medicaid managed care once Medicare eligibility was determined.)

Medicaid Advantage contracts with 11 SNPs in 27 counties and New York City. Enrollment began in 2005; as of August 2009, there were 5,413 members in the New York City metro area and a limited number of other counties.

²⁹ PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE programs provide social services and Medicare and Medicaid medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs.

Medicaid Advantage Plus (MAP) is specifically targeted to dual eligibles with long-term care needs who are certified for nursing home admission. The state contracts with a Medicare SNP to provide Medicaid benefits. To enroll in MAP, Medicaid beneficiaries must be 18 years of age or older and meet criteria for nursing home level of care. Enrollment in the SNP for Medicare services is a prerequisite of MAP enrollment for Medicaid. The SNP therefore provides the full range of Medicare and Medicaid covered primary, acute, and long-term care services, including home and community-based long-term care services and up to 100 days of nursing home care.

MAP is offered as an alternative to the MLTCP health plans, which provide Medicaid services only. The goals of MAP include improving access to community-based long-term care services, reducing Medicaid costs by requiring SNPs to offer specific enhanced Medicare benefits, and reducing the demand for higher-cost services through improved care management.

In addition to being authorized by CMS as a Medicare SNP, MAP plans must also qualify as an MLTCP under New York law, which involves obtaining a designation from either the speaker of the Assembly, the Senate majority leader, or the commissioner of health in order to participate. Plan participation has developed slowly since 2005; today, New York Medicaid has MAP contracts with four Medicare SNPs in five counties and New York City. As of August 2009, there were 421 members. In contrast, there are 26,799 enrollees in the Medicaid-only MLTCP. In the future, the state will require new MLTCP providers to also be qualified Medicare SNPs; the health plans will then be expected to offer both an MLTCP and a MAP option. The state hopes this will raise the visibility of the MAP option.

See appendix D for a summary of the provisions of each case study state's integrated products.

KEY FINDINGS FROM CASE STUDY STATES

State officials interviewed for this report described varied experiences with developing, implementing, and managing integrated Medicare-Medicaid health coverage products for dually eligible beneficiaries through Medicare SNPs. Key findings from these include: identifying potential advantages of contracting with SNPs, underscoring the critical role that effective stakeholder engagement plays in successful design and implementation of a SNP strategy, and describing the barriers that states have experienced regarding the use of SNPs for dually eligible groups.

1. Integrated plans have the potential to provide more cost-effective care for dually eligible beneficiaries, including improved access to community long-term care services.

Of the three case study states, **Minnesota** has the most experience with operating an integrated product and therefore has the most evidence of effectiveness. The MSHO was designed to:

- Provide a seamless point of access for both acute and long-term care benefits for the older consumer;

- Align fiscal incentives to support sound clinical practice;
- Move toward a single point of accountability for care for this population; and
- Reduce cost shifting between Medicare and Medicaid.

State Medicaid officials consider MSHO a successful model of integration, and the state Medicaid program remains very committed to promoting full integration of Medicare and Medicaid services for dual eligibles. In particular, the state credits MSHO for a significant increase in the number of people who are screened for and receive community-based long-term care services and supports and notes that Minnesota continues to experience reductions in the rate of institutionalization for long-term care.

In addition, Minnesota credits MSHO with encouraging more effective utilization of other services. For example, an evaluation of Minnesota's early initial demonstration project, which transitioned into the current SNP model, found that program enrollees living in nursing facilities had fewer preventable hospitalizations and reduced use of emergency services. However, the study also reported that the cost to Medicaid may have been higher in the early years of the integrated product than the cost of serving program participants in fee for service.³⁰ Minnesota Medicaid disagreed with this conclusion, arguing that the state did not experience an increase in per member costs, but rather an increase in access to additional waiver services, which was expected. The state also noted that cost reduction was never a goal of the demonstration.

A qualitative evaluation of care coordination in MSHO concluded that the program had been a catalyst for some care systems to provide higher-quality geriatric care than through traditional Medicare or Medicaid. The study found that care coordination was more intensive and ongoing for community-dwelling participants than in other managed care models in Minnesota.³¹ Minnesota also found higher levels of consumer (and family member) satisfaction from enrollment in the integrated product versus fee-for-service arrangements.

New York Medicaid officials report similar goals for its Medicare-Medicaid integrated SNP products, seeking a comprehensive approach to services that will:

- Provide a continuum of services throughout the consumer's full life span;
- Save money for Medicaid by maximizing the value of Medicare services offered to dual eligibles, by preventing or delaying nursing home use, and by preventing unnecessary hospitalizations;
- Achieve full integration of services between Medicare and Medicaid for beneficiaries; and
- Achieve high consumer satisfaction.

³⁰ R. L. Kane and P. Homyak, *Multistate Evaluation of Dual Eligibles Demonstration: Final Report* (Minneapolis: Division of Health Services Research and Policy, University of Minnesota School of Public Health, 2004).

³¹ J. Malone, et al., *Minnesota Senior Health Options Care Coordination Study* (St. Paul, MN, submitted to Minnesota Department of Human Services, [June 2004]).

New York reported high levels of consumer satisfaction with SNP products, but slower-than-anticipated enrollment for Medicaid Advantage and especially for Medicaid Advantage Plus (which includes Medicaid long-term care services) has stymied more detailed analyses of program impact. The state attributes the slow pace of MAP growth in part to the relatively low number of participating plans. Many of the interested entities in New York are long-term care provider organizations, rather than traditional managed care plans, which may result in a slower start-up due to the need for more development of care management and other capacity. In addition, the state has experienced some push back from plans regarding the state's expectation of an enriched Medicare benefit package (see discussion below). The state remains optimistic that increased enrollment will produce many of the hoped-for improvements in utilization and outcomes, and it is implementing new strategies to increase the number of MAP participating plans.

