

STATE PURCHASING STRATEGIES
DRIVE STATE CONTRACTS WITH
MEDICARE SPECIAL NEEDS PLANS

JUNE 2009

DRAFT


ASPE SERIES ON SPECIAL NEEDS PLANS AND
STATE MEDICAID PROGRAMS: ISSUE BRIEF NO. 2



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SUMMARY

Beginning in 2010, new and expanding Medicare Special Needs Plans (SNPs) for dual-eligibles must have contracts in place with state Medicaid agencies to coordinate Medicare and Medicaid benefits for their members. This brief provides information on the extent and nature of SNP-state contracting in 2008, the last year in which new SNPs were authorized prior to a federal moratorium. With the moratorium now lifted for plan year 2010, past contracting practices provide insight into how and why future SNP-state relationships will take shape. Key findings include:

- Eighteen states contracted with dual-eligible SNPs in 2008. This represented a slight change from the 2006-2007 period, despite significant growth in the number of dual-eligible SNPs between 2006 and 2008.¹
- SNP-state contracts fell into three categories, based on state purchasing strategy:
 - A) Contracts which promoted Medicare-Medicaid coordination/integration;
 - B) Medicaid managed care contracts which included duals, and where the Medicaid plan or its corporate sponsor held a parallel SNP contract;
 - C) Medicaid contracts for Medicare cost-sharing only.
- Existing state Medicaid contracts with SNPs raise important definitional questions about the dual-eligible SNP contracting mandate established under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). A dual-eligible SNP is often operated as a distinct product within a larger corporate entity. The corporate parent may or may not also operate a Medicaid managed care contract that includes dual-eligibles (also referred to as “duals”). What types of contracts between states and SNPs (or their corporate parents) meet the MIPPA requirement is ambiguous in many situations.

Placing the new federal contracting mandate in the context of existing state practice underscores the need for greater dual-eligible policy coordination between the federal and state governments. While state and federal policy makers share the goal of greater service coordination for dual-eligibles, state approaches to achieving the goal vary according to a state’s Medicaid purchasing strategy generally, and its approach to long-term services in particular. Federal mandates for more coordinated management of dual-eligibles must recognize state Medicaid long-term care purchasing objectives as well as Medicare purchasing strategies for medical care.

¹ We assessed SNP-state contracting for calendar year 2008. SNP-state contracting in 2006-07 is reported in Chapter V of the federal evaluation of the SNP program: Schmitz R, Merrill A, Schore J, Shapiro R, and Verdier J (2008). *Evaluation of Medicare Advantage Special Needs Plans, Summary Report*. Submitted by Mathematica Policy Research, Inc. to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.



BACKGROUND

The high costs and fragmented care provided to persons dually eligible for Medicare and Medicaid are matters of increasing focus among the federal and state health policy communities. The 8.8 million persons who are eligible for both Medicare and Medicaid benefits accounted for almost half of all Medicaid spending in 2005, and about 25 percent of Medicare spending.² Various models of health care financing and delivery which can more effectively address cost and quality issues for dual-eligibles have been tested for two decades, but no single approach has yet been embraced universally and brought to national scale. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress authorized, for the first time, the establishment of Medicare managed care plans that focused solely on enrolling and managing care for persons with dual eligibility.³ These plans—called Special Needs Plans (SNPs)—grew rapidly in their first five years of federal authority, and by 2008, there were approximately 436 SNPs serving dual-eligibles, with a total enrollment of approximately 906,000.⁴

While some observers believed that SNPs could become the national model for serving dual-eligibles, it became clear that more formal mechanisms would be needed if SNPs were to become the vehicle for integrating federal Medicare services with state Medicaid services. In 2008, Congress created new requirements for dual eligible SNPs in the Medicare Improvements for Patients and Providers Act (MIPPA), mandating increased Medicare-Medicaid coordination. Specifically, MIPPA requires all new SNPs established after January 1, 2010, and any existing SNP which wants to expand its service area, to have a contract with its respective state Medicaid agency for the coordination of Medicaid services.⁵

In order to better understand the MIPPA mandate for SNP-state contracting, it is important to understand the current status of SNP contracting with state Medicaid agencies for their dually eligible members. Prior to MIPPA, a number of SNPs already had state Medicaid contracts for their members and were already coordinating both Medicare and Medicaid benefits. Indeed, a number of SNPs were Medicaid managed care plans that served dual-eligibles *prior* to applying for SNP certification status. Other SNPs were operating under as special demonstrations to test integrated care models for dual-eligibles, and converted from a demonstration authority to the SNP authority after the enactment of the MMA in 2003. This brief describes the extent of SNP-state contracting in 2008, and the nature of those contractual relationships, in order to better inform federal and state implementation of the new MIPPA mandate, as well as the broader policy objective of improving coordination of Medicare and Medicaid services for dual-eligibles.

