

# Developing an Integrated Care Program for Dual Eligibles Using Special Needs Plans

Technical Assistance Brief

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Individuals who are dually eligible for Medicare and Medicaid (“dual eligibles”) are among the highest-need and highest-cost participants in the U.S. health care system. Dual eligibles often experience a confusing, fragmented, and inefficient medical and long-term supports and services (LTSS) delivery system, in large part because administration of their services is split between the federal and state governments.

Some states have developed integrated care programs to reduce fragmentation, duplication of services, avoidable hospitalizations and institutionalizations, and improve the quality of life for dual eligibles and their families. Integrated care programs provide Medicare and Medicaid services, and often LTSS and behavioral health services through one entity. There are myriad reasons, however, why integrated care has yet to establish itself as part of the health care system. These include lack of stakeholder support for integrated care; fear and resistance among consumers; ineffective messaging and education about the benefits of integrated care; difficulty in combining Medicare and Medicaid rules; and the absence of a strong, replicable, and scalable model.

Over the past five years, several states have attempted to develop integrated care programs by taking advantage of the Medicare Modernization Act’s establishment of special needs plans (SNPs). SNPs are a type of managed care plan that is specifically designed to provide specialized services to high-need individuals, such as dual eligibles. To date, SNPs have proven to be the most successful means to integrate care for states, however, only a small number of states have successfully developed these programs.

With support from The Commonwealth Fund, the Center for Health Care Strategies worked with five innovative states—**Colorado, Maryland, Michigan, Pennsylvania, and Texas**—to develop or expand integrated care programs using SNPs. This technical assistance tool draws from the experiences of these and other forward-thinking states to outline the process and considerations for states in developing a SNP-based integrated care program.

## IN BRIEF

To date, special needs plans (SNPs) offer the most successful means to integrate care for individuals who are dually eligible for Medicaid and Medicare. Even though the Patient Protection and Affordable Care Act is supporting new alternatives for integrated care, SNPs remain a viable opportunity for integration. This brief draws from the experiences of pioneering states to outline critical steps and considerations for states in developing a SNP-based integrated care program. Key steps include:

- 1) Engaging stakeholders;
- 2) Developing the program design;
- 3) Obtaining CMS approval; and
- 4) Contracting with dual SNPs.

Considerations include: stakeholder support of dual SNP contracting; extent of dual SNP integration; presence of a Medicaid managed care infrastructure; presence of dual SNPs in the state and their capacity to provide LTSS; likelihood of federal authorization for SNPs beyond 2014; continued interest by health plans in the SNP market; and available state resources. Though this brief focuses on achieving integration through SNPs, many of the considerations discussed can apply to the development of any integrated care model.

Today, the SNP marketplace is at a turning point and states pursuing integration are encouraged to explore the full range of available options. In the past year, the Patient Protection and Affordable Care Act of 2010 (ACA) set rate cuts for SNP-covered Medicare services. This reduction in funds may decrease the ability of SNPs to provide enhanced care coordination and critical benefits such as vision and hearing services and may minimize health plan interest in serving as SNPs. The ACA also opened the door for new integrated care options, and the Centers for Medicare & Medicaid Services (CMS) recently announced funding for states seeking to develop innovative ways to integrate care. Though this technical assistance brief focuses on developing an integrated care program through SNPs, many of the decision points and processes discussed can be transferred to development of any integrated care model.

## Overview of Special Needs Plans

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The Medicare Modernization Act (MMA) of 2003 established Medicare Advantage (MA) plans to offer greater choice to Medicare beneficiaries and expand the role of private health plans serving Medicare. The MMA also established SNPs as an MA plan that offers specialized health care services for: (1) individuals eligible for both Medicare and Medicaid (dual eligibles); (2) individuals requiring an institutional level of care; and (3) individuals with chronic conditions.

SNPs must offer Medicare Parts A, B, and D benefits and follow the majority of Medicare Advantage rules, with some exceptions. MA plans and SNPs both have greater accountability and reporting requirements than traditional Medicare. These plans can also offer enhanced benefits that are not typically provided to Medicare enrollees such as vision, hearing, and dental care.

