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Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer

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ABSTRACT: The Special Needs Plan (SNP), a new type of Medicare Advantage plan created by the Medicare Modernization Act of 2003 (MMA), targets one of three special-needs populations—including beneficiaries who qualify both for Medicare and Medicaid benefits ("dual eligibles"), the focus of this issue brief. It identifies the key issues that underlie one of the MMA's central goals for dual-eligible SNPs—"the potential to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan"—and it outlines their progress thus far. The brief observes that true coordination between SNPs and Medicaid programs, despite some state and federal initiatives, has largely failed to occur, and it discusses some of the reasons why. Consequently, the brief offers recommendations for improving dual-eligible SNPs' prospects and extending their lives (legal authorization for SNPs is scheduled to expire at year-end 2008).

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Overview

The Special Needs Plan (SNP), a new type of Medicare Advantage plan, was authorized by the Medicare Modernization Act of 2003 (MMA) to target any one of three special-needs populations—beneficiaries who are institutionalized, have severe or disabling chronic conditions, or qualify both for Medicare and Medicaid benefits ("dual eligibles"). This issue brief focuses on SNPs for dual eligibles.

The nation's approximately 7 million dual eligibles have been deemed a special-needs population because they are likely to be in poorer health than other Medicare beneficiaries. They are 50 percent more likely to have diabetes, 600 percent more likely to reside in a nursing facility, and 250 percent more likely to have Alzheimer's disease. Consequently, dual eligibles require more resources. In 2002, they comprised 17 percent of Medicare beneficiaries yet accounted for

29 percent of Medicare spending, and while they comprised only 14 percent of Medicaid beneficiaries in 2003 they accounted for 40 percent of Medicaid expenditures.[1] The benefits provided to dual eligibles through the two programs overlap to some extent (e.g., both Medicare and Medicaid cover many acute and ambulatory care services), but they also tend to be complementary (Medicare covers hospital care and post-acute rehabilitation, for example, while Medicaid covers long-term nursing home care). Efforts have been made over the years to improve the coordination of the two programs, but these efforts have not been as successful as hoped.[2]

SNPs were introduced as one way to better coordinate Medicare and Medicaid benefits. According to the Centers for Medicare and Medicaid Services (CMS), they have "the potential to offer the full array of Medicare and Medicaid benefits, and supplemental benefits, through a single plan so that beneficiaries have a single benefit package and one set of providers to obtain the care they need."

In the pages that follow, we describe Medicare Advantage SNPs for dual eligibles and the legislation that established this new type of specialty health plan; provide a snapshot of the SNP participation levels thus far; discuss the opportunities and challenges presented by SNPs; and describe the federal and state actions taken to advance the goal of coordinating care for dual eligibles through SNPs.

Absent reauthorization, the legislative authority for SNPs will expire on December 31, 2008. Therefore this brief also discusses new legislative provisions that would promote more coordinated care and greater accountability, and it addresses the outlook for reauthorization.

SNPs: New Medicare Advantage Plans

Previously, "Medicare+Choice" provided Medicare beneficiaries with the option of enrolling in private plans for their benefits. But in the MMA, Congress replaced Medicare+Choice with Medicare Advantage, which included additional types of private plans to choose from and higher payment rates.

Medicare Advantage plans can be: 1) health maintenance organizations, 2) local or regional preferred provider organizations, 3) private fee-for-service plans, or 4) SNPs.[3] By law, each Medicare Advantage plan must offer additional benefits (in the form of expanded coverage or reduced out-of-pocket payments relative to traditional Medicare) to its enrollees if the aggregate benchmark payment rate for its service area exceeds its anticipated cost of providing traditional Medicare benefits.[4] These additional benefits are intended to induce individuals to join a Medicare Advantage plan and agree to obtain care through its participating network of providers.

SNPs were authorized in Section 231 of the MMA as a special type of Medicare Advantage plan, permitted to enroll targeted subpopulations within Medicare that have special needs. SNPs offer individuals in those populations the option to enroll in a private health plan that specializes in treating their needs—as opposed to receiving their care through the traditional Medicare fee-for-service program or Medicare Advantage plans that treat the general population.

