



Dual Eligibles & Medicare Advantage Plans: Do New Rules Make Them a Better Fit?

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Principal Authors:

Deepti Sethi
Legal Consultant

David Lipschutz
Staff Attorney

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NOTE: this report on dual eligibles¹ in Medicare Advantage (MA) plans is divided into two parts (or briefs): Part 1 explores the topic of dual eligibles in MA plans in general and whether recent legislative and regulatory changes make MA plans, as a whole, a more viable option for dual eligibles; Part 2 explores these changes as they specifically apply to MA Special Needs Plans (SNPs) for dual eligibles.²

PART 1

DO RECENT CHANGES BY CONGRESS AND CMS MAKE MEDICARE ADVANTAGE A MORE VIABLE OPTION FOR DUAL ELIGIBLES?

I. INTRODUCTION

The Medicare Advantage (MA) program is often presented as a panacea for all Medicare beneficiaries who wish to pay less in out-of-pocket costs and have access to broader coverage than through Original Medicare. Of the various options within the Medicare program to access benefits, Medicare Advantage (MA) plans can and do work as a viable option for some individuals.³ Joining MA plans, however, may not be advantageous for all Medicare beneficiaries. The difficulties many enrollees face in MA plans include: restriction of access to providers (including specialists); out-of-pocket expenses (sometimes greater than Original Medicare); and other barriers to care such as utilization management. These problems typically impact individuals dually eligible for Medicare and Medicaid more than others because of their limited incomes, higher use of health services, and limited education. Hence, duals can end up worse off in MA plans than if they had Original Medicare and Medicaid.⁴ This is true even of Special Needs Plans (SNPs) – some of which are ostensibly designed particularly for dual eligibles (note that Part 2 of this report focuses specifically on issues relating to Dual SNPs).⁵

Both Congress and the Centers for Medicare and Medicaid Services (CMS) have recently recognized some of the problems

that dual eligibles face in MA plans. Congress' passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) with final and interim rules and regulations issued by CMS contain provisions that, among other things, are meant to assist dual eligibles by providing cost sharing protections and ensuring access to Medicaid benefits. Despite these efforts, many advocates and those who assist dual eligible beneficiaries wonder: Do these changes go far enough? Moreover, is the MA program really appropriate for duals?

II. DUAL ELIGIBLES & MEDICARE ADVANTAGE PLANS

Medicare Advantage (MA): An Overview

Medicare Advantage (MA) plans are private organizations through which enrollees obtain all Medicare covered services. Plans are obligated to offer all services covered by Medicare Parts A and B.⁶ MA plans are not required, though, to structure the payments for these services in the same manner as Original Medicare.⁷ For example, Original Medicare has no cost sharing for home health benefits but many MA plans require a payment for these services.⁸

By and large, "coordinated care" MA plans require enrollees to see providers having contracts with the MA plan in order for the

MA plan to pay for services.⁹ If an enrollee goes “out of network” for non-emergency or urgent services, they are generally responsible for 100% of the cost of obtaining care.¹⁰ To the contrary, those with Original Medicare have the choice of seeing any provider that accepts Medicare, and those who are eligible for Original Medicare and full Medicaid benefits have the choice of seeing any provider that accepts both programs.¹¹

Dual Eligibles

The dually eligible population (specifically low-income Medicare beneficiaries also eligible for Medicaid) is a particularly high-cost, high-need population.¹² There are approximately 955,000 full dual eligible beneficiaries in California.¹³ California’s Medicaid program, known as Medi-Cal, plays a critical role in reducing out-of-pocket costs for this population. In California, Medi-Cal pays for the monthly Medicare Part B premium, Medicare Part A and B deductibles and co-payments, and additional benefits.¹⁴

Individuals who are dually eligible for Medicare and Medicaid are entitled to the broad range of benefits provided by both programs.¹⁵ This population, many of whom have significant and complex health needs and generally have a lower level of health literacy, rely heavily upon the overlapping coverage of the two programs. Original Medicare serves as the primary payer and Medicaid is the secondary payer often paying both Medicare cost-sharing and providing coverage for services not covered by Medicare. Despite the array of services and coverage available through Original Medicare and Medicaid, federal authorities have encouraged delivery through private managed care plans as a mechanism to deliver services for the dually eligible.¹⁶ As discussed below, enrollment into an MA plan, though, can create problems not encountered for dual eligibles enrolled in the Original Medicare and Medi-Cal programs.

Problems Faced by Dual Eligibles in MA Plans

Within all MA plans that accept dual eligibles as enrollees (Special Needs Plans, Health Maintenance Organizations, Preferred Provider Organizations, and Private Fee for Service Plans) several factors magnify existing barriers to dual eligibles’ access to providers and benefits. CMS, in its own proposed regulations issued in May 2008, concluded that:

CMS’ review of MA plans serving dual eligible beneficiaries over the past few years has identified that a number of providers are charging the beneficiaries Medicare Parts A and B cost-sharing that is the responsibility of the State. Additionally, many dual eligible enrollees are unclear about the Medicare and Medicaid rules and benefits. Some new enrollees have experienced interruptions in treatment,

resulting in a negative impact on their health. These experiences suggest that additional requirements are needed to ensure that both providers and beneficiaries understand Medicare and Medicaid rules and that beneficiaries do not pay cost-sharing for which they are not responsible.¹⁷

Upon enrollment into an MA plan, many dual eligibles do not understand or are not informed of the fact that an MA plan curtails how they can use their Medicare coverage. Dual eligible beneficiaries must get all their Medicare covered benefits through the MA plan. They may need to go outside the MA plan to obtain Medicaid covered benefits, often with no help by the MA plan.

While the MA appeals process is available to all enrollees, the time frame and the risk of inadequate resolution favors the option of disenrolling, available to dual eligibles and a few others but not to most Medicare beneficiaries, from a current MA plan and returning to Original Medicare and Medicaid rather than completing the appeals process. However, for some enrollees there is a benefit to being in an MA plan (i.e. for End-Stage Renal Disease (ESRD) enrollees that are often excluded from MA enrollment). These enrollees must navigate a complex MA appeals process to seek adequate resolution of liability and access to appropriate services.¹⁸ Those helping dual beneficiaries with the appeals process should ensure that the appropriate MA process is being applied by the plan (i.e. appeal or grievance).

Dual eligibles commonly experience a lack of information regarding the benefits they are entitled to as MA enrollees, as individuals with Medicaid, and how to access Medicaid covered services that are also covered by the MA plan. MA plans are only required to offer Medicare services, yet may provide services that are in fact covered under Medicaid. There is nothing requiring MA plans to offer Medicaid covered services or assist enrollees in accessing services outside of the MA plan. The lack of clear information regarding various MA plan benefit structures compromises informed decision-making. Furthermore, the inability to compare MA offerings to coverage under Medicare and Medicaid leads to confusion and incorrect interpretations of those offerings. Often, the www.medicare.gov web site serves as a comparative starting point for Medicare beneficiaries, including dual eligibles, and those who assist them. It is difficult to determine, though, what cost-sharing could be incurred by a dual eligible or if preauthorization will inhibit access to needed services within MA plans. The comparison of MA plan offerings to each other beyond prescription drug coverage is extremely difficult given the variance in the offerings and the lack of standard models for structuring benefits. Even when looking at plans designed specifically for dual eligibles, the CMS MA Compare template fails to reflect Special Needs Plans

(SNP) offerings in an accurate manner often showing cost-sharing amounts that the individual is obligated to pay instead of the individual.¹⁹

Within this context, many dual eligibles seeking information first-hand turn to the marketing and sales materials provided by the plans. Naturally, this information consists of generalizations meant to increase sales and enrollment. This material is often rendered meaningless when used to discern the actual coverage for an individual's specific health care needs.

Dual eligibles have the right to enroll in any MA plan, with the exception of Medicare Medical Savings Accounts (MSAs). Sales agents and marketing materials often aggressively target dual eligibles for enrollment into MA plans, in part, because they have an ongoing enrollment period allowing enrollment, and changes in enrollment, throughout the year.²⁰ Frequently, duals are enrolled into plans by a sales representative at best minimally qualified to explain the plan offerings and the intersections with Medicaid or, at worst, engaged in deceptive practices to enroll duals for his or her own personal gain through commissions.²¹

Issues Specific to Coordinated Care Systems: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Special Needs Plan (SNP) MA Plans²²

Coordinated care plans are organizations with a closed network of providers that have established contracts with the plans. In HMOs, referrals are needed to see specialists. In both HMOs and PPOs, preauthorization for services is often required. These "gatekeeper" systems have the potential to coordinate the care that is provided to an enrollee since communication, medical records, diagnosis, and treatment can more easily be facilitated among all involved in treating an enrollee within the organization. Because dual eligibles frequently require health care and utilize (at least) two programs to provide health care coverage, it seems as if these coordinated care systems would be advantageous for these individuals. However, as discussed below, this is not necessarily the case for dual eligibles.

Lack of Information Sharing and Coordination

While MA plans are only required to offer Medicare benefits, even those that have arrangements with the state Medicaid agency do not generally share basic beneficiary level data on eligibility for coverage, health services received, health diagnoses, or additional diagnoses needed to improve case management. In addition, provider participation standards are not coordinated within these plans so some providers do not have a contract with Medicaid. Beyond the billing issues previously mentioned, providers may fail to identify services that

can help the beneficiary outside the MA plan since they lack familiarity with services covered under Medicaid. Providers lacking information regarding the full range of services that someone is entitled to – or receives – may shift their health care decision-making to accommodate perceived coverage limitations for specific individuals. There are also risks and incentives to shift costs away from the MA plan to Medicaid for dual eligibles, which can easily lead to a compromised quality of care. For example, since Medicaid covers long-term care and Medicare does not, preventative measures that may delay or remove the need for long-term institutionalization may be avoided.²³

MA plans often lack the ability and impetus to confirm dual eligible status in real time, communicate the benefits the enrollee is entitled to outside the plan, and actually direct beneficiaries to appropriate providers for those services in a meaningful manner. Many MA plans promise communications strategies to assist individuals and coordinate their care. However, without centralized member records with up-to-date information on other health coverage, plans are not able to identify and target duals for special communications.