New Mexico officials report that CoLTS has been designed to produce improved access to community long-term care and more effective utilization of a wide range of services. Specific expectations for SNP plans include:

- Offer seamless access to a choice of culturally responsive, appropriate, and quality long-term services while coordinating all Medicare and Medicaid services;
- Promote improved health status and quality of life and reduced dependency on institutional care;
- Use best practices from other states seeking to improve coordination and reduce fragmentation, including community integration and use of multidisciplinary teams;
- Provide the framework for an aggressive program of quality management and data sharing;
- Enhance the infrastructure of long-term services, especially in rural areas, and increase access to less-restrictive home and community-based services; and
- Provide service coordinators in local communities improve individual access to Medicare and Medicaid services.

2. Integrated Medicare-Medicaid products can improve the total range of benefits available to dually eligible enrollees.

All three of the case study states offer enhanced Medicaid care coordination services through their SNP products that are not available under fee for service. **New York** also provides social day care, respite care, and environmental supports that are not otherwise available under Medicaid fee for service. In **New Mexico**, CoLTS plans cover a range of additional Medicaid services not found in fee-for-service Medicaid, including community-level service coordinators, discharge planning, services to assist individuals in relocating from institutional to community-based long-term care settings, disease management, home-delivered meals, and Medicaid consumer handbooks. Native American enrollees are also eligible for retinal scans.

In addition to enhanced Medicaid benefits, **New York** has established a uniform Medicare SNP benefit package that participating plans must file with CMS in order to qualify for a Medicaid contract.³² The package includes enhanced Medicare services, for example, coverage for Medicare hospital deductibles and physician office visit copayments. The state's goal was to ensure that the total benefit package is as comprehensive as possible, maximizing the value of the Medicare benefit within the federal SNP funding parameters applicable to New York and thereby providing state savings on Medicaid wrap-around services. The state has also viewed an enhanced Medicare benefit as an important incentive for enrollment.

Participating SNPs in New York have protested that they find it difficult to offer all the required benefits within the available Medicare rate structure. Some SNPs would prefer to offer alternative enhanced Medicare benefits that plans believe might be more effective marketing tools for the Medicare SNP plans, for example, reimbursement for nonprescription health-related items. However, these benefits might not offset state Medicaid costs. In light of plan concerns, state officials report they may reexamine the Medicare benefit requirements.

3. States have the capacity and experience to manage SNPs to achieve specific objectives for their dually eligible populations.

All three case study states reported placing a priority on ensuring that integrated SNPs offered necessary consumer protections, maintained high levels of consumer satisfaction, and achieved more-effective service utilization and improved outcomes.

States officials reported a variety of similar tools used to ensure consumer protection. Each state has a long history of contracting with managed care organizations to serve Medicaid consumers, and states indicated that their approach to consumer protections builds on the standards and processes already in place. All states reported that they monitor consumer complaints/grievances/appeals and voluntary disenrollments from plans. All states require encounter-level data reporting. Some states reported that state staff will call health plan consumer lines to monitor responsiveness of telephone systems. All states ensure that Medicaid fair hearing rights are offered and observed. In addition, states conduct consumer satisfaction surveys (annually or periodically).

Minnesota has a pay-for-performance incentive that links up to 8 percent of the capitation rate to specific performance measures. The state tracks activities of daily living (ADLs) assessment data for all nonwaiver community enrollees as well as the federal Minimum Data Set data collected for nursing facility residents and waiver enrollees to monitor levels of service need. The state measures utilization of services in various settings, including the use of personal care, and monitors the rate of avoidable hospitalizations. Further, the state engages all the contracting plans and the state's External Quality Review Organization in developing common Performance Improvement Plans.

While Minnesota Medicaid has access to all Medicare, Medicaid, and Part D data from the contracting SNPs, officials expressed concern that the lack of full integration of

³² New Mexico reported that SNPs may offer enhanced Medicare coverage, but the state does not attempt to standardize the offerings. Minnesota reported that, because Medicare SNP payments, which are geographically adjusted, are less generous in Minnesota than in other parts of the country, it is less common for SNPs to offer significant enhanced services under Medicare.

health plan encounter data into the state's Medicaid management information system prevents the state from using the information to identify areas where improvement of service coordination or outcomes is needed. Further, state officials reported significant frustration over inadequate research capacity at the state level to evaluate and use the available data more fully.

New Mexico intends to collect data from SNPs on more than 50 performance standards, including Health Plan Employer Data and Information Set (HEDIS) acute care measures, preventive care measures (e.g., rate of procedures, including flu shots and fecal occult blood tests), safety measures (e.g., rate of falls, mobility, health assessments, and critical incidents), information on self-direction, timeliness of claims payment, information on care management and disease management, and information on claim denials and financial and administrative measures. The state has strong oversight of encounter data reporting, requiring 99 percent of encounter claims to be reported within 90 days and using external auditors to review data samples for reliability and validity. Like Minnesota, New Mexico collects Medicare utilization data from the SNPs for enrolled individuals. State officials view the requirement for CoLTS contractors to offer consumer-directed care options, where consumers have more control over hiring caregivers and deciding what personal care services they need, as one important tool for improving consumer satisfaction with, and control over, services.

New York reviews a variety of reports from SNPs through both desk reviews and on-site visits, including monthly enrollment data, quarterly financial data, quarterly reports on grievances and appeals, semiannual disenrollment reports, and annual cost reports. State staff also review care management records. New York also requires SNPs to report Medicare encounter data for enrolled dual eligibles. No formal evaluation has been performed as yet, since the program is still new and enrollments are relatively low.

4. Engaging stakeholders in the design of an integrated product can help overcome resistance to managed long-term care and ensure better consumer protections.