The most significant difference between MA plans and SNPs relates to enrollment; especially for individuals interested in enrolling in a dual SNP. Dual SNPs are open only to dual eligibles and individuals can enroll in and disenroll from a dual SNP any time throughout the year.<sup>1</sup> This makes it extremely difficult for dual SNPs to achieve enrollment stability and coordinate benefits effectively. Of the roughly nine million dual eligibles in the United States, as of December 2010, there were 1,372,626 individuals—just over 15 percent of dual eligibles enrolled in one of the 335 CMS-approved dual SNPs.<sup>2</sup>

## Evolution of Special Needs Plans

Initially, states saw dual SNPs as a way to provide care through a single entity. In the most successful state programs, enrollment in a dual SNP provides the full array of Medicare, Medicaid, and supplemental benefits so that individuals have one benefit package and one set of providers for their care. However, most states have encountered significant obstacles and have not been as successful. Over the past few years, Congress has attempted to eliminate some of these obstacles by amending select rules for SNPs through the Medicare Improvements for Patients and Providers Act of 2008, the Patient Protection and Affordable Care Act of 2010, and the Health Care and Education Reconciliation Act of 2010. Following is a brief description of the implications for SNPs related to each of these federal acts.

### ***Medicare Improvements for Patients and Providers Act of 2008***

Following the MMA, Congress attempted to facilitate greater SNP integration through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MIPPA established new standards for SNPs including: (1) requiring new plans or those that are expanding into new service areas to contract with state Medicaid agencies; and (2) establishing new care provision requirements, including: evidence-based models of care; interdisciplinary care teams; and individual care plans to identify goals, objectives, measurable outcomes, and specific benefits.

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<sup>1</sup> Final MA Enrollment and Disenrollment Guidance for CY 2011, Section 30.4 Special Election Period, August 17, 2010. Available at <https://www.cms.gov/MedicareMangCareEligEnrol/Downloads/FINALMAEnrollmentandDisenrollmentGuidanceUpdateforCY2011.pdf>

<sup>2</sup> Special Needs Plan Comprehensive Report, CMS Health Plan Management System, December 2010. Available at <https://www.cms.gov/MCRAAdvPartDENrolData/Downloads/SNP-201012.zip>

MIPPA §164 required that all dual SNPs must contract with the state Medicaid agency to provide benefits for the dual eligibles enrolled in its plan. The regulations specify that dual SNPs contracts must address the following areas:<sup>3</sup>

- SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
- Eligibility categories of dual-eligibles to be enrolled under the SNP;
- Medicaid benefits covered under the SNP;
- Cost-sharing protections covered under the SNP;
- Identification and sharing of information on Medicaid provider participation;
- Verification of enrollee's eligibility for both Medicare and Medicaid;
- Service area covered by the SNP; and
- Contract period for the SNP.

Initially, state-SNP contracts were required by 2011; however, the ACA amended this timeline through 2013.

### ***Patient Protection and Affordable Care Act of 2010***

The ACA further refined the rules for MA plans and SNPs. Most notably §3205 of the ACA extends SNP authority until 2014 and delays the state-SNP contracting requirement that was mandated in MIPPA until 2013. The ACA also establishes payment provisions to reimburse SNP plans for the higher acuity levels of enrollees. These provisions allow fully integrated dual SNPs to apply the Program of All-Inclusive Care for the Elderly (PACE) frailty adjustment and mandate an evaluation of payment adequacy for SNPs serving high-risk beneficiaries. In addition, as of 2012, SNPs must be approved by the National Committee for Quality Assurance (NCQA), based on standards established by the Secretary of Health and Human Services.

The ACA also establishes the Federal Coordinated Health Care Office, known as the “Office of the Duals” and the Center for Medicare and Medicaid Innovation. Many states are now hopeful that these new CMS offices will enhance communication, innovation, and decision making on integrated care at the federal level.

### ***Health Care and Education Reconciliation Act of 2010***

The Health Care and Education Reconciliation Act of 2010 (Reconciliation Act) also established payment provisions that apply to all Medicare Advantage plans and SNPs. The Reconciliation Act freezes payment rates to MA plans and SNPs in 2011. Beginning in 2012, it gradually reduces payment to levels closer to the costs of enrollees in traditional Medicare.<sup>4</sup> The Reconciliation Act also supports quality-based bonus payments to plans and requires that MA plans and SNPs spend at least 85 percent of revenue on medical costs or activities that improve quality of care, rather than on profit and overhead.