Confusion on the part of beneficiaries can further complicate how an individual receives health care. Beneficiaries are often unclear in their understanding of what services are paid for under which program. If there is a lack of coordination between the programs at the MA plan level, the inability of a beneficiary to discern which processes or program to use can complicate care.²⁴

Increased Cost to Access Care

Dual eligible beneficiaries must see providers who accept both Medicare and Medicaid in order to receive the full scope of services covered under both programs and, all too often, to ensure continuity of care.²⁵ Despite seeing MA providers, duals may find themselves erroneously billed for services rendered. In addition, some duals have to pay premiums for MA plans to receive coverage that is no different and sometimes worse than under Medicaid. Medicare rules do not protect duals from paying a premium for the portion of the MA plan coverage that is not for Part D prescription drugs.

The cost of out-of-network care is not generally covered by Medicare and, because Medicaid is a secondary payer, might not be covered by Medicaid if the MA plan would otherwise pay for services in-network. These issues are magnified in HMO structures where referrals to specialists are usually required before the visit is authorized as covered by the MA plan.

Barriers to Accessing Providers and Services

In addition to billing errors resulting from an MA plan's

misidentification of a dual eligible beneficiary or because an individual sees doctors outside of the limited provider network for care, enrollees are often misinformed by providers and plan representatives as to what services they qualify for or are often unable to get the services they need from the MA plan due to plan denials.²⁶ CMS notes while referring only to Dual SNPs that

...if the MA organization is not aware of the benefits available to its members through other sources, such as Medicaid, it cannot ensure that the model of care it delivers offers adequate coordination of the essential services.²⁷

This concept applies to all MA plans. Given the complex needs of dual eligibles, access to a broad spectrum of physicians, specialists, and suppliers that are participating Medicaid providers along with a complete array of health and social services are required.

The mere inclusion of physicians, hospitals, nursing homes, community-based providers, and assisted living facilities into an expanded network does not ensure access to care.²⁸ Referral processes, prior authorizations, and structured networks of providers all work to limit from whom and where an enrollee can seek care within HMOs and PPOs. HMOs often contract with medical groups instead of independent providers, imposing an additional limitation on the network of providers accessible to enrollees as they become limited to a specific medical group operating like an HMO within an HMO. While PPOs typically have broader networks, there is no guarantee that the doctors an enrollee has established relationships with are in the provider network. HMOs not only consist of a network of providers that an enrollee is required to use, but additional referrals to specialists through a primary care physician are necessary. Both HMOs and PPOs can impose preauthorization requirements before specific services are covered.²⁹ Disruptions in access to care provided by beneficiaries' usual doctors result in unmet medical needs as doctor visits are delayed while duals navigate an MA system that might be new to them. Under Original Medicare and Medicaid, dual eligibles can see any provider that contracts with both of these programs.

Issues Specific to Private Fee For Service (PFFS) MA Plans

Perhaps the least suitable MA option for a dual eligible is a PFFS plan. PFFS plans differ from other MA plans because they are not currently required to establish a network or contractual relationships with health care providers prior to a beneficiary's receipt of services.³⁰ Until recently PFFS plans had no requirements to contract or establish network arrangement with physicians, hospitals and other providers. Instead, PFFS plans have been allowed to pay providers with which they have no contracts at Medicare fee-for-service rates, called "deem-

ing authority." Although enrollees can seek care from any provider willing to accept the plan's terms and conditions, providers who do not have a contract with the plan can decide whether to continue to accept the plan with each visit or treatment. As a result, many PFFS plan enrollees struggle to find providers willing to accept the plan's terms and conditions. For example, the California Medical Association reports low participation by its members in PFFS plans, and expresses concern that PFFS plan networks are inadequate, particularly for specialty referrals.³¹ In the experience of California's Health Insurance Counseling and Advocacy Program (HICAP), dual eligibles have faced particular difficulty finding providers who are willing to treat them under the "deemed" provider PFFS model.³²

The lack of information regarding how to make an appointment or other health care arrangements is pronounced in PFFS plans due to the lack of provider networks or guaranteed access to care at specific and convenient locations. While restrictive provider networks can limit access to care, the lack of even an informal care network, coupled with separate sources of coverage (i.e. Medicare and Medicaid), often prevents any meaningful coordination of care efforts.³³ PFFS plans are generally remiss in identifying prospective and appropriate providers since they do not have an established network and it is not guaranteed that providers will accept the PFFS terms and conditions prior to service delivery.³⁴

The rise in numbers of duals enrolled in PFFS plans cannot be a standard by which to infer satisfaction or even possible attraction to PFFS plans by dual eligible individuals. The well-documented marketing abuses by these plans have typically targeted dual eligible individuals due to their ongoing enrollment rights and the vulnerability of this population.³⁵ In our experience, some of the worst and most widespread marketing violations have involved dual eligibles who are sold PFFS plans. Information about the suitability of MA plans for dual eligibles, including meaningful comparisons with Medicaid benefits already available to them, is not made available by the plans or is misleading, and, at best, glossed over during sales pitches.³⁶ Duals are often enticed by "extra" benefits that agents and plans say will save them money. Examples are \$20 worth of over the counter medications, and "extra" hearing, vision and dental coverage, offered without regard to individual states' rules regarding actual Medicaid benefits to which duals may already be entitled.

Once enrolled, duals often find that their doctors won't take their PFFS plan. If their primary doctor does take the plan many find that they are charged for doctors' visits, services, and items they did not previously have to pay for as enrollment in PFFS, HMO, PPO and SNP plans may result in higher cost sharing for some Medicare covered services. Difficulty finding specialists who agree to accept PFFS plans frustrates efforts to obtain appropriate and necessary health care.

At least one PFFS plan sponsor acknowledges that this plan type is not appropriate for dual eligibles. During a Congressional hearing wherein his company was criticized for the conduct of an agent selling his PFFS plan to dual eligibles, Coventry Vice President Francis Soistman admitted that "...PFFS plans may not be suitable for dual eligibles."³⁷ Other plan sponsors, however, have held themselves out as specially catering to duals – notably WellCare Duet PFFS plans (recently renamed "Melody").³⁸

III. RECENT CONGRESSIONAL & CMS ACTION

In July 2008, Congress passed the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which, among other things, includes new protections for beneficiaries. This law and the final, interim, and proposed regulations issued by CMS are a meaningful step towards ensuring access to care and affording greater protections to the most vulnerable Medicare beneficiaries. However, this legislation and accompanying regulations fail to prospectively ameliorate access to care issues and remove barriers to obtaining services for dual eligibles across all MA plan types. The legislative and regulatory focus on Special Needs Plans (SNPs, and Dual SNPs in particular) leaves many beneficiaries just as vulnerable as they were prior to the actions of Congress and CMS. MIPPA addresses out of pocket costs for duals, increases access to information prior to enrollment, ensures contracts with the states to align the delivery of and/or referrals for Medicare and Medicaid services, creates models of care and requires "appropriate networks" of providers. These protections, however, are only applicable to SNPs with the majority of improvements limited to Dual SNPs; they do not extend to all MA plans and they do not protect all dual eligible beneficiaries. Expansions in marketing protections

Dual eligibles logically make up a high percentage of those enrolled in all SNPs. The dual eligible population is, on average, a sicker population with many coexisting conditions. Due to the prevalence of chronic conditions among duals, many are enrolled in Chronic SNPs (for those with specific severe or disabling chronic conditions). Medicaid covers the costs of long-term care, and many individuals who reside in institutions are dually eligible. Hence, Institutional SNPs are also made up of a significant number of dual enrollees. The limitation of protections to Dual SNPs fails to protect the dual eligible population as a whole and is an incomplete measure to remove barriers to care or solve existing problems. It is important to note that dual eligibles are able to enroll in all MA plans (with the exception of Medicare Savings Accounts).

will help alleviate some of the marketing abuses that duals face, but in our view, could go even further. Minimum requirements for PFFS plans will also provide greater access to care for duals in some geographic areas, but it is unclear whether these plans will be able to provide networks that meet the needs of their dual enrollees.

Out-of-Pocket Costs

MIPPA addresses the issue of out-of-pocket costs for dual eligibles in Dual SNPs only.³⁹ While the Act states that SNPs may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted through Medicaid if the dual were in Original Medicare, this provision does not reference other types of MA plans.

Prior to the passage of MIPPA, CMS issued proposed regulations that articulated a cost sharing protection for dual eligibles in all types of MA plans. In order to address problems of dual eligibles being inappropriately charged for services, misinformed regarding the use of their benefits, and experiencing interruptions in treatment and negative impacts on their health, CMS codified policy previously set forth in informal guidance.⁴⁰

The intent behind these proposed regulations is laudable, however the mechanism by which CMS imposes this cost sharing restriction is flawed as no responsibility is placed upon MA plan sponsors to create systems by which true coordination in the administration of benefits occurs. CMS gives providers the following choice to either "(A) Accept the MA plan payment as payment in full, or (B) Bill the appropriate State Source."⁴¹ By utilizing the contract between the plan and the provider as the mechanism to ensure protection, administrative burdens are imposed on providers, while little is required of plans concerning the confirmation of dual eligible status and basic care coordination at the beneficiary level.