SNPs for dual eligibles were authorized for two reasons. First, Medicare beneficiaries who also qualify for Medicaid, on the basis of poverty or disability, tend to have higher than average—or "special"—needs. Second, because these individuals not only qualify for Medicare benefits but also Medicaid benefits, the potential for coordination of benefits across the two programs creates a unique opportunity for a specialty health plan. It may organize the combined set of services in a way that is most appropriate for the beneficiary.

As with other Medicare Advantage plans, Medicare pays SNPs a capitated payment for each enrollee to provide Medicare Part A (Hospital Insurance) and Medicare Part B (Supplementary Medical Insurance) benefits. But because payments to Medicare Advantage plans are risk-adjusted to reflect the anticipated costliness of each plan's enrollees, the amounts that SNPs receive are generally higher, given that their enrollees are generally sicker or more at risk. In 2006, SNPs were paid rates that on average were

18 percent higher than payments to the average Medicare fee-for-service beneficiary.[5]

The MMA requires that the Secretary of the U.S. Department of Health and Human Services report to Congress by December 31, 2007, on the impact of SNPs on the cost and quality of services provided to Medicare enrollees as well as on any savings to the Medicare program. This report to Congress will be considered when the program is up for reauthorization; the current authorization of SNPs expires on December 31, 2008.

Growth of SNPs

The total number of authorized SNPs—of all three types—has grown rapidly since passage of the MMA. The total went from 11 plans in 2004 to 477 plans in September 2007, including 320 plans for dual eligibles, as shown in Table 1. Enrollment in all types of SNPs now numbers more than 1 million individuals, with over 720,000 in dual-eligible plans. Contractors range from large national health insurance companies to regional Blue Cross/Blue Shield plans. In 2006, 87 percent of SNPs were offered by organizations that also offered regular Medicare Advantage programs.[6]

However, enrollment in capitated Medicaid managed care programs for dual eligibles has been far below that of Medicare managed care SNPs, as shown in Table 2. Of the seven states with existing capitated Medicaid managed care programs targeting dual eligibles,[7] only three have Medicaid enrollments that exceed 10,000 enrollees, and the largest of these programs enrolls just 35,000 dual eligibles.

SNPs for dual eligibles operate or are planned in 42 states and Puerto Rico, as shown in Table 3. States with the most plans are Florida (58 plans), New York (45 plans), and California (26 plans). Puerto Rico, with 33 plans, ranks high as well. The rapid growth of Medicare SNPs in Florida may be due in part to the approval of Florida Senior Care, a new Medicaid managed care program scheduled for implementation in pilot areas of the state in 2008. None of these jurisdictions operates large Medicaid managed care programs for dual eligibles.

Table 1. Number of, and Enrollment in, Special Needs Plans, 2004–07

	All SNPs*		Dual-Eligible SNPs	
Year	Number of Plans	Enrollment	Number of Plans	Enrollment
2004	11	Not available	Not available	Not available
2005	125	Not available	42	Not available
September 2006	276	602,881	256	491,877
September 2007	477	1,021,800	320	722,286

* Includes all types of SNPs.

Source: Centers for Medicare and Medicaid Services, *Special Needs Plan Comprehensive Report,* Sept. 2007. Available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp.

Table 2. Dual Eligible Enrollment in Medicaid Managed Care Programs in States with at Least 10,000 Enrollees

State	Enrollment
Minnesota	35,000
Arizona	24,000
Texas	20,000

Source: P. Saucier and B. Burwell, *The Impact of Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care,* Jan. 2007. Available at http://www.hcbs.org.