Officials in all three of the case study states commented on the challenges inherent in developing managed long-term care arrangements for Medicaid-covered populations. **Minnesota** and **New Mexico** officials described significant caution or outright opposition on the part of providers, advocates, and even public agencies when the state initially introduced the idea of managed long-term care. Concerns raised included the adequacy of networks; the fear of a loss of choice; and, for providers and some public entities, loss of revenue or traditional roles and responsibilities. New Mexico underscored the importance of strong support from the governor and cabinet-level leadership. Both states noted that support for managed care increased as advocates came to view these arrangements as a strategy for improving access to community long-term care options. Support also increased as specific concerns (e.g., a continuing role for local agencies or assurance of financing for certain providers) were explicitly addressed in program design.

New Mexico officials reported that stakeholder involvement was critically important in developing CoLTS. Advocates, providers, Native Americans, other government partners, and consultants helped to design the program, providing valuable input regarding enrollment, transitions, communication, quality, outreach, provider relations, and many other issues.

Stakeholder Engagement

Minnesota worked closely with the Aging system in the initial design and development of MSHO. Medicaid officials reported that the Aging system was largely supportive, since they saw the reform as a way to increase access to community-based long-term care services. Large advisory committees involved senior federal staff, legislative aides, aging advocates, consumers, and all affected provider groups. State officials reported that stakeholder involvement around the development of MDHO has been intense and significant.

The strongest stakeholder concerns raised early in the development of MSHO centered on the impact on existing county-level support activities for the target population. These concerns were somewhat resolved by health plans agreeing to use county staff as care coordinators for the plans. A more recent concern among consumers had to do with health plan efforts to restrict use of personal care services. Health plans were attempting to respond to state concerns over discrepancies in assessments and possible fraudulent practices by provider agencies; the state saw a spike in consumer appeals.

New Mexico undertook an extensive effort to involve the full range of stakeholders during the development of the CoLTS waiver. Stakeholder meetings were held monthly from December 2005 through May 2008; a subcommittee of the Medical Care Advisory Committee now meets quarterly to consider program issues, and ad hoc groups are formed to consider specific issues. Because New Mexico is home to 22 Native American nations, there has been significant engagement with Native American tribal leaders.

A quality workgroup including consumers, advocates, and staff from the Center for Health Care Strategies also influenced the design of the final waiver. Medicaid officials reported that most stakeholders in New Mexico understood the need for reform; the state has the fourth largest senior population in the United States and had experienced “skyrocketing” costs for Medicaid personal care services. Advocates and others wanted a system that was sustainable and effective over time.

Key stakeholder concerns included what services would be available, whether sufficient network capacity would exist, how the process of change would be managed, and whether this new delivery mechanism could be used to address existing problems in the larger health care delivery system. Providers were concerned over how plans would contract and how much providers would be paid. Stakeholder concerns influenced the waiver design, including provisions for ongoing oversight and consumer and provider education.

The experience in some case study states suggests stronger acceptance of managed care strategies for older populations than for younger populations with disabling conditions. **Minnesota** added an integrated option for people with disabilities four years after establishing the option for people 65 and older, but enrollment remains at a lower percentage of the eligible population than for seniors. **New Mexico’s** new integrated program includes all seniors in need of long-term care, building on a prior commitment to managed acute care for this population, but does not include those with developmental disabilities, HIV/AIDS, or medically fragile conditions. State officials reported that opposition to a managed care strategy was still too strong among stakeholders in these areas.

As described in the box on page 19, the decision in 2008 to end Washington State's Medicare-Medicaid Integration Project (MMIP) underscores the importance of a fully engaged stakeholder process in the design and implementation of a SNP product. Medicaid officials in that state point to lack of sufficient engagement and buy-in by stakeholders as a significant reason that the state's integrated product for dual eligibles was not a success.

5. The process for a state to obtain federal authorization for an integrated Medicare-Medicaid managed care product is lengthy and unpredictable and changes over time.

States described lengthy, sometimes multiyear, processes for obtaining federal authorization of integrated delivery models. Each of the case study states operates its integrated managed care program under a distinct set of federal authorizations.

Minnesota was awarded Medicare and Medicaid waivers in 1995 for a five-year demonstration designed to test delivery systems that integrate long-term care and acute care services for elderly dual eligibles. The demonstration began as a section 1115³³ demonstration for Medicaid, but CMS eventually decided that the Medicaid program could instead be offered under section 1915(a),³⁴ combined with a section 1915(c) waiver.³⁵ Integration of the Medicare services was approved under a different demonstration waiver, section 402 of the Social Security Amendments of 1967.³⁶

Under the 1995 demonstration, the state was allowed to manage the contracts for both Medicare and Medicaid in conjunction with CMS. The state created MSHO in 1997 and received federal approval to create MDHO in 2001.

The state reports that CMS became increasingly uncomfortable with the decision to contract with the state for Medicare services, questioning whether approving this arrangement was really within the secretary's authority. With the enactment of the new Medicare SNP options under the MMA, CMS began to transition the Minnesota programs from a Medicare waiver to use of the new Medicare SNP option.

³³ Section 1115 of the Social Security Act provides the secretary of health and human services broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. (U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Research and Demonstration Projects – Section 1115," accessed at [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03 Research&DemonstrationProjects-Section1115.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03%20Research&DemonstrationProjects-Section1115.asp).)

³⁴ Section 1915(a) of the Social Security Act provides states with the option of offering managed care arrangements with voluntary enrollment.

³⁵ Section 1915(c) of the Social Security Act gives the secretary of health and human services the authority to waive Medicaid provisions to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

³⁶ Section 402 of the Social Security Amendments of 1967 authorizes the secretary to conduct demonstrations to test whether methods of payment or reimbursement will increase the efficiency and economy of Medicare programs without adversely affecting the quality of those programs' services, and authorizes the secretary to waive requirements in title XVIII that relate to reimbursement and payment in order to carry out these demonstrations.