Until final regulations on this topic are issued, we do not know if the inclusion of prohibitions on billing for Parts A and B cost-sharing for duals in contracts with MA providers are required.⁴² In guidance to plans, instead of following their proposed rule, CMS states that the decision regarding whether to finalize the prohibition on charging cost-sharing for dual enrollees in MA plans will be based on comments received.⁴³

Information Prior to Enrollment

MIPPA imposes new requirements for SNPs specifically serving dual eligibles that require the plan to provide enrollees with a comprehensive written statement describing the benefits and cost-sharing protections afforded under Medicaid, effective January 1, 2010.⁴⁴ Prospective dual SNP enrollees must also be informed of which benefits and cost-sharing protections are covered by the plan prior to enrollment.⁴⁵ It is important to note that this requirement is *only* applicable to Dual

SNPs.⁴⁶ As long as all MA plans are able to market to and enroll dual eligibles, we believe that similar information about Medicaid benefits should be provided by all MA plans to all dual eligible enrollees.

Contracts between MA Plans and State Medicaid Agencies

Effective January 1, 2010, MIPPA requires that each SNP enter into a contract with the state Medicaid agency to provide benefits, or arrange for benefits to be provided.⁴⁷ As a practical matter, SNPs that are currently operating *without* a contract with the state can continue to do so until January 1, 2010. There is a moratorium on new SNPs entering the marketplace through December 31, 2010.⁴⁸

We believe that this is a step in the right direction since contracts with the state have the potential to alleviate many billing and access to care problems by either making the SNP responsible for Medicaid benefits or setting contractual parameters for referrals to care. However, only enrollees in Dual SNPs benefit from this requirement. CMS' proposed regulations include minimum standards, again applicable only to Dual SNPs, of a "documented relationship with the state Medicaid agency..." with the means to "identify Medicaid benefits which are not covered by Medicare."⁴⁹

There are no requirements that all MA plans contract with the state for Medicaid services. It is unclear exactly what form the contracts required by MIPPA between SNPs and the state will take or to what extent these contracts will reduce access to care issues within this subset of MA plans.⁵⁰ CMS' implementing regulations specify that such contracts include: the category of Medicaid eligibility covered by the SNP; the service areas covered by the SNP; and the contract period for the SNP.⁵¹ Dual eligible SNPs can continue to operate without a contract in place through 2010 but they cannot expand their service areas.⁵² Regardless, if SNPs do not have a contract with the state Medicaid agency, they must have the institutional ability to help navigate Medicaid benefits.⁵³ We believe that any coordination with Medicaid should apply to all MA plan types that enroll dual eligible beneficiaries.

Access to Appropriate Services

MIPPA includes individual care management requirements effective January 1, 2010 for SNPs. The components of this requirement are: an "evidence-based model of care with an appropriate network of providers and specialists to meet the specialized needs of the SNP target population"; and "care management services."⁵⁴ CMS' interim rules require a SNP model of care with appropriate networks, comprehensive initial and annual (re)assessments of the enrollees' needs, individualized plans of care with measurable outcomes, and interdisciplinary teams to

manage that care.⁵⁵ These very important requirements for care coordination and provider networks are only applicable to SNPs. Dual eligibles in other MA plans are not afforded this protection.

Marketing

As discussed elsewhere, marketing misconduct surrounding the sale of MA plans has had a debilitating impact on all Medicare beneficiaries, including dual eligibles.⁵⁶ MIPPA addresses the issue of marketing abuses and misinformation by prohibiting specific activities that could be used as an incentive to enroll someone in a specific plan despite the plan's inappropriate constraints on access to care for that individual. These limitations include prohibitions on: door-to-door solicitation (a rule already in effect but newly codified); provision of meals at sales events; marketing or sales at educational events; and outbound telemarketing.⁵⁷ These specific prohibitions are effective October 1, 2008 to provide protection during the 2008 Annual Coordinated Election Period (AEP).⁵⁸ Effective November 15, 2008 (at the start of the AEP), MA organizations must use representatives that have completed an initial training and testing program on Medicare and the MA products sold.⁵⁹ We believe that this is a good start but more is needed to ensure that dual eligibles – and other Medicare beneficiaries – are not enrolled in products that are inappropriate for them (see, e.g., forthcoming CHA issue brief on the new marketing rules).

PFFS Plans

MIPPA changes the requirements for PFFS plans in counties where there are two or more non-PFFS "network" plans (either an HMO or local PPO). As of 2011, in such counties, PFFS plans will no longer be able to "deem" providers into the plan, but instead will have to form contracted provider networks.⁶⁰ We believe that this requirement will significantly improve access to providers for all PFFS enrollees of plans that must establish such networks. In the meantime, though, many dual eligible enrollees (among others) still lack a level of confidence that their medical needs will be met by their preferred providers or in convenient locales if enrolled in PFFS plans. In addition, in counties that will not have two or more non-PFFS plans (as is the case now in many rural counties of California where PFFS marketing abuses have been documented), this network rule will not apply and PFFS plan enrollees are likely to continue facing problems accessing providers should PFFS plan sponsors choose to continue offering plans in these areas. For example, if the PFFS network rules going into effect in 2011 applied to the MA marketplace in California as of 2009, PFFS plans in 30 out of 58 counties would be exempt from the rule and would still operate under the current deeming rules.⁶¹

PFFS plans are exempt from quality reporting require-

ments that other MA plans are subject to under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).⁶² The lack of quality reporting requirements for PFFS plans makes it impossible to compare clinical measures or individual satisfaction measures to other plans. Hence, it is difficult to gauge exactly how, or if, these plans provide any additional benefits to dual eligible enrollees. MIPPA imposes new requirements for quality improvement programs and data collection thresholds equivalent to those for local PPOs for PFFS effective January 1, 2010.⁶³ We believe that collection of this information will shed greater light on the plight of dual eligibles in these plans.

IV. CONCLUSION

If Medicare Advantage plans wish to truly provide comprehensive health care to dual eligibles that is greater than Original Medicare and Medicaid, they must coordinate services along with ensuring access to adequate providers. The key component of care coordination is linking and coordinating services and resources that are appropriate for the individual's needs to provide him/her with optimal health care. Since dual eligibles are a heterogeneous population, these services must be individually tailored to an enrollee's needs.

While recent legislative and regulatory changes acknowledge and address some of the challenges dual eligibles face in MA plans, most of these changes only improve the conditions of duals enrolled in SNP plans, not other MA plans. There is no rationale for limiting these changes to SNPs when duals can be marketed to, and can enroll in, other MA plans. The need for oversight to gauge how well MA plans are serving the dual eligible population and accountability when duals face barriers to accessing care that they are entitled to under Medicaid is critical.

Furthermore, plans that are simply not able to serve the needs of dual eligibles should be prohibited from marketing to, and enrolling, these individuals. When asked about the appropriateness of PFFS plans targeting dual eligibles for enrollment, a high-ranking CMS official replied at a hearing before the House Ways & Means Subcommittee on Health that Medicare Advantage "is a market-based program and dual-eligibles, like everyone else, have the option of choosing how they wish to obtain services and where they wish to be enrolled."⁶⁴ This prevalent attitude fails to consider the ability of MA plans to adequately serve this marginalized population.

What Medicare MA plans purport to offer, however—reduced cost sharing and covered services beyond the basic benefit package—is precisely what Medicaid actually provides. The relevant policy questions that should be raised include: How much value does a dual eligible get by enrolling a particular MA plan? Is there specific

care coordination? Is there specific benefit coordination? Can an individual access more (or fewer) providers? Is it easier or more difficult to access Medicaid benefits? Are there additional benefits provided by the MA plan that a dual eligible individual is not already entitled to? If so, are these additional benefits worth the constraints imposed by enrollment? Will a dual eligible be subject to higher out-of-pocket expenses within the MA plan than what they experience in Original Medicare and Medicaid? Can care coordination be achieved through means other than a private, MA plan?

While MIPPA promises some relief through increased limitations on marketing, the establishment of networks for PFFS plans offered in certain areas, quality improvement and data collection requirements, and requirements for SNPs, we are likely to continue to see problems experienced by beneficiaries prior to and following implementation of these new provisions. It can be argued that Congress did not go far enough to legislate protections for dual eligibles and to guarantee their access to health benefits afforded by Medicare and Medicaid. The failure of Congress to force accountability through immediate reforms will bear an impact on the most susceptible Medicare beneficiaries.

Some MA plans have served dual eligible populations for years prior to the implementation of Part D and the expansion in MA offerings. For other MA plans who may have entered the market following favorable changes in reimbursement rates, attempts to develop expertise usually come at a high cost to the beneficiary. Without a concerted effort by MA plans coupled with heightened standards, oversight, and compliance/corrective action by CMS and Congress, the enrollment of dual eligibles in MA plans too often undermines the protection that Medicaid coverage was intended to provide.

While MIPPA has focused attention and efforts on the SNP model of MA plans, and Dual SNPs in particular, the dual eligible population itself should serve as the focal point of reform. MA plans in general are not being held to standards that would best serve the dual eligible population. It is imperative that advocates, policy makers, and those directly serving dual eligible beneficiaries remain vigilant in their efforts to strengthen the protections given to duals within SNPs and apply those strengthened rules to all MA plans that enroll dual eligibles. High expectations of MA plan programs are justifiable due to the economic incentives and payments afforded them.⁶⁵ The potential for confusion and continuing degradation of health care service and quality for the most vulnerable Medicare beneficiaries remain unjustifiable.