Table 3. Special Needs Plans for Dual Eligibles: Number of Plans and Total Enrollment by State (as of Sept. 2007)

State	Number of SNPs	Total SNP Enrollment
States with Operational Programs to Coordinate Medicare and Medicaid Benefits		
Arizona	11	47,557
Massachusetts	11	9,277
Minnesota	13	36,028
New York	45	52,438
Texas	19	38,922
Washington	3	1,474
Wisconsin	4	2,575
States with Planned Programs to Coordinate Medicare and Medicaid Benefits		
Florida	58	55,879
New Mexico	1	269
Other States		
Alabama	3	17,789
Alaska	–	–
Arkansas	5	847
California	26	76,305
Colorado	4	6,484
Connecticut	6	2,308
Delaware	1	–
District of Columbia	–	–
Georgia	8	3,313
Hawaii	3	1,038
Idaho	1	652
Illinois	5	4,821
Indiana	1	384
Iowa	–	–
Kansas	1	11
Kentucky	1	9,638
Louisiana	3	2,063
Maine	2	309
Maryland	3	4,591
Michigan	1	764
Mississippi	1	939
Missouri	3	923
Montana	–	–
Nebraska	2	101
Nevada	2	178
New Hampshire	–	–
New Jersey	1	2,049
North Carolina	1	4,463
North Dakota	–	–
Ohio	3	3,929
Oklahoma	1	311
Oregon	8	17,318
Pennsylvania	11	100,214
Puerto Rico	33	182,990
Rhode Island	2	2,845
South Carolina	1	286
South Dakota	1	170
Tennessee	13	27,336
Utah	2	2,178
Vermont	–	–
Virginia	1	266
West Virginia	–	–
Wyoming	–	–
U.S. Total	**320**	**722,286***

* Includes 54 enrollees that are not included in the state totals. To comply with privacy law requirements, CMS does not specify enrollment for SNPs with enrollments of fewer than 11.

Source: Centers for Medicare and Medicaid Services, *Special Needs Plan Comprehensive Report,* Sept. 2007. Accessed Oct. 5, 2007, at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp.

One-third of dual-eligible SNPs are located in the seven states with operational capitated Medicaid programs that coordinate Medicare and Medicaid benefits. In these states, dual eligibles enrolling in SNPs for their Medicare benefits total 188,271, or 26 percent of total enrollment in dual-eligible SNPs. Two of the seven states—Arizona and Texas—have exclusively mandatory Medicaid managed care programs, though the Texas program does not operate statewide.[8] Minnesota began a mandatory program in 1983 that still exists; the state subsequently launched a separate voluntary program (known as the Minnesota Senior Health Option) that dual eligibles may select instead. The other four states with operational capitated Medicaid managed care programs for dual eligibles—Massachusetts, New York, Washington, and Wisconsin—have exclusively voluntary programs.

Other states with a significant enrollment in Medicare dual-eligible SNPs are Alabama, Oregon, Tennessee, and especially Pennsylvania, with more than 100,000 enrollees. Yet none of these states operates companion Medicaid managed care programs for dual eligibles.

Opportunities and Challenges

SNPs offer the opportunity for significant improvement in the coordination of Medicare and Medicaid benefits for dual eligibles. In addition to their contracts with CMS to deliver Medicare-financed services, SNPs could enter into formal relationships with state Medicaid agencies so that the delivery of Medicare benefits is coordinated with state-administered Medicaid benefits. These formal relationships could take several forms. One might involve a SNP's receipt of a separate capitation payment from a state Medicaid agency for delivering Medicaid benefits in coordination with Medicare; another could be a non-risk-based contract under which a SNP and state Medicaid program share clinical or utilization information with each other. For example, a SNP could alert a Medicaid agency when a dual-eligible beneficiary begins a Medicare-financed hospital stay; by so doing, the SNP could coordinate with Medicaid to secure access to Medicaid-financed services—such as attendant care upon the person's discharge.

Similarly, if a Medicaid agency alerts the SNP when a dual eligible begins a custodial nursing home stay, Medicare-financed primary care supports could be arranged inside the institution so that unnecessary hospitalizations might be avoided.[9]

Whatever the particular vehicle for coordination between a Medicare-financed SNP and a state Medicaid agency, key objectives would be to better serve the needs of the dual-eligible enrollees, enhance cost-effectiveness, and improve outcomes. These could be realized through individual plans of care that coordinate Medicare services (such as physician visits, pharmacy, hospital care, skilled nursing facility, and skilled home health) with Medicaid services (such as custodial long-term care, attendant care, home- and community-based services authorized under Medicaid waivers, and non-emergency medical transportation).