² Holahan J, Miller D, Rousseau D (2009). *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005*. Kaiser Commission on Medicaid and the Uninsured.

³ Saucier P, Kasten J, and Burwell B (2009). *Federal Authority for Medicare Special Needs Plans and their Relationship to State Medicaid Programs*. Prepared under contract to the Office of the Assistant Secretary for Planning and Evaluation, HHS.

⁴ CMS SNP Comprehensive Report November 2008 available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/> and Schmitz et al 2008.

⁵ Public Law 110-275, July 15, 2008.



APPROACH

We used numerous data sources to ascertain which dual-eligible SNPs had contracts with state Medicaid programs in 2008. States with high-profile dual eligible programs (e.g., Minnesota, Massachusetts, Wisconsin) which were originally developed as demonstration programs are well documented in the literature and we were able to confirm the existence of contracts with officials in those states. To supplement this information, we reviewed:

1. The federal evaluation of Medicare Advantage SNPs conducted in 2006-2007;⁶
2. Proposals submitted by health plans to the Centers for Medicare & Medicaid Services (CMS) in 2007 to establish or expand SNP products for the 2008 Medicare Advantage contract year; and
3. CMS administrative data related to SNP enrollment and dual-eligible enrollment in Medicaid managed care.

The federal evaluation identifies states with SNP contracts as of 2006-2007. The SNP proposals provide the most current information available on SNP-state contracts from Medicare Advantage Organizations (MAOs) requesting CMS approval to introduce new SNPs or make changes to existing SNPs in 2008.⁷

Using the SNP-state contracts cited in the federal evaluation as a starting point, we analyzed the 2008 SNP proposals to identify new contracts and developing contracts. Since the proposals represented only a subset of SNPs (new SNPs and existing SNPs requesting changes), we used additional sources to confirm the current status of SNP-state contracts referenced in the federal evaluation and to investigate other states we thought might have SNP contracts. We relied on a combination of CMS administrative data and strategic follow-up calls with state Medicaid officials, CMS Regional Office staff, and health plan administrators. First, we validated the possibility of a SNP-state relationship based on CMS reports on dual-eligible enrollment in Medicaid managed care by state in 2007. We assumed a SNP-state relationship would be highly unlikely in states which do not permit dual-eligibles to enroll in Medicaid managed care (with the exception of contracts pertaining solely to Medicare cost-sharing).⁸ For states that include dual-eligibles in Medicaid managed care, we then checked whether the Medicaid managed care organizations (MCOs) operating in these states had companion dual-eligible SNPs.⁹

⁶ Schmitz et al 2008, Table V.1 SNP Activity by State, 2006-2007.

⁷ Starting in contract year 2008, CMS included a series of questions on state contracts in the Medicare Advantage SNP application.

⁸ See the Kaiser Family Foundation's 50-state report of dual-eligible enrollment in Medicaid managed care by plan type as of June 2007 (based on CMS data), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=220&cat=4>. See Saucier P, Burwell B (2007). *The Impact of Medicare Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care: Final Report, January 2007*, submitted by Thomson Medstat to the Centers for Medicare & Medicaid Services; Verdier J, Gold M, Davis S (2008). *Do We Know If Medicare Advantage Special Needs Plans Are Special?* Submitted by Mathematica Policy Research, Inc., to the Henry J. Kaiser Family Foundation; and Schmitz et al 2008, for discussion of the link between the development of SNP-state contracts and Medicaid managed care.