PART 2

DO RECENT CHANGES FORCE SPECIAL NEEDS PLANS (SNPs) TO LIVE UP TO THEIR PROMISE?

I. INTRODUCTION

In California, Special Needs Plans (SNPs) vary in their ability to specifically serve those with Medicare and Medi-Cal. This report examines the potential that Dual SNPs have to serve dual eligibles' needs, the failings of some Dual SNPs to meet this promise, and Congressional and CMS efforts to establish baseline expectations for Dual SNPs and where these efforts fall short.

Our focus on Dual SNPs is the result of a significant presence in California and continued enrollment by the majority of existing plans. Through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress extended the authority for SNPs through December 31, 2010, limiting development within the market to extensions in service areas and adjustments to those SNPs that are already active.¹ A moratorium on *new* SNPs has been extended through December 31, 2010.² In California, 26 plan sponsors are currently offering 103 dual eligible SNPs (in 2008), reflect more plan sponsors than any other state.³ The CMS landscape of plan offerings for 2009 shows 24 plan sponsors offering 97 dual eligible SNPs.⁴ Consistent with 2008, there are SNP offerings in 30 of California's 58 counties, all of which are organized as local HMOs.⁵ Despite concerns regarding the ability of SNPs to adequately serve dual eligibles and others with special needs, there has only been a slight decrease in the number of plan offerings. Since the moratorium is preventing new organizations from entering the market, and existing plans are not immediately required to establish contracts with the state, it is critical that we reflect upon what existing SNPs have done on their own accord to enhance health care for dual eligibles.

Part 1 of this report explores dual eligibles and Medicare Advantage (MA) plans generally and concludes that—at the very least—many of the recent legislative and regulatory changes applicable to dual eligibles in SNPs should be applied to all MA plans that enroll dual eligibles. However, several questions regarding these improvements remain. Are the recent changes applicable to SNPs enough to adequately address the challenges that duals currently experience in these plans that are—at least in name—specially designed to address their myriad needs? Given ongoing issues with SNPs serving duals, do recent Congressional and CMS actions solve these problems? Ultimately, even with these improvements, are SNPs a good idea for dual eligibles?

II. THE SNP EXPERIENCE SO FAR ...

Background

The desire for coordination of care between Medicaid and Medicare drove the demonstrations that preceded SNPs and is the impetus for the government's continued investment in SNPs. Dual SNPs must be organized as either an HMO or PPO.⁶ These plans can target enrollment to populations covered by two programs, Medicare and Medicaid. In serving populations covered by two programs, Dual SNPs may face two separate and distinct administrative systems *if* they have a contract with the state Medicaid agency. SNPs are only required to provide Medicare services and might not coordinate care or benefits. SNPs are a creation of the MA program. Before SNP authority, waivers and variances were used to establish demonstration programs aligning many administrative processes required by Medicare and Medicaid.⁷

SNPs created a "permanent home" for innovative demonstration projects.⁸ Prior to SNP authority, comprehensive integration models were used by Minnesota, Massachusetts and Wisconsin to design programs for dually eligible Medicare and Medicaid beneficiaries. Drawing upon the successes in these "integrated" care models, CMS created and authorized SNPs.⁹ In this setting, SNPs offer a fast-track to federal approval and provide the opportunity to combine Medicare and Medicaid managed care contracting for dual eligibles without the necessity to procure approval from CMS under special demonstration authority, which typically took several years.¹⁰

Though SNPs are not required to integrate with state Medicaid programs, SNPs were intended to improve care coordination with state Medicaid programs and to improve care coordination for individuals with complex health care needs.¹¹ Nevertheless, until very recently, there have been few requirements imposed by CMS to specify what SNPs must do or provide for the populations they are allowed to target (duals and others with special needs).¹²

By looking to demonstrations servicing dual eligibles, SNPs *could* adopt best practices that have worked for both beneficiaries and plans. One such approach is to bring in staff, information systems, teams, and benefits specifically to coordinate medical and social care services not covered in Medicare and Medicaid. This has worked in Massachusetts, Minnesota, and Wisconsin demonstrations. Another possibility is to cover community care services to avoid institutionalization - which may include help with personal care, transportation,

meals, home modifications, incontinence supplies, and personal emergency response systems.¹³ There are also documented examples of care coordination, access to patient information, integration of benefits, specialized provider networks, and consumer engagement.¹⁴ Given the flexibility to design benefits, SNPs have the potential to create sustainable models of care for dual eligibles. However, for Dual SNPs to address the care challenges presented by growing numbers of duals (along with the high cost of providing this care), they must build upon the successes and rectify the failures of the past two years. The question remains as to whether SNPs are rising to their potential.

SNPs in Practice 2006-2008

With SNPs' limited interaction with state Medicaid systems, it is difficult to distinguish existing SNPs from other MA managed care options. Since 2006 enrollment in SNPs has increased exponentially, however a number of dual eligibles in California—most of whom did not seek out a SNP on their own but were automatically enrolled into one—have experienced significant problems with accessing care and coordinating coverage and payment with state Medicaid programs.¹⁵ While SNPs present the opportunity for better care coordination, integration and targeted care management, until recently, there have been no formal requirements set out in law, regulation, or CMS guidance that SNPs actually deliver on these goals. In the words of one advocate with significant experience assisting dual eligible clients who encounter problems with their SNPs, “[a]bsent minimum standards for meeting the special needs of the populations they serve, labeling these plans as specially designed to do so is misleading.”¹⁶

It is generally recognized that SNPs with “significant relationships” with states are better positioned to expand enrollment and improve beneficiary care than SNPs that offer only Medicare benefits.¹⁷ Yet, there is nothing in the Medicare Modernization Act that requires SNPs to provide Medicaid services or coordinate their activities with state Medicaid programs.¹⁸ The majority of SNPs have no affiliation with Medicaid programs and when these plans were first offered in 2006, there was scant evidence of any intent to form tangible relationships unless required (i.e. data sharing or joint management protocols).¹⁹

By focusing on Medicare services alone, SNPs have mimicked the roles of traditional MA coordinated care plans (HMOs and PPOs) while enrolling a disproportionate number of individuals that guarantee a higher payment rate from CMS (i.e. dual eligibles under risk adjusted payments). Since SNPs generally cannot use lower cost-sharing as an enticement to enroll, without coordination of benefits between Medicare and Medicaid many are offering little in return to dual eligibles for their enrollment into the plans.

Even though SNP availability in California has grown, some contracted plans and plan providers lack knowledge of, and experience with, the needs of dual eligibles. Dual eligibles are directly impacted by whether SNPs have *actual* expertise serving: those with Medicare and Medicaid, those who are institutionalized, and those with disabilities and chronic conditions. It is troubling that some SNPs are cultivating experience through trial and error with current enrollees. Care coordination for duals is of particular importance because there is a larger scope of covered benefits under Medicare and Medicaid than Medicare alone and duals tend to be a sicker population (whereas SNPs are only required to provide Medicare services). In addition, protocols for serving dual eligible individuals directly impact how dual eligibles receive information, services, and care.²⁰

Limited provider networks heighten the importance of experience serving dual eligible individuals and experience with both the Medicare and Medicaid programs. The SNP, network providers, and the organization administering the plan need this expertise. When SNPs focus on Medicare only, which is all they are required to do, there is little to distinguish many of them from other MA offerings since most Medicare Advantage plans with prescription drug benefits (MA-PDs) have experience in coordinating Medicare acute benefits.

The difficulties faced by dual eligibles in coordinated care plans (HMOs and PPOs) are present in SNPs as well.²¹ The experiences of dual eligibles reveal gaps in SNP understanding of, or concern with, *how* Medicaid intersects with Medicare benefits. Dual beneficiaries experience a wide range of difficulties within SNPs ranging from inappropriate cost-sharing charges to reduced access to care compared to Original Medicare and Medicaid. The limited provider networks utilized by SNPs can disrupt the continuity of care and services that a dual eligible has been receiving.

IV. RECENT CONGRESSIONAL & CMS ACTION

Congress and CMS have recently acknowledged some of the difficulties faced by dual eligible beneficiaries in Medicare Advantage plans, yet recent legislation and CMS' proposed rules and implementing regulations fail to adequately rectify the problems. Instead, as discussed in Part 1 of this report, Congress and CMS focus narrowly on Dual SNPs despite the enrollment of dual eligibles in most forms of MA plans, including institutional and chronic care SNPs.²² Therefore, cost-effective health care, and what constitutes adequate and appropriate health care, continues to be largely defined by private MA plans. As discussed below, recent rules impacting enrollment, disclosure of information, contracting with

state Medicaid agencies, cost protections, care management, and quality improvement offer some improvements, but fail to establish sweeping standards that will significantly raise the bar for SNPs.

Enrollment

Through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress extended the authority for SNPs through December 31, 2010 limiting development within the market to extensions in service areas and adjustments to those SNPs that are already active.²³ A moratorium on new SNPs has been extended through December 31, 2010.²⁴ From January 1st 2010, all SNPs must limit their enrollment to those individuals meeting the definition of “special needs.”²⁵ We believe that this limitation is a marked improvement over the “disproportionate enrollment” rule that has allowed SNPs to enroll many Medicare beneficiaries who do not fit the profile of the special needs population that the SNP is allegedly serving. The incentive for this action lies in the fact that, as noted by CMS, “[d]isproportionate percentage SNPs are enrolling significant numbers of non-special needs individuals, thus diluting the focus on serving those individuals with special needs.”²⁶ We applaud this improvement. To ensure that 100% special needs enrollment will “encourage SNPs to design benefit packages that best serve the certain special needs populations for which they have been created,” we note that CMS should couple this requirement with standards requiring a specific level of service and outcomes for these populations.²⁷ Without these standards, SNPs run the risk of becoming segregated plans for the most ill beneficiaries without assurances that cost-effective delivery of health care is not translating into inadequate care.