For example, better hospital discharge planning under Medicare could help avoid a lengthy Medicaid nursing home stay. Community-based long-term care could be improved by coordinating Medicare-covered physician services, skilled home health services, and prescription medications with Medicaid-covered attendant care, non-emergency medical transportation, and home and community-based waiver services. Active monitoring of long-term nursing-home stays (a Medicaid service) could help avoid unnecessary Medicare hospitalizations related to pressure ulcers, infections, or falls.

To date, when SNPs have coordinated with state Medicaid programs they have primarily done so under capitated Medicaid managed care programs; SNPs and state Medicaid programs have not entered into non-risk forms of coordinated care arrangements to any appreciable degree. In the existing formal arrangements that involve separate capitation payments to the same entity—acting as a Medicare SNP and a Medicaid managed care organization (MCO)—there have been favorable outcomes for dual eligibles:

- In Arizona, the percentage of dual eligibles with nursing-facility levels of care who resided in the community (with supports) instead of in an institution rose from 5 percent to 63 percent over 17 years.[10]
- In Texas, dual eligibles received 31 percent more personal care, and 38 percent more adult day health services, than they had in the fee-for-service system. Hospitalizations were reduced by 22 percent and emergency room visits were reduced by 38 percent.[11]
- In Minnesota, 94 percent of the program's beneficiaries would recommend their care coordinator to another person.[12]

This vision of well-coordinated services has not been well realized at the health plan level, however. Despite the rapid growth in SNPs, just 12 percent of the dual-eligible population is enrolled in one.[13] On the Medicaid side, even fewer dual eligibles nationwide—and not necessarily the same individuals—are enrolled in Medicaid managed care plans. Clearly, SNPs still have far to go before they gain a substantial share of the dual-eligible market. An even greater challenge is increasing enrollment of dual eligibles in coordinated Medicare–Medicaid plans where the individual receives, through the same health plan, Medicare benefits (offered by the health plan's SNP) and Medicaid benefits (provided through the health plan's Medicaid managed care plan).[14]

One reason why growth in the coordination of Medicare and Medicaid benefits has been slow is that participation is voluntary for the key participants. First, the MMA in no way obligates SNPs to form any relationship with the Medicaid program in its host state, nor to share clinical and utilization data on the Medicare services delivered by a SNP to its dual-eligible enrollees. Congress did not want to inhibit the growth of SNPs by mandating a formal relationship with the state, given the very real concerns some SNPs might have about the experience, politics, and leadership at the state level.

Similarly, out of respect for states' traditional rights to set Medicaid priorities and to focus on other kinds of reforms if they so choose, nothing in the federal law compels a state Medicaid agency to coordinate with a SNP that operates within the state. This is true even when the SNP is eager to forge a relationship

with the state agency to coordinate care for the dual eligibles it enrolls.

As for beneficiaries, there is nothing to encourage them to enroll in plans that are best able to coordinate care across programs, and in fact there is much confusion about whether a given plan is capable of accomplishing that objective. Moreover, a dual-eligible beneficiary retains the right to leave a SNP plan at any time during the year, making it more difficult to achieve the stability that would enhance the plan's coordination of benefits.

That each of the three key parties noted above—the SNP, the state, and the dual-eligible beneficiary—has the right not to participate in a coordinated approach to care delivery, despite the fact that involvement of *all three* is crucial for seamless coordination of benefits, is the crux of the SNP program's challenge.

Federal Action to Encourage SNPs

The federal government has taken a number of actions to encourage the development of SNPs for dual eligibles.