⁹ To identify the Medicaid managed care organizations, we referred to a CMS Medicaid managed care summary statistics report at <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf>. To verify the SNP, we used CMS' SNP Comprehensive Report which shows SNP enrollment by SNP, SNP type, and state at <http://www.cms.hhs.gov/MCRAdvPartDEnrollData/SNP/list.asp>



For additional clarification on some states, we spoke with CMS and state Medicaid agency officials, and health plan administrators familiar with each state's SNP-Medicaid relationship.

FINDINGS

1. Eighteen states contracted with dual-eligible SNPs in 2008. This represented a very slight change from the 2006-2007 period, despite significant growth in the number of dual-eligible SNPs during that period.

As indicated in Table 1, we found a net increase of only 1 additional state contracting with dual-eligible SNPs between 2006 and 2008. This is in contrast to the rapid growth of dual-eligible SNPs in the same period, during which the number of these plans nearly doubled from 225 to 436.¹⁰

The federal evaluation of Medicare SNPs identified 17 states with SNP contracts in the 2006-2007 period.¹¹ We identified 18 states with SNP contracts in 2008. We found two additional states, Alabama and Idaho, that had contracts with SNPs, and found that the previously reported contract in Illinois was no longer in effect. The shaded rows in Table 1 highlight differences between our findings and the previous findings.

¹⁰ Centers for Medicare & Medicaid Services (CMS) Special Needs Comprehensive Report November 2008 available at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/> and Schmitz et al 2008, Table II.1.

¹¹ SNP-state contracting in 2006-07 is reported in Chapter V of the federal evaluation of the SNP program: (Schmitz et al 2008).



TABLE 1. STATES CONTRACTING WITH DUAL-ELIGIBLE SNPs

2006-2007	2008
	Alabama
Arizona	Arizona
California	California
Colorado	Colorado
	Idaho
Illinois	
Kentucky	Kentucky
Massachusetts	Massachusetts
Minnesota	Minnesota
New Jersey	New Jersey
New Mexico	New Mexico
New York	New York
Oregon	Oregon
Tennessee	Tennessee
Texas	Texas
Utah	Utah
Washington	Washington
Wisconsin	Wisconsin
Puerto Rico	Puerto Rico
Total States: 17	18

Source for 2006-2007: Schmitz et al (2008)



2. Existing SNP-state contracts fall into one of three categories, based largely on state purchasing strategy:

- A) Medicare-Medicaid Coordination/Integration;
- B) Medicaid Managed Care; and
- C) Capitated Cost Sharing.

The presence of a SNP-state contract may be an indicator of Medicare-Medicaid coordination, but the range of existing contractual relationships points to a continuum of coordination efforts. Table 2 categorizes the relationships as demonstrated in the contracts themselves and in related program materials. Figure 1 provides a map of the type of contractual relationship by state.

Category A, Medicare-Medicaid Coordination/Integration, includes state programs where coordination or integration of Medicare and Medicaid is a key program goal. These include the Massachusetts Senior Care Options and Minnesota Senior Health Options programs, which were designed to integrate the full range of primary, acute and long term care for dually eligible beneficiaries. These programs are voluntary for both Medicaid and Medicare, and members are choosing dual enrollment when they opt into the program.

Also in Category A are mandatory Medicaid managed long term care programs, including the oldest state program (Arizona's Long Term Care System) and the most recent effort (New Mexico's Coordinated Long Term Services program). In these programs, the state promotes coordination by requiring its vendors to offer Medicare Advantage companion plans, but because Medicare enrollment may never be compulsory under federal law, only a subset of the state programs' Medicaid enrollees are also enrolled for Medicare services. Those who do not select their Medicaid plan's companion Medicare product continue to receive Medicare services in whatever manner they were receiving it before enrolling the state's managed long term care program.

Category B is comprised of Medicaid Managed Care programs that include dually eligible beneficiaries but focus on Medicaid services. As part of a business strategy, some of a state's Medicaid contractors also offer Medicare services through a companion SNP, but the state has no contractual expectations in this regard. In Category B programs, only a subset of participating Medicaid plans offer SNPs. Coordination of Medicaid and Medicare services is possible, but depends on the offerings of a particular plan. The dynamics of dual enrollment vary by plan, as the following examples illustrate.