Information to Enrollees

Effective January 1, 2010, MIPPA requires Dual SNPs to provide current and prospective enrollees with comprehensive written statements (using standardized content) describing the benefits and cost-sharing protections under Medicaid and which of these benefits and cost-sharing protections are covered by the SNP.²⁸ This information must be included in any description of benefits made by Dual SNPs and must be provided prior to enrollment.²⁹ As noted by beneficiary advocates, this information should be available in a manner that can be understood by those who have limited-English proficiency and low health literacy. Plans should be required to have this information available in multiple languages and must be prohibited from actively marketing to non-English speakers if they cannot provide information to those same individuals in their native language.³⁰ These requirements do not currently appear in guidance or regulations.

State Contracts

MIPPA imposes a requirement for SNPs to contract with the state Medicaid agency to provide benefits or arrange for benefits to be provided effective January 1, 2010.³¹ Under MIPPA, only SNPs that wish to expand their service area are required to contract with the state; other SNPs can continue to operate without a contract. As referenced above, there is a moratorium on new SNPs entering the marketplace through December 31, 2010.³² If SNP authority is continued, new plans will be required to establish contracts with the state to gain entry to the market.³³ This means existing SNPs have incentives to seek contracts with the state.³⁴ It is important to distinguish establishing a contract from a requirement for coordination or integration. However, entering into contracts with states is a necessary prerequisite for this to occur.³⁵ A system that allows plans to identify duals and refer them to Medicaid providers, or refer them to the Medicaid agency, would meet the standards Congress has set and is a step in the right direction, but does not ensure integrated care or coordination of care. Why not require a contract with even minimal obligations prior to marketing and enrollment for *all* SNPs?³⁶ Moreover, it is imperative that there are protections for dual eligibles where it is permissible for SNPs to operate without a contract with the state Medicaid agency.

By entering into contracts with states, SNPs provide the opportunity to facilitate integration between Medicare and Medicaid and subsequently improve care coordination across the two programs.³⁷ However, CMS’ proposed regulations set a minimum obligation that falls short of ensuring improvements. These proposed regulations include standards, applicable only to Dual SNPs, to establish “arrangements with States.”³⁸ The required obligation of SNPs is a “documented relationship with the State Medicaid Agency” with the means to “identify Medicaid benefits which are not covered by Medicare.” Congress and CMS’ failure to obligate SNPs to any meaningful relationship with the state reduces expectations for greater benefits and care coordination between Medicare and Medicaid. The statute and regulations simply require plans to:³⁹

- Verify dual eligible status;
- Identify and share information regarding which providers are contracted with Medicaid; and
- Identify Medicaid wrap around benefits.

Shouldn’t the bar be set higher? The requirement that SNPs establish “arrangements with States” to obtain information “on a routine and timely basis” will most likely entail a transfer of data.⁴⁰ While CMS is aware of the many consumer level issues that have occurred due to faulty data exchanges between states, plan sponsors, CMS, Social Security and other entities, it has failed to require the development of an integrated data system or require minimal transfer of data obligations.⁴¹ If CMS

is going to encourage dual eligibles to enroll in SNPs, it should outline systems to ensure that SNPs are paving a path toward increased care coordination and greater efficiencies. Systems requirements for real-time confirmation of dual eligible enrollment status could also facilitate enforcement action and oversight for enrollment issues, gauge liability, and ensure appropriate reconciliations.

Further, the requirements for identifying Medicaid providers and benefits do very little to ensure that beneficiaries are directed to appropriate care when the scope of Medicaid services falls outside of what the SNP offers. In addition, these requirements often can be satisfied through a simple web search, a brochure, or a simple list. This information should be currently available outside of any effort by the SNP. However, it is often difficult to obtain accurate and up to date information regarding Medicaid providers. Without requirements for SNPs to assist dual eligibles in identifying and making appointments with Medicaid providers, this requirement does little to add a meaningful intervention by the SNP or raise the bar for SNP performance.

CMS proposed regulations are missing requirements for assistance for the SNP member in accessing benefits under Medicaid. Without any meaningful assistance to coordinate benefits between the two programs, an individual enrollee is arguably trading unlimited access to Medicare and Medicaid providers under Original Medicare and Medicaid for a limited provider network since SNPs, like other MA plans, are only required to provide Medicare benefits.

One could argue that the flexibility of the CMS requirements regarding contracting arrangements provides states with the ability to define the Medicare data that it wants from SNPs and how it wants SNPs to refer enrollees to Medicaid. States *should* exert influence because administrative barriers to coordinating Medicare and Medicaid exist. The numerous differences between the two programs' rules for private plan bidding, contracting, enrollment, marketing, complaints and grievances, reporting, monitoring, and rate setting complicate beneficiary access to protections and do not ensure that plans are delivering health care in a manner that justifies the payment rates.⁴² There is a pronounced need for data and data-sharing systems to capture what SNPs are doing and to establish best practices.⁴³ In addition, the lack of centralized member records with up-to-date information on health coverage inhibits dual eligibles' access to benefits they are entitled to through Medicaid and possible access to supplemental services beyond those covered by the MA plan. Access to this information through contracts with Medicaid is critical, yet currently does not exist and is not required.

CMS is allowing states to obtain more data regarding dual eligible beneficiaries.⁴⁴ For Part A and B claims,

states can request to expand the use of data (which is currently limited to the determination of payment liability and payment purposes) to quality improvement activities, treatment and other purposes.⁴⁵ It is unclear what data states will request, whether CMS will grant requests, and how the data will be used.⁴⁶ This increased access to information coupled with the discretion provided to states, though, is a step in the right direction. CMS also allows states to request Part D "claims prescription drug event data for research, care coordination, quality improvement, program oversight and monitoring, and other purposes".⁴⁷

Since state Medicaid programs cover the majority of costs for institutionalization, states have an interest in ensuring that Medicare benefits that postpone or reduce these services are provided. Without adequate data on service utilization, the state is unable to gauge where cost-shifting is occurring and will be unable to ascertain what types of plans provide the best care for dual eligibles.⁴⁸ It is not clear that states would be able to do this politically or in practice. States with smaller populations may lack adequate market leverage to take this approach and may be unable to get useful data that can help states protect Medicaid beneficiaries.⁴⁹

Cost Protections

Effective January 1, 2010, MIPPA prohibits cost-sharing within a Dual SNP that exceeds the amount a dual eligible would pay outside of MA enrollment.⁵⁰ This is an important level of protection for dual eligible beneficiaries that will help prevent inappropriate changes. In California, dual eligibles in Medicare and Medi-Cal (the Medicaid program in California) do not pay for Part A or Part B services. Medi-Cal extends state coverage for:

- Physician directed clinic services;
- Home health therapies physical, speech and language, occupational, audiology services
- Dental
- Physical therapy
- Occupational therapy
- Therapies for speech, hearing, and language disorders
- Prescribed medication for some Medicare excluded drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Preventative services
- Rehabilitative services (mental health stabilization and other services)
- Inpatient hospital, nursing facility, and intermediate care facility services in institutions for mental disease
- Intermediate care facility services for those with mental retardation

- Inpatient psychiatric services (under age 21)
- Targeted case management
- Hospice care
- Transportation services
- Nursing facility services (under age 21)

Due to the extensive coverage those with Original Medicare and Medi-Cal receive, it is critical that SNPs are required to ensure that their provision of the same benefits does not result in higher costs to the beneficiary.⁵¹ As discussed in Part 1 of this report, though, this statutory provision fails to help dual eligibles across the board by providing protection only to those enrolled in SNPs. While CMS originally proposed in regulations a broader protection, reflecting its current guidance applicable to duals in all MA plans, it is unclear whether CMS will merely articulate MIPPA provisions in its final rules and/or guidance to plans.⁵²

Care Management

Consumer advocates who have urged CMS for several years to adopt regulations including specific care management requirements for SNPs are pleased to see rules that previously appeared only in CMS Call Letters for 2008 and 2009 are now proposed for regulations. However, many advocates believe that the vague and somewhat random content appears to reflect CMS' unwillingness to provide genuine oversight of SNPs. In guidance to plans, CMS gives SNPs a great deal of discretion in meeting MIPPA requirements. For example: there is no reference to best practices or standards in SNP development of an evidence-based model of care; CMS does not require health risk reassessments upon specific triggering events (i.e. hospitalization, stroke, heart attack, diagnostic changes); and the composition of the interdisciplinary care team is left up to the SNP without a threshold number of participants, professionals, or physicians required.⁵³

The fact that many SNPs are profit-oriented managed care entities, with consequent incentives for minimizing provision of costly services, combined with the fact that SNP enrollees are particularly vulnerable by definition, makes it imperative that CMS act responsibly to regulate their activities.