There has been a great deal of legislative activity around MA plans and SNPs over the past seven years; however, to date none of these changes have substantially simplified the process for developing SNP-based integrated care programs. Stakeholders, however, are hopeful that ACA provisions will have a positive impact and that CMS is ready to engage states on this topic. Even with new support from CMS, developing SNP-based integrated care programs is still a very challenging task.

## **Current State Options for Contracting with SNPs**

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By 2013, dual SNPs are required to contract with the Medicaid programs of each state in which the plan operates. MIPPA sets out the minimum level of interaction that dual SNPs must have with states. States, however, are not required to contract with dual SNPs and have the flexibility to contract with dual SNPs to whatever extent best meets the needs of beneficiaries, stakeholders, and the state Medicaid program.

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<sup>3</sup> 42 CFR § 422.107.

<sup>4</sup> “Explaining Health Care Reform: Key Changes in the Medicare Advantage Program.” Kaiser Family Foundation Issue Brief, May 2010.

Examples of contracting options are listed below in order of the contracting complexity and degree of integration likely to be involved, with the least complex/comprehensive Medicaid coverage listed first.

- **MIPPA Minimum Requirement Agreement:** Medicaid programs that do not want to exclude dual SNPs from their states, but are not in the position to fully embrace dual SNP integration may choose to have a minimum requirement agreement with SNPs. This agreement meets all of the abovementioned requirements, but all that is consistently shared between the state and dual SNPs is the ability to verify Medicaid eligibility and dual SNP enrollment. Some states may choose to take their minimum requirement agreement a step further by also arranging for the exchange of data to allow parties involved in the care of dual eligibles to receive information related to that care.
- **Medicare Cost-Share Only:** States enter into contracts with dual SNPs to verify eligibility information and a capitation rate to cover beneficiary cost sharing (e.g., coinsurance, copayments, and deductibles) that Medicaid covers for dual eligibles.
  - *State Examples:* Texas (STAR+PLUS), Maryland.
- **Medicare Cost-Share and Medicaid Wraparound Services:** In addition to providing plans with eligibility information and a monthly capitation rate that covers Medicare cost-sharing responsibilities, states also contract with dual SNPs to provide Medicaid medical services not covered or only partially covered by Medicare (e.g., vision, dental, hearing, durable medical equipment, transportation, care coordination, etc).
  - *State Examples:* New York (Medicaid Advantage), Minnesota (Special Needs Basic Care)
- **Medicaid Medical and Long-Term Supports and Services:** States enter into contracts with dual SNPs for the provision of the full array of Medicare and Medicaid medical and LTSS. This model provides fully integrated care for dual eligibles.
  - *State Examples:* Arizona, Minnesota (Minnesota Senior Health Options), New Mexico (CoLTs), New York (Medicaid Advantage Plus), Texas (STAR+PLUS), Washington (Washington Medicaid Integration Partnership).

## Factors to Consider in Deciding Whether to Contract with Dual SNPs

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State-SNP contracts allow states to choose the level of integration that best meets the states' and stakeholders' needs. Contracting with SNPs also offers a capitated model that provides states with greater budget predictability (although consideration needs to be given to the degree of financial risk that will be included). However, contracting with dual SNPs may not be an appropriate solution for all states. There are a number of issues for states to consider when determining whether to contract with dual SNPs and the extent of integration for which it wants to contract.

Factors that states should consider that are detailed below include: (1) stakeholder support of dual SNP contracting; (2) desired extent of dual SNP integration; (3) presence of a Medicaid managed care infrastructure; (4) presence of dual SNPs in the state and their experience and capacity to provide LTSS; (5) likelihood of federal authorization for SNPs beyond 2014; (6) likelihood of continued interest by health plans in the SNP market; and (7) available state resources.

- **Stakeholder support of dual SNP contracting:** Initially, stakeholders, including providers, will likely be reluctant to support expanded enrollment into a managed delivery system—especially for seniors and individuals with disabilities. States that already successfully included this population in their current managed care program may be able to use this experience to address this population's needs in a SNP-based integrated care program. States that expect significant stakeholder resistance should allocate substantial time at the beginning of program development to educate stakeholders and incorporate their input.