In 2005, CMS allowed 42 SNPs in 13 states to "passively enroll" dual eligibles, effective January 1, 2006, if the individual was already enrolled in a Medicaid managed care plan offered by the same health plan. Because of Medicare's freedom-of-choice rights, individuals were allowed to opt *out* of this passive enrollment (in which they had taken no action to enroll) and elect to go back to Medicare fee-for-service. But most people stayed. This passive-enrollment process, part of the implementation of the Medicare Part D drug benefit, significantly increased the number of individuals enrolled in a health plan with both a Medicare and Medicaid contract.[15,16]

In Minnesota, Texas, and Arizona, for example, mandatory Medicaid managed care programs for dual eligibles predated the MMA, and dual eligibles were enrolled in plans offered by Medicaid MCOs. After the MMA, many of these Medicaid MCOs were approved by CMS as Medicare SNPs, and given the dual eligibles' existing enrollment in the Medicaid MCOs, these individuals were passively enrolled in the related SNPs. In this way, Minnesota SNPs added 23,000 enrollees, Texas SNPs added 16,000, and Arizona SNPs added 8,000.[17]

To assist states in partnering with SNPs to provide more comprehensive benefit packages to dual eligibles, CMS is creating "how to" guides for aligning Medicare and Medicaid program rules on marketing, enrollment, quality, and rate-setting.[18] For example,

The Advantages of Coordinated Care

When Medicare and Medicaid benefits are delivered in a coordinated manner:

- *Each program has a financial incentive to avert unnecessary or inappropriate care financed by the other program.* For example, if Medicaid-financed nursing home services are not of high quality, the resident could suffer a fall, acquire an infection, or develop a pressure ulcer that results in a Medicare-financed hospitalization. Similarly, many individuals linger in nursing homes when they could have gone home because the initial post-acute Medicare-financed stay in the nursing home did not include active discharge planning.
- *Beneficiaries receive higher-quality care, with respect for individual preferences.* For example, Medicaid-financed attendant care services to assist with bathing and dressing, coordinated with Medicare-financed home health nursing services, may keep a dual-eligible beneficiary highly functioning, independent, and living in the community. A coordinated plan of care that incorporates both Medicare and Medicaid services is the best approach for avoiding what most dual-eligible beneficiaries fear—an unnecessary institutionalization.

guides on new performance measures and the Medicare bidding process are forthcoming. Moreover, a new CMS policy allows SNPs to target certain subsets of a state's dually eligible population, provided that the enrollment limitations parallel the structure and care-delivery patterns of the Medicaid wraparound program or the Medicaid plan that is being integrated with the SNP.[19]

The newest guidance from CMS seeks to better focus SNPs on their unique potential for providing high-quality care to Medicare's most vulnerable beneficiaries. In that spirit, CMS is encouraging dual-eligible SNPs, in partnership with state Medicaid programs, to offer as integrated a product as possible, and the agency is promoting development of specialized models of care for particular SNP subpopulations.[20]

State Action to Encourage Coordination with SNPs

A number of states are considering ways to coordinate Medicare and Medicaid benefits using SNPs. In a 2007 survey conducted by the National Association of State Medicaid Directors, 20 states reported having operational SNPs but also expressed concerns about the coordination of services between Medicare and Medicaid.[21]

Since the MMA became law in 2003, three states have developed new programs that coordinate Medicare and Medicaid benefits for dual eligibles using SNPs. These programs utilize the vehicle of capitated Medicaid managed care programs that contractually assign benefit-delivery responsibility to a Medicaid MCO that is also a Medicare SNP.

In June 2005, the State of Washington began enrolling dual eligibles in its voluntary Medicare–Medicaid Integration Program in two counties. This program, offered through SNPs, provides a capitated wraparound Medicaid benefit.

Florida Senior Care, approved by CMS and scheduled for implementation in two pilot counties during 2008, is also intended to take advantage of SNPs for coordinating Medicare and Medicaid benefits. The state's application noted that "Florida is exploring options to further integrate care and financing for dually eligible Medicaid participants under Florida Senior Care through integration with Medicare Special Needs Plans."[22]

New Mexico has submitted applications to CMS for Coordinated Long-Term Services, a mandatory (for Medicaid beneficiaries) statewide program scheduled for implementation in July 2008. The state anticipates initial participation by two Medicaid MCOs, which will be required to obtain approval as SNPs. These entities will be expected to coordinate primary, acute, and long-term care for individuals who enroll in the same plan for their Medicare and Medicaid benefits.