1. AmeriChoice Personal Care Plus: Medicare enrollment leading to Medicaid enrollment in New Jersey. AmeriChoice Personal Care Plus is a dual-eligible SNP operating in eleven New Jersey counties. It is also one of several health plans from which New Jersey Medicaid beneficiaries, including but not limited to dual-eligibles, can choose for their Medicaid services. AmeriChoice Personal Care Plus views itself first and foremost as a Medicare Advantage SNP, and its business model focuses on attracting new Medicare members. When it does, it lets members know that they can also receive their Medicaid services through AmeriChoice, and refers them to New Jersey's Medicaid enrollment broker. If the member also chooses AmeriChoice for its Medicaid, the result is dual enrollment for both Medicaid and Medicare. Long term care is not part of New Jersey's Medicaid HMO program, so that remains outside AmeriChoice either way.

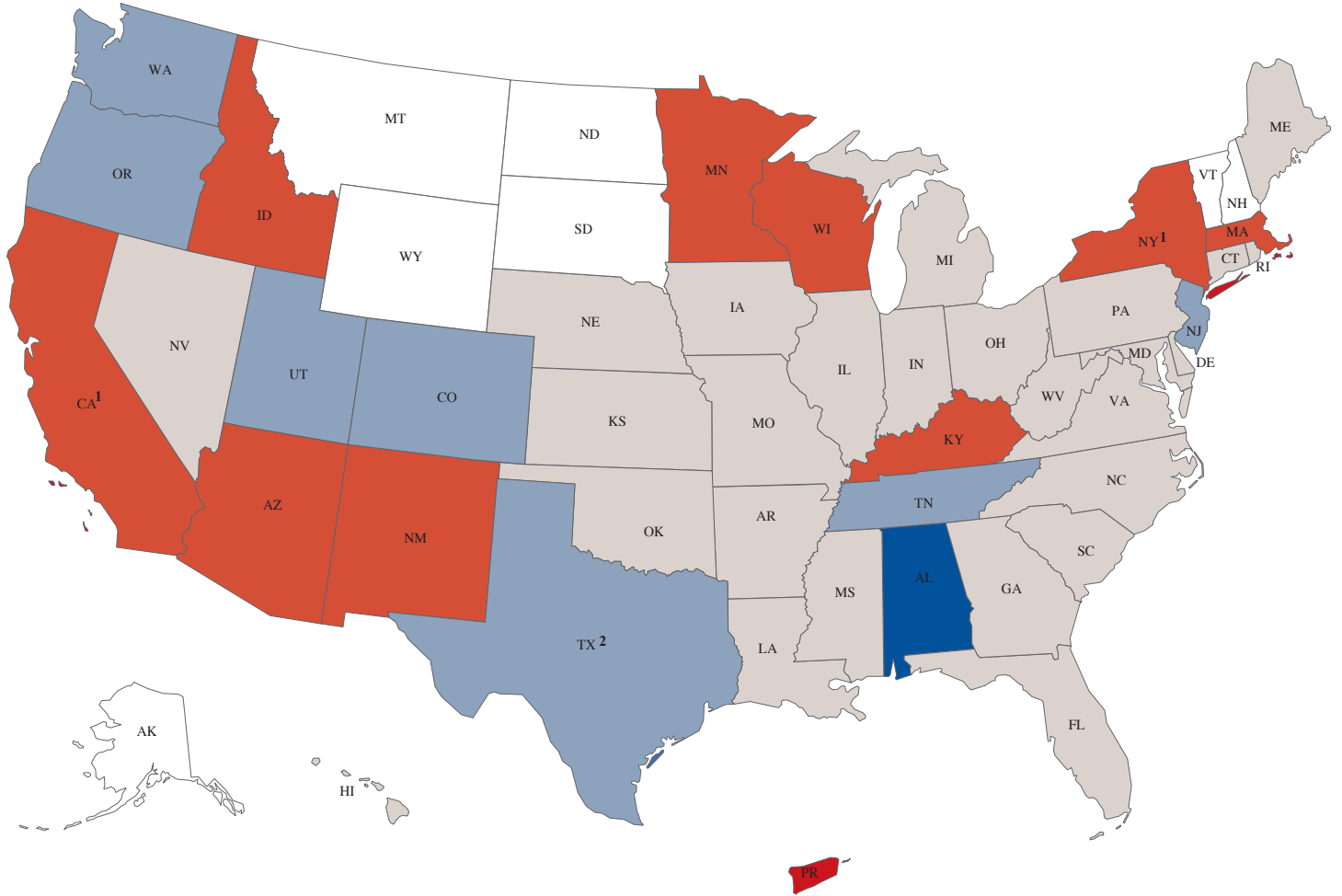


TABLE 2. SNP-STATE CONTRACTS CATEGORIZED BY STATE PURCHASING STRATEGY






	A. MEDICARE-MEDICAID COORDINATION/INTEGRATION	B. MEDICAID MANAGED CARE	C. CAPITATED COST SHARING
Characteristics	<p>Medicare-Medicaid coordination or integration is an articulated program expectation.</p> <p>Beneficiary enrollment in both Medicaid and Medicare managed care products is required or encouraged.</p>	<p>SNP or its parent MCO has a Medicaid managed care contract with the State that includes dually eligible beneficiaries.</p>	<p>SNP contract with Medicaid only covers the State’s cost sharing obligations.</p>
State Programs	<p>Arizona Long Term Care System</p> <p>California SCAN plan and some County Operated Health Systems</p> <p>Idaho Medicare-Medicaid Coordinated Benchmark Benefit Plan</p> <p>Kentucky Passport Advantage</p> <p>Massachusetts Senior Care Options</p> <p>Minnesota Senior Health Options and Disability Health Options</p> <p>New Mexico Coordinated Long Term Services</p> <p>New York Medicaid Advantage and Medicaid Advantage Plus</p> <p>Puerto Rico Platino</p> <p>Wisconsin Family Care Partnership</p>	<p>Colorado Health Access</p> <p>New Jersey HMO Program</p> <p>New York Managed Long Term Care Program</p> <p>Oregon Health Plan</p> <p>TennCare</p> <p>Texas Star+Plus</p> <p>Utah Health Program</p> <p>Washington Medicaid Integration Partnership</p>	<p>Alabama Healthspring Agreement</p> <p>Texas Medicare Advantage Health Plan Agreements</p>