Of particular importance is a dual eligible's access to medically necessary services through providers and suppliers. A disproportionate percentage of dual eligibles suffer from poor health status or limitations in activities of daily living. Intersections of poverty, limited education, the lack of familial networks, and racial disparities further impede their ability to obtain care.⁵⁴ These beneficiaries typically need immediate and ongoing medical care.⁵⁵ The complex needs of dual eligibles require access to a broad spectrum of physicians, specialists, and suppliers that are participating Medicaid providers along with

a complete array of health and social services. MIPPA imposes care management requirements effective January 1, 2010.⁵⁶ The care management requirements include "appropriate network[s] of providers and specialists to meet the specialized needs of the SNP target populations" and a series of care management services.⁵⁷ Access to providers and facilities with experience serving individuals who are chronically ill is of the utmost importance. CMS makes little effort, though, to address burdensome prior authorization or referral systems. In addition, the definition of "appropriate" must include those who have experience providing care specifically to duals.⁵⁸

Care management includes an initial assessment and annual reassessment of physical, psychosocial, and functional needs along with plans that identify goals and objectives (including measurable outcomes) of the specific services and benefits to be provided for each individual enrollee.⁵⁹ MIPPA requires the use of an interdisciplinary team in this management of care, which we applaud, but does not specify what disciplines the team must be drawn from.⁶⁰ While flexibility in care management is necessary to meet individual needs, regulation to ensure access to the appropriate medically trained professionals is crucial.

Finally, to aid in monitoring, as well as to assist beneficiaries who are not receiving promised services, CMS should institute an effective complaint process for beneficiaries who cannot access, or are not satisfied with, the care management they are offered. CMS monitoring activities and reports should reflect complaints that have been investigated.⁶¹

Models of Care

CMS' proposed regulations require SNPs to create specific models of care. These models must specify "how the plan will coordinate and deliver care designed for the plan's enrollees."⁶² The model of care plan must include provisions for:⁶³

- Coordinating care
- Including a specialized provider network
- Targeting populations with "special needs" (i.e. dual eligibles)
- Use of appropriate protocols for delivering care to the target populations
- Service delivery systems for frail, disabled, and those who are at the end of life
- Application of performance measures

Models of care must be meaningful and take the full array of a dual eligible's needs into consideration. Appropriate protocols and assessments of ancillary social support services should be made in conjunction with advocates, those with expertise serving the dual eligible community, and individuals representative of the diver-

sity of the dual eligible community. Care coordination should be readily available upon an enrollee's request or a determination by an independent party. SNPs should be required to coordinate the care of enrollees according to the evolving needs of the individual and on an individualized basis. Any denials of care coordination must be explained in full by the SNP and subject to appeal.⁶⁴ SNPs must also ensure that their provider networks meet the specific needs of their enrollees with respect to specialists, geographic spread, transportation needs, language and cultural access and access for people with disabilities.⁶⁵ Without specific required elements to a model of care and target objectives for SNP enrollees, the risk remains that processes will exist on paper yet the provisions will not translate into action for the majority of dual eligibles.

Quality Improvement

The bar for SNPs should be set especially high for quality monitoring and improvement.⁶⁶ MIPPA requires SNPs to provide for the "collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality" by January 1, 2010.⁶⁷ Under MIPPA, SNPs are required to submit documented quality improvement program information to CMS and CMS is required to monitor SNPs.

CMS has already contracted with the National Committee on Quality Assurance (NCQA) to capture data on quality measures regarding the effectiveness of the models of care that SNPs design in increments. Measurements of health outcomes and other indices of quality must occur by January 1, 2010.⁶⁸ The NCQA is not prescriptive in its assessments and plans are not provided with templates or methodologies. It is important to note that SNPs did not have any reporting requirements pertaining to health plan performance, structure, process, or outcomes for enrollees prior to June 2008. The structure and process measures to be evaluated by NCQA consist of case management, member experience, and clinical quality improvements. The addition of design, care transitions, caregiver experience, and provider experience structure and process measures are contemplated for inclusion by 2010. These measures are designed to "raise the bar over time." While NCQA measures provide guidelines and a pathway for improvement of SNP services over time, SNPs should be held to standards and expectations drawn from the best practices already established in demonstrations.

V. CONCLUSION

Some plan sponsors currently offering SNPs have served dual eligible populations for years prior to the implementation of Part D. For other SNPs, the development of expertise comes at a cost to the beneficiary as

Is improved care coordination in SNPs a precursor to mandatory integration under managed care?

In California there are 194,561 Medicare beneficiaries enrolled in SNPs.⁷³ Of these, 103,411 are in Dual SNPs. From 2006-2008, passive enrollment into SNPs contributed significantly to the number of SNP enrollees.⁷⁴

According to a 2006 Congressional Research Service Report, policymakers have cited the following advantages in integrating Medicare and Medicaid under managed care:⁷⁵

- Reducing fragmentation and improving service coordination;
- Removing the incentive to cost-shift from one program to another and increasing care accountability;
- Enhancing the quality of care and improving health outcomes;
- Increasing flexibility in the types of services that can be provided to beneficiaries;
- Focusing on prevention and care coordination activities in delivering health care services; and
- Creating budget predictability for state Medicaid agencies — particularly in preparation for demographic changes with the aging of the population.

We have seen an inability of some SNPs to meet the needs of duals. With economic incentives to balance costs when there are high care needs enrollees against those with low risk or low costs, it seems as if full integration or putting all the people with the highest needs in a segregated model would not be financially viable without serious compromises in care.

Both Medicare and Medicaid law give beneficiaries freedom of choice of provider, which is limited within managed care networks. If SNPs are being used to promote the expansion of Medicaid managed care, the role of states and counties should be strengthened as they may be in the best position to determine whether private plans meet the needs of their dual eligible populations.

plans fail to coordinate care, minimize cost-sharing, or ensure access to providers.⁶⁹ Until recently, there have been no standards, obligations, or expectations attached to SNP performance in serving dual eligible beneficiaries.⁷⁰ The expectation seems to have been that SNPs would, simply through their enrollment of duals, develop a method for coordinating their care.

Most Medicaid programs are aware of which MA plans effectively serve duals and have experience dealing with the two programs. Congress has given states the ability to “certify” Dual SNPs in a sense, through the contractual obligations imposed by MIPPA.⁷¹ The state’s ability to influence the strength of plan offerings is dependent on their power to shape plan policy and practice via contracts. States have the ability to determine which plans are best suited for the marketplace through the requirement for contracts. They can encourage existing plans to strengthen service delivery through communication and strategic plans for contract establishment, conditions, and subsequent growth in new service areas. While states are free to contract with SNPs on their own accord, it remains to be seen how these contracts will be structured and what leverage states will exert.

Given the flexibility to design benefits, SNPs have the potential to create sustainable models of care for dual eligibles. However, the efficiencies of previous demonstration projects are still not being put forth in any expectations or regulatory requirements of SNPs; instead less coordinated and inefficient approaches have flooded the market. Both Congress and CMS have shown restraint in their expectations of MA plan programs and SNPs.⁷² We believe the expectations of, and the delivery of services by, SNPs should be higher than those of other MA plans and those of Original Medicare and Medicaid. These expectations are justifiable due to the economic incentives and payments afforded SNPs. Room remains for many improvements to ensure that the bar for health care is set high. It remains to be seen whether corralling dual eligibles into SNPs is worth the risks for our most vulnerable Medicare beneficiaries.

ENDNOTES: PART 1

1 “Dual eligible” is sometimes used to mean those who get full Medicaid, it is also used to refer to those who get help with Medicare cost-sharing only. The discussion in both Part 1 and Part 2 of this report is focused only on those who receive full Medicaid benefits.

2 The authors would like to thank Patricia Nemore and Vicki Gottlich of the Center for Medicare Advocacy, Inc. (CMA) for their invaluable input and feedback on this report. All errors, omissions, and mistakes are solely those of the authors. For more information on MA plans and dual eligible beneficiaries, see CMA’s article by Mary Ashkar, Vicki Gottlich and Patricia Nemore, “Medicare Advantage: What’s the Advantage If You’ve Got Medicaid, Too?” *Clearinghouse Review*, Vol.42 Pg 232, Sept-Oct 2008.

3 Beneficiaries have the option of Original Medicare, Original Medicare with a Medigap supplement, these options coupled with private Part D prescription drug coverage, or various types of MA plans (some inclusive of prescription drug coverage).

4 The issues discussed in this brief apply to all Medicaid enrollees, including those in California’s Medicaid program, Medi-Cal.

5 In our experience, Private Fee-for-Service (PFFS) MA plans have proven to be particularly ill-suited for dual eligibles, yet there are no barriers preventing PFFS plans from enrolling duals, despite the outcome of such enrollment.

6 42 CFR Chapter IV §§ 422.100-422.105.

7 Id.

8 Some MA plans use the excess payments they receive from the government to offer supplemental benefits.

9 MA plans are required to pay for out-of-network emergency and urgent care. See 42 CFR Chapter IV § 422.113.

10 CMS does provide for limited retroactive disenrollments from MA plans under specific circumstances that alleviate this enrollee liability. See Medicare Managed Care Manual (MMCM), Chapter 2.

11 By choosing providers contracting with Medicare and Medicaid, a dual eligible individual is entitled to protection from being billed for services covered under the programs.

12 Kaiser Commission on Medicaid and the Uninsured estimates based on Medicare Current Beneficiary Survey Cost & Use, 2000 and Centers for Medicare and Medicaid Services and March 2003 Congressional Budget Office data.

13 See Kaiser Family Foundation website at: <http://www.statehealthfacts.org/comparetable.jsp?ind=303&cat=6>

14 It is important to note that often the state does not actually pay the Medicare copayments, however dual eligible beneficiaries are not liable for these costs and should not be billed for services if they see a Medicaid provider. Liability protections are more closely followed in the Original Medicare setting than in MA plans. See Center for Medicare Advocacy, Inc. *Weekly Alert* “Medicare Cost-Sharing for Dual Eligibles: Who Pays What for Whom?” April 24, 2008 at http://www.medicareadvocacy.org/MedSavProgs_08_04.24.CostSharing.htm

15 Medi-Cal offers many benefits not found in other Medicaid programs. Therefore, California’s dual eligible population is entitled to a relatively broad range of benefits.