Outlook and Reauthorization

In a number of states, SNPs are in discussion with the Medicaid agencies to develop coordinated health care delivery programs for dual eligibles. These programs range from initiatives that better coordinate Medicare and Medicaid benefits to efforts that more fully integrate the financing and delivery of services.

This movement is likely to gain more momentum. The National Governors Association recently urged greater coordination of Medicare and Medicaid benefits and specifically suggested that states be granted access to Medicare Part D claims data.[23] The federal Medicaid Commission recommended a number of reforms to support the development and expansion of integrated care programs for dual eligibles.[24] However, with legislative authority for SNPs scheduled to expire on December 31, 2008, Congress must reauthorize the program. Otherwise, health plans and states alike may become increasingly reluctant to develop new initiatives involving SNPs.

In taking up the debate on reauthorizing SNPs, Congress should consider new legislative provisions that promote consumer protection, integrated care, and accountability. For example, health plans should be required, both in their initial applications to CMS and in their periodic reports, to demonstrate how the SNPs differ from other Medicare Advantage plans and fee-for-service Medicare in meeting the "special needs"

of dual-eligible beneficiaries. Marketing materials, from the health plans and CMS alike, should provide clear guidance to consumers on whether SNPs are an appropriate choice for them. And CMS should define, adopt, and monitor standards to help ensure that a basic level of care is provided to all SNP enrollees and that services are coordinated across Medicare and Medicaid.

Better-integrated care can be encouraged by breaking down administrative barriers, promoting data sharing, and creating financial incentives that reduce cost shifting and promote better collaboration between SNPs and state Medicaid programs. New provisions in the federal legislation might include: 1) a requirement that dual-eligible SNPs share data with state Medicaid programs regarding utilization, encounters, diagnostics, and key events (e.g., provide alerts when Medicare-financed admissions to nursing facilities occur); 2) a requirement that state Medicaid agencies similarly share data with SNPs on Medicaid-financed services; 3) easing of federal requirements so that states may contract with SNPs for Medicaid-financed services without having to first secure a Medicaid waiver; and 4) enhanced federal Medicaid matching funds for SNP-Medicaid data-sharing activities such as joint electronic health records for dual eligibles.

The SNP program should be structured so that SNPs can be brought to scale in a reasonable period of time, thereby reducing market fragmentation, balancing risk, and improving cost-effectiveness. Meanwhile, the development and monitoring of performance standards by CMS will help to promote SNPs' accountability and provision of quality care. SNPs will thus be better able to benefit both the Medicare and Medicaid programs and, most importantly, to help ensure that the needs of dual-eligible beneficiaries are being met.

Notes

[1] Henry J. Kaiser Family Foundation. *Medicare Chartbook,* 3d ed., summer 2005.

[2] See, for example, J. Ryan and N. Super, *Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy,* National Health Policy Forum, Sept. 30, 2003.

[3] Congressional Budget Office, June 28, 2007.

[4] A plan must submit a bid that represents its estimate of the cost of providing the traditional Medicare benefit package. If that bid is less than the benchmark rate (which applies for almost all plans), it receives the bid amount plus 75 percent of the difference between the benchmark rate and the bid. The additional benefits that the plan provides must be equal in actuarial value to the difference between the rate the plan receives and its bid. Alternatively, the plan may set aside some or all of that differential into a "stabilization fund," but in practice this option is not exercised.

[5] When Puerto Rico is excluded, the average rate paid to SNPs drops from 118% to 111% of the average Medicare fee-for-service rate. See Medicare Payment Advisory Commission. *Report to Congress: Medicare Payment Policy,* Mar. 2007, p. 244.

[6] Medicare Payment Advisory Commission. *Report to Congress: Promoting Greater Efficiency in Medicare,* June 2007, p.72.

[7] The seven states are Minnesota, New York, Massachusetts, Arizona, Texas, Wisconsin, and Washington.