Washington: Medicare-Medicaid Integration Project (MMIP)

In June 2005, the state of Washington, through its Department of Social and Health Services (DSHS), launched a two-county voluntary pilot project called the Medicare-Medicaid Integration Program (MMIP) to test the ability of an integrated Medicare and Medicaid health plan to rein in costs and deliver high-quality, well-coordinated services (including long-term care) to dually eligible individuals. DSHS contracted with a Medicare SNP to manage the MMIP in King and Pierce Counties.

Participation in the MMIP was voluntary, but those who chose to enroll were required to be age 65 or older and had to voluntarily elect to receive all of their Medicare and Medicaid services through the health plan. This meant that beneficiaries were required to enroll in both the plan's Medicare SNP and the MMIP. By December 2007, the program had enrolled 225 (out of 500 targeted) duals.

Although plan sponsors and state officials reported high levels of enrollee satisfaction with MMIP, challenges related to low program enrollment and erosion of public support led the state and the SNP to mutually agree to end the program in early 2008.

Barriers to the Success of MMIP

State officials attribute the lack of MMIP success to several factors:

- **Failure to invest adequate time and resources in the planning process:** Developing a complex integrated system, especially one that includes acute and long-term care services, required more planning, coordination, and communication within the state agency than the state anticipated. As a result, the program was not sufficiently tailored to meet the specific needs of the state, and there were start-up problems with marketing and enrollment that might have been avoided or better managed.
- **Inadequate stakeholder engagement and buy-in:** In hindsight, state staff realized that it was important to engage community-based service providers, including the area agencies on aging and other community stakeholders and consumers, more directly in the design and implementation of the MMIP. The project would have benefited from having a champion from within the long-term care leadership in the state. In addition, more time should have been taken to identify and address pervasive negative attitudes toward managed care (among some state staff, advocates, and providers) early in the planning process to address legitimate concerns as well as misperceptions. Traditional community providers of case management and social support services were fearful that their service networks would be undermined by the SNP. The lack of trust often led to traditional providers refusing to participate in the SNP network, which in turn made it difficult to gain voluntary consumer enrollment.
- **Lack of a clear marketing message for consumers:** During the same time the state was implementing MMIP, the SNP was also marketing a separate stand-alone SNP product to duals apart from the MMIP fully integrated product. This created a lot of confusion within the community, angered consumer advocates, and eroded public support for the project. The roll-out of MMIP coincided with the initiation of the Medicare Part D prescription drug benefit, which may have made it difficult to deliver clear messages about the benefits of MMIP to a population already being inundated with information related to changes in traditional Medicare and Medicaid coverage.
- **Conflicting program rules:** It was difficult for the SNP to keep track of, align, and correctly implement the separate rules for both programs, and it was equally difficult for the state agency to monitor the contract for compliance with both sets of rules. State officials described the process as “cumbersome” and “complex.”

CMS allowed Minnesota Medicaid to expand the waiver program statewide before transitioning to SNPs, which allowed the state to take advantage of the passive enrollment provisions of the new SNP law. On January 1, 2006, the nine MSHO plans became SNPs offering Medicare A, B, and D services; CMS immediately passively enrolled 23,000 dually eligible seniors, already enrolled in these health plans under MSHO, into the new SNPs for Medicare.

New Mexico received federal approval of a combined section 1915(b)³⁷ and (c) waiver at the end of July 2008 to implement CoLTS. However, the state began work on the initiative four years earlier, when it issued a request for proposals and selected two health plans to work with the state on program design.

The state submitted a first concept paper to CMS in 2004, outlining a section 1115 waiver approach, but early efforts at working with CMS were disappointing. State officials cite a lack of attention and little coordination among federal staff assigned to review New Mexico's plans. As the state continued to refine its ideas, it asked the Center for Health Care Strategies (CHCS)³⁸ for assistance. CHCS facilitated a productive, in-person meeting for state and federal officials in Baltimore in December 2006 to present the second version of the waiver design. CMS assistance improved, and the agency named a point person at both the central and regional offices to work with the state. Based upon CMS advice, New Mexico formally submitted a request for a combined section 1915(b) and (c) waiver in July 2007. The waiver was approved in July 2008.

New York's Medicare-Medicaid integrated program evolved from two separate state managed care initiatives, one for acute care and one for long-term care. Medicaid Advantage was created in 2005 as an extension of the state's Medicaid acute care managed care program. Medicaid's acute care program is operated under a section 1115 demonstration waiver, first approved in 1997 to enroll most Medicaid beneficiaries into managed care organizations, and later amended to authorize the Medicaid Advantage option.

The Medicaid Advantage Plus (MAP) SNP option developed on a parallel track as an extension of the state's preexisting managed long-term care program and is offered under New York's section 1915(a) managed care option. As noted earlier, New York has long offered an integrated PACE program. In 1997, the New York Assembly consolidated state authority for all Medicaid managed long-term care demonstrations and plans under the Long-Term Care Integration and Finance Act. This was intended as a building block for integration of long-term care and other health care services for aged and disabled populations. Since the late 1990s, New York has offered a partially capitated option covering Medicaid long-term care services. (Under the partial capitation program, Medicaid acute care services remain in fee for service.)

³⁷ Section 1915(b) of the Social Security Act provides the secretary of health and human services the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

³⁸ CHCS is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS created the Integrated Care Program and awarded grants to Florida, Minnesota, New Mexico, New York, and Washington to assist in the development of integrated models for financing, delivery, and administration of primary, acute, and long-term care and chronic and behavioral health services for adults who are dually eligible for Medicaid and Medicare, as well as those who receive services solely through Medicaid. States received funding and technical assistance from CHCS.

