



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles

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Synopsis

Special Needs Plans (SNPs) are intended to improve care coordination, improve quality of care, and reduce the costs for treating high-risk, high-cost Medicare beneficiaries, including those who qualify for both Medicare and Medicaid benefits. Many SNPs, however, do not coordinate their benefits with state Medicaid programs. Combined with negative perceptions of managed care among some of the elderly, this has led to low plan enrollment and limited impact.

"Special Needs Plans have the potential to add value by coordinating Medicare and Medicaid benefits and services for dual eligibles."

Background

An estimated 7.5 million Americans qualify for both Medicare and Medicaid benefits. Although a relatively small population, so-called dual eligibles account for roughly 24 percent of Medicare spending and 42 percent of Medicaid spending, owing to their poor health and complex health care needs. Dual eligibles are also much less likely than Medicare-only beneficiaries to receive certain types of preventive and follow-up care. SNPs, a type of Medicare Advantage managed care plan created by the Medicare Modernization Act of 2003, are intended to address these unmet needs while reducing the costs of caring for these individuals.

Dual-Eligible Special Needs Plans: Opportunities and Challenges

Currently, dual-eligible SNPs currently serve only about 11 percent of the total dual-eligible population. Enrollment in the plans has been concentrated in a handful of states that offer capitated Medicaid managed care programs: Puerto Rico and nine states account for 60 percent of SNPs and 85 percent of enrollees.

Several factors have stalled enrollment since 2006, when Medicaid managed care plans were given a one-time opportunity to passively enroll dually eligible members in their companion Medicare plans. First, the original legislation authorizing dual-eligible SNPs did not require them to coordinate benefits with state Medicaid programs. “SNPs need to have some contractual relationship with state Medicaid plans to add value for dually eligible beneficiaries beyond traditional [Medicare Advantage] plans,” says the author.

Dual eligibles also may have been reluctant to enroll in SNPs because of a lack of evidence showing that SNPs actually improve coordination and quality of care. Evidence from an evaluation of two programs shows improved or stable quality of care and access to services, but higher program costs relative to comparison groups. Whether the benefits of increased coordination are worth the additional costs is an issue that requires further exploration, the author says.

Lastly, many elderly people have a negative perception of managed care. This likely stems from concerns about having to change doctors and go to new locations for care, as well as having fewer choices.

Addressing the Problem

The author concludes that the success of dual-eligible SNPs may hinge on the following:

- A robust Medicaid managed care market, which is essential for encouraging a fully capitated Medicare–Medicaid model. An important first step will be to ease federal requirements so that states can contract with SNPs for Medicaid-financed services without having to obtain a Medicaid waiver.
- Allowing state Medicaid agencies to contract with an SNP to administer fee-for-service benefits, which could improve coordination of benefits and services. While the Medicare Improvements for Patients and Providers Act of 2008 ensures that new dual-eligible SNPs will offer a joint Medicare–Medicaid product, it does not require states to contract with SNPs, which may leave many U.S. markets without the plans.
- Tracking whether the improved care coordination promised by dual-eligible SNPs translates into better outcomes and lower spending. Thus far, there has been little evaluation of SNPs’ performance in terms of costs and outcomes.

The Bottom Line

Special Needs Plans have the potential to coordinate care under Medicare and Medicaid, but enrollment to date has been modest. Additional steps are now needed to expand the market and improve coordination between these plans and state Medicaid programs.

Citation

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This summary was prepared by Helen Garey and Deborah Lorber.