FIGURE 1. CONTRACTING STATUS OF STATE MEDICAID PROGRAMS WITH DUAL-ELIGIBLE SPECIAL NEEDS PLANS IN 2008



Legend


	No Dual-Eligible SNPs
	No SNP-State Contracts
	SNP-State Contract: Medicare-Medicaid Coordination/Integration
	SNP-State Contract: Medicaid Managed Care
	SNP-State Contract: Capitated Cost-sharing

Source: Thomson Reuters analysis of 2008 SNP proposals, CMS administrative data, and phone interviews.

1: Also has SNP-State contract for Medicaid managed care

2: Also has SNP-State contract for capitated cost-sharing





2. *AmeriGroup's Star+Plus Program in Harris County, Texas: Medicaid enrollment leading to Medicare enrollment.* AmeriGroup is one of two health plans offering Star+Plus in Harris County (Houston), Texas. Star+Plus is a Medicaid program that includes primary, acute and long term care services to SSI-eligible adults of all ages. The program serves older persons with long term care needs, as well as younger adults with disabilities. Many, but not all, are dually eligible. For those who are, AmeriGroup offers a dual-enrollment option through Amerivantage Specialty + Rx, a dual-eligible SNP. Star+Plus is mandatory for Medicaid, so AmeriGroup has a readily-identified group of Medicaid members to whom it can offer its companion Medicare plan.

3. *VNS CHOICE Medicare: Dual enrollment in either direction.* The Visiting Nurse Service of New York operates a New York Medicaid MLTC (Managed Long Term Care) program, in which Medicaid beneficiaries certified for nursing-home level care can receive alternative care in the community. As a longstanding provider of Medicare home health and related services, VNS was also able to coordinate Medicare services on a fee-for-service basis. In 2006, VNS entered the SNP market with three products. All three were targeted to VNS's traditional client base of low-income beneficiaries. One of the three, MLTC Plus, was specifically designed as an add-on to VNS's already existing Medicaid MLTC program, allowing an MLTC enrollee to add Medicare to achieve a comprehensive package. The other two are marketed as Medicare-only products, but as the members of those products develop long term care needs, an opportunity exists to offer them the Medicaid MLTC plan.