Like Minnesota, New York obtained a federal Medicare waiver under section 402; however, the state was not able to implement the waiver as planned and, in 2005, the waiver authority was withdrawn by CMS. New York then adopted the basic Medicaid Advantage model, added Medicaid long-term care services and supports, and offered MAP under section 1915(a).

6. It is challenging to fully integrate administrative activities regarding Medicare-Medicaid SNPs because of differences in state and federal program regulations.

The case study states reported that the inability or unwillingness of CMS to adjust the Medicare administrative requirements to accommodate better integration with Medicaid created barriers to timely adoption of the SNP model. States had to modify state procedures or, where this was not possible, health plans; enrollees have to consider and navigate dual processes. States noted that it is especially difficult to coordinate grievance and appeals processes between the two programs.

Minnesota, with many years of experience, reported the greatest level of integration across programs. The state has worked closely with the CMS regional office and with health plans to develop communication and enrollment models that all plans can use. The state has also worked with SNPs to integrate benefit determination processes, for example, to better coordinate decision making regarding which days of institutional care are paid by Medicare versus Medicaid, or which payer will cover specific durable medical equipment requests. Consumers receive one combined benefit notice that meets the timelines for both programs regarding notifications and appeals. This helps prevent situations in which, for example, a service is denied under Medicare (and the consumer receives a notice of denial) and subsequently approved under Medicaid (with a second notice sent to the consumer).

However, Minnesota officials believe they had a more fully integrated administrative process under its initial demonstration program. For example, Minnesota was allowed to handle enrollment for Medicare directly, and the state is confident this approach improved consumer understanding and convenience and helped increase rates of enrollment into the integrated product. With the introduction of the SNP option, the responsibility for Medicare enrollment moved to the health plans. However, because the state enrollment staff is expert in the interface between Medicare and Medicaid eligibility, all but one of the SNP plans chooses to contract with the state unit to handle their Medicare enrollment submissions.

In addition, state officials believe they had a more fully integrated grievance and appeals process while operating under the demonstration authority than under the current SNP arrangements. Consumers could more easily file a complaint—whether through the state fair hearings process, the state ombudsman, the Department of Health, or the health plan—and the state’s process triaged complaints into the right process for Medicare or Medicaid. Consumers were notified of their right to appeal, and the process appeared relatively simple. Under the SNP model, health plans and the state must now provide consumers with a full description of the Medicare grievance and appeals process and of the Medicaid grievance and appeals process, and consumers are told they may choose one or the other (or both), assuming the denied or disputed service is covered in both programs. While the state has developed an algorithm to assist state and health plan staff in determining if the denied or disputed service is actually the responsibility of Medicare

or Medicaid (many services are covered in both programs but with different limits or coverage criteria), the state reports that the current, less-integrated process is much more confusing for enrollees.

In **New Mexico**, state eligibility staff process enrollment into the SNP for Medicaid services. Consumers who fail to make a selection of a plan are auto-assigned, then given 90 days to change plans. Enrollment help is being offered throughout the state at senior centers, Native American chapter houses, provider sites, and even—with the help of area aging offices—through some in-home visits. Information on Medicare SNP options is included in the Medicaid welcome packet, but enrollment into a SNP for Medicare services is handled separately by the SNP.

The state notes that successful enrollment into the two programs within a SNP requires significant coordination and data sharing between Medicare and Medicaid. Even with coordination, New Mexico is concerned that the separation in enrollment processes between Medicaid and Medicare, especially since enrollment in the Medicare SNP product is voluntary, will result in a very small percentage of dual eligibles actually receiving coordinated care across Medicare and Medicaid.

New York officials reported that managing consumer appeals across the two programs has been one of the biggest challenges of implementing the integrated product. For Medicaid-only services (e.g., personal care) or Medicare-only services (e.g., in New York, chiropractic services), enrollees must use either the Medicaid or the Medicare grievance and appeals process, as appropriate. For services provided in both programs (e.g., hospital, physician, home health, and other services where Medicaid wraps around Medicare), consumers can choose either the Medicaid or Medicare process. Time frames as well as definitions vary between the two programs' processes. Early in the development of Medicaid Advantage, New York attempted to create a standard where the appeals process of the "primary payer" would govern, but CMS would not approve the approach, concerned that it might restrict a consumer's options. State officials report that, despite considerable effort to provide clarity in member handbooks, consumers frequently do not understand their choices.

Officials in New York and Minnesota both noted that it was easier for a state to offer an integrated product under the auspices of the old federal Medicare demonstration authority, because it allowed specific waiver of Medicare as well as Medicaid provisions. Officials in New York suggested that, under the current regulations, states cannot offer a truly integrated product; rather, they do their best to align the operation of two separate health programs. They noted that the PACE program offers an alternative approach, where Medicare and Medicaid are fully integrated into a single program, with one set of governing rules.

7. Start-up for a state requires significant time and effort, including actuarial resources, while Medicaid savings may take time to accrue.

States reported that considerable staff and contractor time and effort were required to implement integrated SNP products. Administrative resources were required to negotiate federal approval, develop and administer health plan procurements and contracts, modify or create new state regulations to support the new product offering, and conduct education and outreach to dual eligibles. Rate setting has been a particularly intensive

process because states are concerned that they appropriately reflect the wide range of risk that can be represented by dual eligible enrollees, but also because some states want the rate structure to encourage specific changes in how services are delivered to improve outcomes and reduce the growth in spending.

Minnesota has built incentives for the use of home and community-based services in its capitation rates for MSHO, with rates reflecting an assumed 15 percent reduction in the use of nursing home days and an increase in the use of waiver and personal care attendant services. Rates for MSHO include adjustments that reflect age and geographic location, as well as a factor to reflect variation in ADLs and housing arrangements.