[8] A "mandatory" program is described in detail in the companion Commonwealth Fund issue brief, C. J. Milligan, Jr., and C. L. Woodcock, Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans (New York: The Commonwealth Fund, Feb. 2008).

[9] Three distinct models in which SNPs and state Medicaid programs could coordinate care are discussed in the above-noted companion issue brief.

[10] State of Arizona claims data.

[11] S. K. Aydede, *The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Patients,* Institute for Child Health Policy, Sept. 2003.

[12] Minnesota Health Data Institute, *2004 Consumer Assessment of Health Care: MSHO Nursing Home Population* (MHDI, Aug. 2004).

[13] Percentages were calculated using these data: 6,229,000 full dual eligibles, 722,286 dual eligibles enrolled in SNPs (see Table 1), and 722,671 dual eligibles enrolled in Medicaid managed care. See Henry K. Kaiser Family

Foundation. *Dual Eligible Enrollment, 2003* (available at http://statehealthfacts.org); Henry J. Kaiser Family Foundation, *Total Dual Eligible Enrollment in Medicaid Managed Care, as of June 30, 2006* (available at http://statehealthfacts.org); and Centers for Medicare and Medicaid Services. *Special Needs Plan Comprehensive Report.* Sept. 2007 (available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp).

[14] It is unknown just how many SNPs have formal relationships with their host state that facilitate Medicare–Medicaid coordination, either through coordinated Medicare–Medicaid programs, administrative service organization (ASO) arrangements, or data-sharing agreements.

[15] J. M. Verdier, *Medicare Advantage Rate Setting and Risk Adjustment: A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefits* (Center for Health Care Strategies, Inc., Sept. 2006).

[16] K. Tritz, *Integrating Medicare and Medicaid Services Through Managed Care,* Congressional Research Service Report for Congress, Order Code RL33495, June 27, 2006.

[17] P. Saucier and B. Burwell, *The Impact of Special Needs Plans on State Procurement Strategies for Dually Eligible Beneficiaries in Long-Term Care,* Jan. 2007. Available at http://www.hcbs.org.

[18] Centers for Medicare and Medicaid Services. *Integrated Medicare and Medicaid Models.* Available at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912.

[19] Centers for Medicare and Medicaid Services. "Permissible Enrollment Subsets for Dual Eligibles Enrolled in Special Needs Plans," Guidance to Medicare Advantage Organizations, Aug. 10, 2006, available at http://www.dads.state.tx.us/medicare/news/2006/Dual_Eligibles_SNP.pdf; and Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors, Aug. 10, 2006, available at http://www.cms.hhs.gov/States/Downloads/SNPEnrollment.pdf.

[20] Centers for Medicare and Medicaid Services, *Medicare Advantage: 2008 Call Letter.* April 19, 2007. Available at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf.

[21] National Association of State Medicaid Directors, "Medicaid Pharmacy and Long-Term Care Surveys Released," press release, Nov. 13, 2007. Available at http://www.nasmd.org/Home/home_news.asp.

[22] State of Florida, Agency for Health Care Administration. *Section 1915(b) MCO Waiver Program: Florida Senior Care Waiver Proposal,* p.3. Approved by the Centers for Medicare and Medicaid Services, effective Nov. 1, 2006. Available at http://www.fdhc.state.fl.us/Medicaid/long_term_care/index.shtml.

[23] National Governors Association, Letter to the Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, Feb. 12, 2007. Available at http://www.nga.org/portal/site/nga/menuitem.cb6e7818b34088d18a278110501010a0/?vgnextoid=b36368325b6b0110VgnVCM1000001a01010aRCRD.

[24] Medicaid Commission, *Final Report and Recommendations,* presented to Secretary Michael O. Leavitt, Dec. 29, 2006. The Commission recommended four reforms to support the development and expansion of integrated care programs for dual eligibles: 1) SNPs or other mechanisms via the state plan; 2) integrated care management programs with "universal" (automatic) enrollment of dual eligibles and an opt-out provision; 3) reducing administrative barriers to an integrated approach to care; and 4) a new program for dual eligibles called Medicaid Advantage (Recommendation E.2).

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