16 See, e.g., http://www.cms.hhs.gov/IntegratedCareInt2_Integrated_Care_Roadmap.asp#TopOfPage

17 73 Federal Register 28556 (May 16, 2008)

18 Mary Ashkar, Vicki Gottlich and Patricia Nemore, “Medicare Advantage: What’s the Advantage If You’ve Got Medicaid, Too?” *Clearinghouse Review*, Vol.42 Pg 232, Sept-Oct 2008.

19 Medicare Payment Advisory Commission, *MedPAC Report to the Congress: Medicare Payment Policy*, at 237-274 (March 2008)

20 See California Health Advocates’ Congressional testimony and policy issue briefs for information on ongoing marketing issues at: <http://www.cahealthadvocates.org/advocacy/index.html#Policy>

21 CMS’ proposed regulation includes requirements that agents selling Medicare products are trained on Medicare rules and regulations, but this does not include Medicare’s interaction with Medicaid. See 73 Federal Register 28556 (May 16, 2008).

22 Special Needs Plans must be organized as either a Health Maintenance Organization or Preferred Provider Organization. In California, all SNPs are organized as HMOs. See Part 2 of this report for discussion of SNPs in more detail.

23 An example of this phenomenon cited by the National Governors Association is found when private entities providing Medicare Part D pharmacy benefits lack a financial incentive to spend money on drugs that would avoid unnecessary long-term nursing facility stays- which are paid for by Medicaid. Therefore, the preventative cost expenditures to avoid more expensive care and institutionalization later on is never made. It is generally acknowledged that most individuals wish to avoid long-term nursing home stays and prefer to remain at home. See National Governors Association “Dual Eligibles: Making the Case for Federalization” February 2005.

24 An illustration of this situation can be found in accessing home health benefits. Medicare has a requirement that beneficiaries who receive this service are “homebound”. Medicaid has more generous guidelines. If Medicare denies home health services because an individual is not homebound, and Medicaid denies the same services under the assertion that the individual is, indeed, homebound and Medicare is primary, the beneficiary may be denied care through both programs. See National Governors Association “Dual Eligibles: Making the Case for Federalization” February 2005.

25 Qualified Medicare Beneficiaries (QMB) are not liable for Medicare associated costs (premiums, deductibles, or copayments) regardless of Medicaid coverage for the same services. A provider who is unable to bill Medicaid may not balance bill the QMB.

26 Prior authorization requirements, required referrals, and service denials can all lead to delays in, or outright refusals of, requests for needed health services and medical supplies and equipment.

27 73 Federal Register 28556 (May 16, 2008).

28 Edward Alan Miller & William G. Weissert, “Managed Care for Medicare-Medicaid Dual Eligibles: Appropriateness, Availability, Payment, and Policy”, *Journal of Applied Gerontology* 2004;23:333.

29 In California, regional and local PPOs appear to have very few dual eligible enrollees.

- 30 See, e.g., Senate Finance Committee, Senate Special Committee on Aging, House Ways and Means Health Subcommittee, and House Energy & Commerce Oversight Subcommittee hearings and testimony pertaining to marketing issues and PFFS plans in 2007 and 2008.
- 31 Correspondence between California Health Advocates and the California Medical Association, February 2008 (on file with authors).
- 32 The State Health Insurance Assistance Program (SHIP) offers independent and individualized free counseling to Medicare beneficiaries. These networks are typically under-funded and under-staffed due to the increase in both the complexity of Medicare and the proliferation of plan choices under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub. L. 108-173). In California, the SHIP program is known as the Health Insurance Counseling and Advocacy Program (HICAP).
- 33 See Medicare Payment Advisory Commission, *MedPAC Report to the Congress: Medicare Payment Policy*, at 237-274 (March 2008) for discussion on the importance of coordinated care to deliver optimal services for dual eligible beneficiaries.
- 34 See, e.g., Senate Finance Committee, Senate Special Committee on Aging, House Ways and Means Health Subcommittee, and House Energy & Commerce Oversight Subcommittee hearings and testimony pertaining to marketing issues and PFFS plans in 2007 and 2008.
- 35 Id.
- 36 Id.
- 37 Testimony of Francis S. Soistman, Jr., Executive Vice President, Coventry Health Care, Inc., before House Energy & Commerce Subcommittee on Oversight & Investigations, June 26th 2007, available at: http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.062607.Soistman-testimony.pdf
- 38 Although WellCare Health Plans, Inc. generally denies that it specifically targeted dual eligibles for enrollment in their Duet plan, the company has discontinued marketing materials targeted towards duals and has renamed the Duet plan "Melody," in part, in response to such criticism. See, e.g., April 30, 2008 letter from WellCare to Abby Block at CMS, and April 30, 2008 WellCare letter to California Health Advocates, both on file with the authors.
- 39 Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) §165, Pub. L. 110-275.
- 40 Center for Medicare Advocacy, Inc. Weekly Alert "Medicare Cost-Sharing for Dual Eligibles: Who Pays What for Whom?" April 24, 2008 at http://www.medicareadvocacy.org/MedSavProgs_08_04.24.CostSharing.htm referencing June 11, 2007 Memorandum from Gale P. Arden, Director, Disabled and Elderly Health Programs Group to All Associate Regional Administrators, Division of Medicaid and Children's Health, Subject: Medicaid Obligations for Cost-Sharing in Medicare Part C Plans, Attachment.
- 41 73 Federal Register 28556 (May 16, 2008).
- 42 Id.
- 43 CMS Guidance to Medicare plans from Abby Block, Director, Center for Drug and Health Plan Choice, Centers for Medicare and Medicaid Services. September 15, 2008.
- 44 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275; 73 Federal Register 54226 (September 18, 2008).
- 45 Id.
- 46 Id.
- 47 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 48 Id.
- 49 73 Federal Register 28556 (May 16, 2008).
- 50 Medicare Improvement for Patients and Providers Act of 2008 §165, Pub. L. 110-275.
- 51 73 Federal Register 54226 (September 18, 2008).
- 52 Id.
- 53 73 Federal Register 28556 (May 16, 2008).
- 54 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 55 73 Federal Register 54226 (September 18, 2008).
- 56 See, e.g., Senate Finance Committee, Senate Special Committee on Aging, House Ways and Means Health Subcommittee, and House Energy & Commerce Oversight Subcommittee hearings and testimony pertaining to marketing issues and PFFS plans in 2007 and 2008.
- 57 Medicare Improvement for Patients and Providers Act of 2008 §103, Pub. L. 110-275.
- 58 73 Federal Register 54208 (September 18, 2008).
- 59 Medicare Improvement for Patients and Providers Act of 2008 §103, Pub. L. 110-275.
- 60 Id., at §162.
- 61 Based upon CMS' Landscape of Plans for 2009 information released in September 2008, 21 counties in California will have no local coordinated care plans (e.g. HMOs) and of the 37 counties with local coordinated care plans, 9 will have only one HMO option available, meaning that 30 out of California's 58 counties would continue to operate under current PFFS rules. See CMS 2009 landscape of plans for California at <http://www.cms.hhs.gov/prescriptiondrugcovgenin/>.
- 62 Medicare Prescription Drug Improvement and Modernization Act of 2003 Pub. L. 108-173.
- 63 Medicare Improvement for Patients and Providers Act of 2008 §162, Pub. L. 110-275.
- 64 Testimony of Abby Block, Director of Division of Beneficiary Choices, before House Ways & Means Subcommittee on Health, May 22nd 2007, available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=5962>.
- 65 Congressional Budget Office, Economic and Budget Issue Brief "Medicare Advantage: Private Health Plans in Medicare" (June 28, 2007).