New Mexico reported that it took six months of weekly meetings of a team that included state staff, contract actuaries, and other state consultants to develop the rates for CoLTS. The Medicaid capitated rates are established to reflect level of care based on care settings as well as the availability of enhanced Medicare benefits. In addition, the state is assuming SNPs will achieve joint enrollment (people enrolled in the SNP for both Medicare and Medicaid services) for at least 8 percent of enrollees, with joint enrollment expected to produce greater Medicaid savings. Overall, Medicaid rates reflect assumed savings of 2 to 5 percent, depending on the cohort of enrollees; a goal for the new program is to slow the rate of growth in Medicaid spending over time.

New York negotiates rates directly with each participating SNP. Beginning in 2009, New York expects to set rates based upon a blend of 75 percent historical experience and 25 percent on clinical rate groups, a methodology that assigns enrollees to mutually exclusive risk categories that relate to predicted health care utilization and cost.

While the case study states remain optimistic that the SNP arrangements will produce savings or at least be budget neutral for the state, a recent report released by the Association of Community Affiliated Health Plans (ACAP) demonstrates a potential short-term financial disincentive to states pursuing SNP contracting. The report suggests that Medicare savings can accrue relatively quickly from care management strategies for the dually eligible population, for example, from avoiding preventable hospitalizations with improved primary care. However, Medicaid savings rely on reducing the demand for long-term care services (through better primary and preventive care) and on offering individuals more cost-effective options as the need for long-term care arises. The evaluation predicted that Medicaid savings do occur, but are likely to accrue over a longer period of time.³⁹ Delayed savings, when coupled with the administrative costs associated with developing and implementing an integrated managed care product, might discourage more states from responding to SNP contracting opportunities.

8. Voluntary enrollment for Medicare can be a significant barrier to achieving full integration.

The case study states all reported that a major purpose of contracting with a SNP is to have dual eligibles experience fully integrated health care for both Medicare and Medicaid. However, the inability to require enrollment in the SNP for Medicare means

³⁹ The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities* (Falls Church, VA: The Lewin Group, November 2008).

that a SNP strategy can fall far short of full integration, even when enrollment in a SNP is mandatory for Medicaid services. As described by **New Mexico**, enrollment in a SNP for both Medicare and Medicaid may not reach even 10 percent of the enrolled population. **New York** requires that enrollees in MA and MAP also enroll in the SNP for Medicare, which means all enrollees should experience full integration of services. However, enrollment has been slow, as enrollment in managed care remains voluntary. Many more Medicaid enrollees choose the state-services-only option, where Medicare services remain in fee for service, over the Medicare-Medicaid integrated MAP. New York has begun requiring that any new MLTCP providers must also offer Medicare (and therefore MAP) in a further effort to encourage consumers to choose full integration. In addition to undermining efforts to achieve the benefits of full integration, voluntary enrollment for Medicare SNP benefits may also make it hard for SNPs to achieve sufficient enrollment to effectively cover start-up costs or achieve state savings targets.

Minnesota appears to have overcome this challenge. This may be attributed to several factors. First, as in New Mexico, Medicaid enrollment in managed care is mandatory. While consumers can choose between a Medicaid-only managed care option and an integrated Medicaid-Medicare option, Minnesota has been promoting its integrated model for more than a decade. Enrollment in the state's integrated product was facilitated when the state was allowed to serve as the point of enrollment for Medicare as well as Medicaid under the early demonstration model. Full integration also benefited from passive enrollment of Medicaid enrollees into Medicare coverage in January 2006, with the implementation of Part D. Finally, the state has worked hard to integrate the marketing and enrollment process and materials between the two programs. As a result, more than three-quarters of eligible seniors now choose MSHO over the Medicaid-only managed care product, with most enrollees enrolled for both Medicare and Medicaid.

9. Federal policy raises questions about the future of SNPs, which may discourage states from pursuing new contracts or undermine existing arrangements.

Officials in the case study states raised three issues that may cause states to feel caution about the future of integration strategies that rely on Medicare SNPs. First, officials in one state raised concerns that evolving rate policy for Medicare SNPs may reduce the availability of viable health plans—either reducing Medicare payments below viability for plans or causing health plans to make bids for Medicare that exceed the “zero premium” options that are needed for dual eligibles. Case study states also noted that there is great uncertainty inherent in pursuing a SNP strategy because SNPs are authorized only through the end of 2010. Overall, states called for more attention to the need to allow states to work with SNPs to fully integrate the operation of the two health programs. At least one state official suggested that this goal might actually be further frustrated by the new administrative and operational requirements being issued by CMS in response to some of the Medicare SNP reform provisions enacted in MIPPA. Even more detailed or inflexible Medicare requirements on SNPs may make it more difficult for states to integrate Medicaid and Medicare for dual eligibles.⁴⁰

⁴⁰ CMS, in “Overview: Special Needs Plans,” reports that final SNP guidance is in revision; however, CMS has contracted with the National Committee for Quality Improvement to develop a strategy to evaluate the quality of care provided by SNPs, including required HEDIS measures and evaluation of structural characteristics and processes (e.g., complex case management, clinical

CONCLUSIONS AND RECOMMENDATIONS

All case study states expressed a strong commitment to pursuing integration of health care services for dually eligible beneficiaries, and all reported that they have seen, or expect to see, improvements in access for beneficiaries, beneficial care management services for populations with significant health needs, and more cost-effective use of long-term care services. States also identified significant barriers to offering an integrated product through contracting with a Medicare SNP. These include administrative start-up costs, when significant state savings may take years to fully realize, and the challenge of gaining community and provider acceptance for the underlying premise of managed long-term care services for the Medicaid population. Additional barriers include lengthy negotiations with CMS to obtain federal authority, a lack of clarity regarding how states can obtain necessary authority to implement integrated strategies, and competing regulations governing managed care in the two programs that serve to frustrate effective integration. Finally, states described the difficulties of identifying effective strategies for encouraging beneficiaries to make what is still two separate enrollment decisions through two separate enrollment processes to obtain the full benefits of integration of services and care management.