Finally, Category C is comprised of contracts that address cost sharing only. These contracts are narrowly written to address only one benefit: the state Medicaid program's obligation to pay Medicare cost sharing for low income beneficiaries. In these programs, the primary goal appears to be administrative simplification by paying a set capitation to the plan for cost sharing, rather than processing cost sharing claims on an encounter-by-encounter basis.



3. Existing contracts raise an important definitional question about the MIPPA contracting requirement. SNPs are often operated as distinct products within a larger health carrier's array which could include Medicaid managed care plans. In some instances, it is difficult to know whether the state contract is with the SNP or with a Medicaid plan owned by the same parent company. If the latter, the contract's application to the SNP is unclear.

As we reviewed the state contracts section of the 2008 SNP proposals to CMS, we noted some ambiguities in applicants' responses as to the existence of state contracts. Some MAOs responded that they had contracts with state Medicaid agencies, but upon further examination it became clear that they were referring to contracts for participation in Medicaid managed care programs, some of which excluded dual-eligibles. Even if duals were included in the managed care programs, some contracts were not necessarily for the specific SNPs' services, nor did they necessarily include provisions for coordinating Medicare and Medicaid benefits. At issue is whether such arrangements will meet the MIPPA SNP-state contracting requirement.


DISCUSSION

Our analysis of the status of SNP-state contracting prior to the MIPPA mandate demonstrates a broad range of relationships between states and SNPs. While there are a number of relationships in which the clear policy goal is integration of Medicare and Medicaid benefits for dual-eligibles, the most interesting finding of our analysis was the large number of contracts which fell into "Category B", where the nature of the SNP-state relationship is considerably more opaque, and whether or how Medicaid and Medicare benefits are coordinated appears to depend on the particular business strategy of a health plan, rather than the program design of the state.

In the further evolution of policy regarding SNP-state contracting, it is important to recognize that most SNPs are part of larger corporate entities. The federal evaluation showed that 86 percent of SNPs were not "stand-alone" organizations. In our analysis of SNP-state contracting, we found many instances in which the SNP parent organization also had a Medicaid managed contract that served dual-eligibles, at least some of whom could be members of both plans, but in which the coordination of care practices across the two plans was not explicitly addressed in the state's Medicaid managed care contract.

Second, it is also important to recognize the enrollment patterns across Medicaid and Medicare SNP contracts held by the same parent organization are, in most cases, asynchronous. For example, the Medicaid contract may cover a broad population of aged and disabled Medicaid recipients, some of whom are duals and others not. In another case, a Medicaid contract may mandate enrollment for duals, but the Medicare SNP enrollment must remain voluntary. Thus, it is not possible for the Medicaid plan to "capture" and coordinate benefits for all of its duals on the Medicare side. A Medicaid plan may have large Medicaid dual enrollment, but low Medicare SNP enrollment, due to its voluntary nature. Indeed, it is possible that dual-eligibles enrolled in a large Medicaid plan are enrolled in a number of different SNP plans, only one of which is associated with the Medicaid plan.





Third, it is important to recognize that unlike Medicare managed care, where MA organizations generally cover all Medicare benefits, Medicaid plans often cover only a subset of Medicaid benefits. For example, a number of states have initiatives in which dual-eligibles are enrolled in specialty behavioral health care plans for the management of mental health services. In these cases, in order to effectively coordinate services, a SNP needs to coordinate with both Medicaid behavioral health vendors and other Medicaid providers who remain fee-for-service.

Better care coordination practices across the full spectrum of Medicare and Medicaid benefits for dual-eligibles is a laudable policy goal. However, coordinated care models for dual-eligibles must recognize that Medicare purchasing strategies for duals, and state Medicaid purchasing strategies for duals, have distinct, and sometimes inconsistent, objectives. The MIPPA mandate for SNPs to secure Medicaid contracts for their dually eligible members may help to promote integrated care models, but only from the Medicare perspective. States have their own purchasing strategies for dual-eligibles, which are usually more focused on improved management of long-term service benefits. Public policy initiatives to better manage acute and long-term care services for dual-eligibles need to take a collaborative approach between the interests of the federal government and the states.

If integrated care models for dual-eligibles are to enter the mainstream, there needs to be greater collaboration between the federal government and the states in bringing their respective purchasing strategies into alignment.