ENDNOTES PART 2

- 1 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 2 Id.
- 3 Kaiser Family Foundation, Medicare Special Needs Plan (SNP) Offerings by Plan Type, 2008 <http://www.statehealthfacts.org/comparetable.jsp?ind=333&cat=6>.
- 4 See CMS 2009 landscape of plans for California <http://www.cms.hhs.gov/prescriptiondrugcovgenin/>.
- 5 See CMS 2008 landscape of plans for California and CMS 2009 landscape of plans for California <http://www.cms.hhs.gov/prescriptiondrugcovgenin/>.
- 6 SNPs are required to offer the Part D drug benefit unlike other MA plans.
- 7 Examples of successful demonstration programs are Massachusetts, Minnesota and Wisconsin which used comprehensive integration models to design programs for dually eligible beneficiaries. These programs streamlined enrollment, and created consistency among grievance and appeal, bidding, and quality assurance and improvement processes. See Paul Saucier, et. al., "The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care Final Report" (January 2007) *Thomson Medstat*.
- 8 Demonstrations that integrated Medicare and Medicaid in Massachusetts, Minnesota, and Wisconsin were established as permanent options through the creation of SNPs. See Medicare Payment Advisory Commission, *MedPAC Report to the Congress: Medicare Payment Policy*, Chapter 3 Update on the Medicare Advantage Program (March 2008). Social Health Maintenance Organization (S/HMO-I and S/HMO-II) and EverCare are no longer demonstrations and have become SNPs. In California, the S/HMO SCAN is now a SNP. Note: the Program of All-Inclusive Care for the Elderly (PACE) also offers integrated Medicare and Medicaid services. This program was established as a permanent option under both programs within the Balanced Budget Act of 1997 (Pub. L. 105-33).
- 9 Minnesota and Wisconsin demonstrations showed evidence of decreased utilization of services (indicating success in substituting community services and care coordination for institutional services), fewer hospital days, reduced length of hospital stays, the ability to prevent hospital admissions and reduced emergency department services. See Christine Bishop, et. al., "Medicare Special Needs Plans Lessons from Dual Eligible Demonstrations for CMS States Health Plans and Providers" (2007) Brandeis University, Prepared for Centers for Medicare and Medicaid Services. Also see, Paul Saucier, et. al., "The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care Final Report" (January 2007) *Thomson Medstat*.
- 10 See Section 1115 of Medicaid and Section 222 of Medicare federal waivers for demonstration programs. See also: Karen Tritz, "Integrating Medicare and Medicaid Services Through Managed Care" *CRS Report for Congress* (June 2006), and Christie Provost Peters, "Medicare Advantage SNPs: A New Opportunity for Integrated Care?" (November 11, 2005) National Health Policy Forum Issue Brief No.808.
- 11 See, e.g., <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912>.
- 12 73 Federal Register 54226 (September 18, 2008).
- 13 Christine Bishop, et. al., "Medicare Special Needs Plans Lessons from Dual Eligible Demonstrations for CMS States Health Plans and Providers" (2007) Brandeis University, Prepared for Centers for Medicare and Medicaid Services.
- 14 See *Community Catalyst* "Medicare Special Needs Plans: A Critical Need for Quality Standards of Care", June 2008.

- 15 According to CMS April 2008 figures, in California there are 194,561 Medicare beneficiaries enrolled in SNPs. Of these, 103,411 are in Dual SNPs. From 2006-2008, passive enrollment into SNPs by the Medi-Cal County Organized Health Systems (COHS) in Orange County and San Mateo, along with passive enrollment in the Kaiser health plans in 2007, contributed significantly to the number of SNP enrollees. Dual-eligible Kaiser enrollees at end of 2006 (approx 50,000) were passively enrolled/ "mapped" into Kaiser's SNP. Similarly, the large number of enrollees in institutionalized SNPs in California is largely a result of the SCAN health plan changing its designation from a demonstration Social-HMO to a SNP.
- 16 Alissa E. Halperin, Managing Attorney, Pennsylvania Health Law Project, author of a paper for the Center for Medicare Advocacy entitled "Medicare Advantage Special Needs Plans: A Beneficiary Perspective" (October 2007); also see, generally, Center for Medicare Advocacy's Special Needs Plan Conference materials (October 2007), available at: <http://www.medicareadvocacy.org/SNP%20Conference/Home.htm>.
- 17 See, e.g., James Verdier and Melanie Au, "Medicare Advantage Special Needs Plans Site Visits" at p.11 (June 2006) Mathematica Policy Research Inc.
- 18 Medicare Prescription Drug Improvement and Modernization Act of 2003 Pub. L. 108-173; also see Paul Saucier, et. al., "The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care Final Report" (January 2007) *Thomson Medstat*.
- 19 James Verdier and Melanie Au, "Medicare Advantage Special Needs Plans Site Visits" at p.11 (June 2006) Mathematica Policy Research Inc.
- 20 The Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles and Medicare Part D" (May 2006).
- 21 See Part 1 of this report.
- 22 See text box in Part 1 of this report.
- 23 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 24 Id.
- 25 "Special needs individuals" (SNP) were identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions. See <http://www.cms.hhs.gov/specialneedsplans/> for general information.
- 26 73 Federal Register 28556 (May 16, 2008).
- 27 Id.
- 28 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 29 Id.
- 30 See California Health Advocates' comments to 73 Federal Register 28556 (May 16, 2008) at <http://www.cahealthadvocates.org/advocacy/index.html#Letters>. Note that these comments were drafted in partnership with several other consumer advocacy organizations. For language access issues in particular, see National Senior Citizens Law Center's website at www.nslc.org.
- 31 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 32 Id.
- 33 Id.
- 34 Id.
- 35 Karen Tritz, "Integrating Medicare and Medicaid Services Through Managed Care" *CRS Report for Congress* (June 2006).
- 36 The authors are suggesting a legislative change, not one that CMS can impose on its own.
- 37 Karen Tritz, "Integrating Medicare and Medicaid Services Through Managed Care" *CRS Report for Congress* (June 2006).
- 38 CMS' proposed regulation includes minimum standards, applicable only to SNPs, of a "documented relationship with the State Medicaid agency..." with the means to identify Medicaid providers. See 73 Federal Register 28556 (May 16, 2008).
- 39 73 Federal Register 28556 (May 16, 2008).
- 40 Id.
- 41 See, e.g., *Situ v. Leavitt* No. C06-02841-TEH (N.D.Cal.), filed April 26, 2006 by the Center for Medicare Advocacy and National Senior Citizens Law Center.
- 42 James Verdier and Melanie Au, "Medicare Advantage Special Needs Plans Site Visits" at p.12 (June 2006) Mathematica Policy Research Inc.
- 43 See Center for Medicare and Medicaid Services Letter to State Medicaid Directors SMDL #08-007 October 3, 2008 which allows states to request and obtain more data regarding duals.
- 44 Id.
- 45 Id.
- 46 Id.
- 47 Id.
- 48 Id.
- 49 Paul Saucier, et. al., "The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care Final Report" (January 2007) *Thomson Medstat*.
- 50 Medicare Improvement for Patients and Providers Act of 2008 §165, Pub. L. 110-275.
- 51 Mary Ashkar, Vicki Gottlich and Patricia Nemore, "Medicare Advantage: What's the Advantage If You've Got Medicaid, Too?" *Clearinghouse Review*, Vol.42 Pg 232, Sept-Oct 2008.
- 52 See Part 1 of this report for further discussion, including perceived drawbacks to enforcement through provider contracts; see also Center for Medicare Advocacy, Inc. *Weekly Alert* "Medicare Cost-Sharing for Dual Eligibles: Who Pays What for Whom?" April 24, 2008 at http://www.medicareadvocacy.org/MedSavProgs_08_04.24.CostSharing.htm referencing June 11, 2007 Memorandum from Gale P. Arden, Director, Disabled and Elderly Health Programs Group to All Associate Regional Administrators, Division of Medicaid and Children's Health, Subject: Medicaid Obligations for Cost-Sharing in Medicare Part C Plans, Attachment.
- 53 CMS Guidance to Medicare plans from Abby Block, Director, Center for Drug and Health Plan Choice, Centers for Medicare and Medicaid Services, September 15, 2008.
- 54 A disproportionate percentage of duals have characteristics that are known barriers to accessing care (i.e. poor, uneducated, unmarried, non-white, female).
- 55 Edward Alan Miller & William G. Weissert, "Managed Care for Medicare-Medicaid Dual Eligibles: Appropriateness, Availability, Payment, and Policy", *Journal of Applied Gerontology* 2004; 23:333; also see Medicare Payment Advisory Commission, *MedPAC Report to the Congress: New Approaches in Medicare*, at 81 (June 2004).
- 56 Medicare Improvement for Patients and Providers Act of 2008 §164 (Pub. L. 110-275) imposes care management requirements effective January 1, 2010.
- 57 73 Federal Register 54226 (September 18, 2008).
- 58 See, e.g., Jennifer Podulka, Medicare Payment Advisory Commission (MedPAC), Medicare Advantage Special Needs Plans presentation slides (October 2007).
- 59 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 60 Id.
- 61 See California Health Advocates' comments to 73 Federal Register 28556 (May 16, 2008) at <http://www.cahealthadvocates.org/advocacy/index.html#Letters>. Note that these comments were drafted in partnership with several other consumer advocacy organizations.
- 62 73 Federal Register 28556 (May 16, 2008).
- 63 Id.
- 64 See California Health Advocates' comments to 73 Federal Register 28556 (May 16, 2008) at <http://www.cahealthadvocates.org/advocacy/index.html#Letters>. Note that these comments were drafted in partnership with several other organizations.
- 65 Id.
- 66 James Verdier and Melanie Au, "Medicare Advantage Special Needs Plans Site Visits" at p.22 (June 2006) Mathematica Policy Research Inc.
- 67 Medicare Improvement for Patients and Providers Act of 2008 §164, Pub. L. 110-275.
- 68 73 Federal Register 54226 (September 18, 2008); note that while coordination of care and case management are captured to a certain extent in 2008 quality measures, the ability to ascertain access and availability of care is not included until phase 3 (2010) measurements -- see <http://www.ncqa.org/tabid/620/Default.aspx> SNP Training #3 Mar-April 08 powerpoint .
- 69 Alissa E. Halperin, "The Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania" (2007).
- 70 Christie Provost Peters, "Medicare Advantage SNPs: A New Opportunity for Integrated Care?" (November 11, 2005) National Health Policy Forum Issue Brief No.808; also see Alissa E. Halperin, "The Medicare Advantage Special Needs Plan Experience: Beneficiary Perspective from Pennsylvania" (2007).
- 71 Paul Saucier, et. al., "The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care Final Report" (January 2007) *Thomson Medstat*.
- 72 Congressional Budget Office, Economic and Budget Issue Brief, "Medicare Advantage: Private Health Plans in Medicare" (June 28, 2007).
- 73 April 2008 CMS figures.
- 74 See discussion at Endnote 15.
- 75 Karen Tritz, "Integrating Medicare and Medicaid Services Through Managed Care" *CRS Report for Congress* (June 2006).