Officials in the case study states were asked what advice they would offer to other states considering the development of an integrated Medicare-Medicaid product. They were also asked for recommendations on federal policy reforms that would better support the success of SNP product offerings.

State officials made three recommendations for states seeking to develop integrated products:

- 1. Involve stakeholders early and allow stakeholder input to guide program design.** Stakeholder engagement can lead to identification of mutual program goals and assurances of consumer and provider protections; engagement is critical to building trust in the community and securing the buy-in of essential community partners. This strategy appears to be especially important to the introduction of managed long-term care.
- 2. Engage CMS early in the process with a detailed concept paper and face-to-face discussions prior to making specific design commitments.** Because federal authority is not standardized, appears to evolve over time, and may require seeking waivers from CMS, states should seek CMS guidance early in the process. By seeking such guidance, states save themselves the time and frustration of developing detailed proposals that CMS may not approve.
- 3. Thoroughly understand the details of Medicare benefits, Medicare Advantage/SNP requirements, the health services needs of the dually eligible population, and the capacity of health plans to meet these needs.** Medicare and Medicaid have many similar but distinct program requirements that must be understood and accommodated to facilitate better integration for beneficiaries. The

dually eligible population typically has numerous medical problems and often may need more sophisticated supports for effective care management, especially when long-term care services and supports are included in the benefit package. Not all health plans have the experience or capacity to provide this level of care coordination.

State officials also recommended specific federal policy reforms to better support integrated products:

- 1. CMS should form a dedicated unit to support Medicare-Medicaid integration models.** This would increase reliability and predictability of federal guidance and facilitate the transfer of best practices across states.
- 2. CMS should formalize policy guidance and clarify state options for offering integrated products to streamline the approval process.** Without formalization, federal auditors will not understand integrated features; states will face ever-changing advice from federal regulators; and states will be discouraged from pursuing burdensome, multiyear approval processes.
- 3. CMS should allow more flexibility in Medicare regulations to support effective integration with Medicaid.** Increased flexibility regarding Medicare administrative requirements would make it easier to fully integrate managed care for enrollees, provide more effective consumer protections, and reduce the start-up costs for states. Officials in two states recommended that a PACE-like approach, where a single, fully integrated program is created (rather than trying to coordinate across two separate programs) would be ideal. In particular, CMS should work with states to create a streamlined, fully integrated process to manage consumer notifications and respond to consumer grievances and appeals. In addition, CMS should work with states to create strategies that encourage enrollment for both Medicare and Medicaid to increase the number of dual eligibles who are fully enrolled in integrated plans. One idea is an “opt-out” approach where enrollment is presumed unless dual eligibles explicitly choose Medicare fee for service. Another is to allow states to create a single point of enrollment for both health plans.
- 4. Federal policy should better support early savings for states offering integrated products.** States must make a significant administrative investment in creating and implementing an integrated product, but may realize only modest savings or break-even results for Medicaid over the near term. Federal policy could encourage more states to develop integrated initiatives by identifying options that give states a share of any early Medicare savings, allowing states to count Medicare savings toward waiver budget-neutrality tests, or providing funding to offset up-front state administrative costs.

APPENDIX A: STATE OFFICIALS INTERVIEWED FOR THE CASE STUDIES

Alabama	Keith Thompson, Director Third Party Division Alabama Medicaid Agency
Minnesota	Pam Parker, Manager Special Needs Purchasing Minnesota Department of Human Services
New Mexico	Carolyn Ingram, Director Medical Assistance Division New Mexico Department of Human Services Larry Heyeck, Deputy Director Medical Assistance Division New Mexico Department of Human Services
New York	Linda Gowdy, Director Bureau of Continuing Care Initiatives New York Department of Health Jay Laudato, Director, Division of Managed Care Office of Health Insurance Programs New York State Department of Health
Washington	Becky McAninch-Dake, Care Coordination Program Manager Care Coordination Section Department of Social and Health Services Shirley Munkberg Health and Recovery Services Administration Department of Social and Health Services

APPENDIX B: AARP SNP STUDY ADVISORY COMMITTEE MEMBERS

The AARP Public Policy Institute and HMA are grateful for the expert input and guidance generously offered by the SNP Study Advisory Committee Members:

Melanie Bella, Senior Vice President for Policy and Operations, Center for Health Care Strategies

William Clark, Centers for Medicare and Medicaid Services

Wendy Fox-Grage, AARP Public Policy Institute

Mary Kennedy, Director of Medicare, Association of Community Affiliated Plans

JoAnn Lamphere, DrPH, Director, AARP State Government Relations, Health and Long-Term Care

Chuck Milligan, Executive Director, the Hilltop Institute at UMBC

Doug Stone, Member, AARP Policy Council

The Advisory Committee provided technical guidance during the development of the study design and very useful comments after the study was completed. Committee members were not asked to endorse the findings and recommendations contained in the report.

APPENDIX C: STATES THAT OFFER MEDICAID MANAGED LONG-TERM CARE,ⁱ JANUARY 2009

State	Implemented?	Mandatory enrollment?	Statewide?	Includes home and community-based waiver services?	Includes Nursing Facility services?	Includes acute care services?	Medicare integration?
Arizona Long-Term Care (LTC) System ⁱⁱ	x	x	x	x	x	x	
Florida Nursing Home Diversion ⁱⁱⁱ	x		x	x	x	x	
Hawaii Quest Expanded Access ^{iv}	x	x	x	x	x	x	
Massachusetts Senior Care Options ^v	x		x	x	x		x
Minnesota Senior Health Options ^{vi}	x	x ^{vii}	x	x	180 days	x	x
New Mexico Coordinated Long-Term Care Program ^{viii}	x	x	x ^{ix}	x	x	x	x
New York Medicaid Advantage Plus ^x	x			x	100 days	x	x
Pennsylvania Integrated Care Initiative ^{xi}			x ^{xii}	x	x	x	x
Tennessee CHOICES in Long-Term Care ^{xiii}			x ^{xiv}	x	x		
Texas STAR+PLUS ^{xv}	x	x ^{xvi}		x	NF carved out	Hospital carved out	

State	Implemented?	Mandatory enrollment?	Statewide?	Includes home and community-based waiver services?	Includes Nursing Facility services?	Includes acute care services?	Medicare integration?
Washington Medicaid Integration Project ^{xvii}	X			X	X		
Wisconsin Partnership ^{xviii}	X			X	X	X	X
Virginia Acute and LTC Integration ^{xix}	On hold ^{xix}	X		X	60 days		X
Vermont MyCare ^{xxi}	Not implemented ^{xxii}			X	X	X	X

State	Implemented?	Mandatory enrollment?	Statewide?	Includes home and community-based waiver services?	Includes Nursing Facility services?	Includes acute care services?	Medicare integration?
<p>ⁱ Some of the states (Minnesota, New York, Wisconsin) in the table offer more than one model of managed care that includes long-term care, other than PACE; the characteristics shown in the table represent one model.</p> <p>ⁱⁱ Arizona Revised Statutes – Title 36 Public Health and Safety – Section 36-2932, Arizona long-term care system; powers and duties of the director; expenditure limitation.</p> <p>ⁱⁱⁱ http://elderaffairs.state.fl.us/english/longtermcarediversion.php.</p> <p>^{iv} http://www.med-quest.us/QExA/QUESTQExAGeneralInfo.html.</p> <p>^v http://www.massresources.org/pages.cfm?contentID=51&pageID=13&subpages=yes&dynamicID=830.</p> <p>^{vi} http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271.</p> <p>^{vii} Minnesota requires enrollment in managed care for seniors, but offers a SNP as an alternative option.</p> <p>^{viii} http://www.nmaging.state.nm.us/COLTS_overview.html.</p> <p>^{ix} To be phased in.</p> <p>^x http://www.nyhealth.gov/health_care/managed_care/mltc/index.htm; http://www.health.state.ny.us/health_care/managed_care/partner/operatio/docs/chapter_29.pdf.</p> <p>^{xi} http://www.dpw.state.pa.us/About/OLTL/SNP/003678231.htm.</p> <p>^{xii} To be phased in.</p> <p>^{xiii} http://www.tn.gov/tenncare/long-transformation.html.</p> <p>^{xiv} To be phased in.</p> <p>^{xv} http://www.hhsc.state.tx.us/starplus/starplus.htm.</p> <p>^{xvi} Mandatory for age 21 and older.</p> <p>^{xvii} http://hrsa.dshs.wa.gov/mip/.</p> <p>^{xviii} http://dhs.wisconsin.gov/wipartnership/.</p> <p>^{xix} http://www.dmas.virginia.gov/altc-home.htm; http://www.dmas.virginia.gov/downloads/pdfs/altc-valtc_updt.pdf; issued RFI 7/07/09; http://www.dmas.virginia.gov/downloads/pdfs/ab-care_coord.pdf.</p> <p>^{xx} http://www.dmas.virginia.gov/downloads/pdfs/altc-valtc_updt.pdf; issued RFI 7/07/09 http://www.dmas.virginia.gov/downloads/pdfs/ab-care_coord.pdf.</p> <p>^{xxi} http://www.ddas.vermont.gov/ddas-archives/special-projects-initiatives-archives/mycare-vermont-archive/hltcip-default.</p> <p>^{xxii} See report at http://www.ddas.vermont.gov/ddas-archives/special-projects-initiatives-archives/mycare-vermont-archive/hltcip-default.</p>							

x=yes; in other words, the state program includes this feature.

APPENDIX D: CHARACTERISTICS OF SNP OPTIONS IN THREE STATES, 2009

Feature	MN	MN	NM	NY	NY
	Senior Health Options (MSHO)	Disability Health Options (MDHO)	Coordinated Long-Term Services Program (CoLTS)	Medicaid Advantage Plus (MAP)	Medicaid Advantage
Name					
Mandatory enrollment			x		
Population covered	Duals 65+	18–64 with PD	ABD adults (except DD, HIV/AIDS)	18+	18+
Must meet LOC			NF	NF	
Must be dually eligible	x	x		x	x
Includes HCBS waiver services	x	x	x	x	
Includes NF services	180 days	x	x	100 days	
State plan acute	x	x	x	x	x
Includes self-directed services		x			
HMO or other licensed managed care entity	x ⁱ	x	x		x
Any willing qualified provider MCO				x ⁱⁱ	
Medicare funding ⁱⁱⁱ	x	x	x	x	x
1915(a)	x	x		x	
1915(b) waiver			x		
1915(c) waiver	x	x	x		
1115 waiver					x
Statewide	x		x		
ⁱ HMOs in Minnesota are required to be not-for profit organizations; MSHO plans became SNPs. ⁱⁱ Must meet certain requirements, including designation from speaker of Assembly, commissioner of health, or Senate majority leader. ⁱⁱⁱ Indicates that a Medicare capitated payment is made to plan if dual enrolls in SNP for Medicare.					



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