- **Desired extent of dual SNP integration:** States can choose to contract with dual SNPs to provide a fully integrated program, including the full range of Medicaid cost-sharing, wrap-around services (including community-behavioral health services), LTSS, and or states can contract with dual SNPs to provide a less integrated program, where the dual SNP is simply an alternative Medicare delivery model for its dual eligibles. States have the option to start out with a less integrated contract and work over the next few years to develop a more fully integrated model.
- **Presence of Medicaid managed care infrastructure:** States without an existing Medicaid managed care program will likely find it difficult to develop a SNP-based integrated program. States without Medicaid managed care can still contract with dual SNPs to offer managed Medicare services to dual eligibles, but if these states want to contract with dual SNPs to cover wrap-around services and cost sharing, they will likely need to make a significant investment in their infrastructure, data, and claims systems. States may also want to consider the presence of home-grown, community-based plans in their state. The pending rate cuts in the Reconciliation Act have caused many SNPs to question how much longer they will stay in the SNP marketplace, particularly larger national plans. Larger plans with numerous lines of business may be more reluctant to continue a program if the reimbursement rates are not perceived to be adequate whereas locally-based SNPs that evolved from providers in the community may be more invested in their region and more willing to try to make the plan sustainable.
- **Presence of dual SNPs in the state and their experience and capacity to provide LTSS:** States should identify which dual SNPs operate in their state<sup>5</sup> and which plans are interested in contracting with the state. States should also determine which regions of the state SNPs are willing to cover, since plans may not be interested in all parts of the state, especially rural areas. Some states may be interested in contracting with dual SNPs to provide the full range of Medicaid services—including both home- and community-based services (HCBS) and facility-based LTSS. It is important for states to consider whether the available dual SNPs have experience managing LTSS services. If not, states will need to invest significant resources in assisting existing dual SNPs to develop this capacity. Alternatively, states could consider contracting with dual SNPs that have experience managing LTSS for other state Medicaid programs. New plans, however, could experience network development issues depending on the types of services and providers included in the program.
- **Likelihood of federal authorization for SNPs beyond 2014:** Since 2003, Congress has only authorized the SNP program for a few years at a time. The ACA extends SNP authority through 2014; however, it is unknown whether Congress will continue to reauthorize SNPs. States should consider this uncertainty when deciding whether or not to move forward with dual SNP contracts.
- **Likelihood of continued interest by health plans in the SNP market:** The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare payments to private health plans in 2010 are on average between nine percent and 13 percent higher than local fee-for-service (FFS) costs. The ACA and the Reconciliation Act alter the rate structure for MA plans and SNPs to bring the MA and SNP rates closer to the average FFS cost for Medicare beneficiaries.<sup>6</sup> The impact of these pending rate cuts is not clear at this time. However, they are likely to cause many plans to reevaluate maintaining this line of business and cause new plans to stay out of the market. In addition, if SNPs no longer have the finances to provide extra benefits like vision, dental, and well-care services, they will not be as attractive to potential enrollees.
- **Available state resources:** Contracting with dual SNPs beyond the minimal level requires substantial commitment, ability, and time from state staff. Working through the complex dual SNP regulations and translating them into a program that aligns with the state's existing Medicaid managed care rules

<sup>5</sup> This information can be found on the SNP Alliance website ([www.nhpg.org](http://www.nhpg.org)).

<sup>6</sup> "Explaining Health Care Reform: Key Changes in the Medicare Advantage Program." The Kaiser Family Foundation, May 2010.



is a daunting task. If the integrated care program also includes LTSS, significant training will likely be necessary between staff members familiar with medical managed care services and staff members familiar with LTSS. In addition, many states are thrust into integrated care program development due to a state legislative mandate. This mandate often contains a very short timeline and a projected budget savings. Adequate staffing resources, though difficult to achieve at this time, are vital to a successful integrated care program.

## **Steps for Developing an Integrated Care Program Using Dual SNPs**

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Following is a list of steps and decisions for states to consider when developing an integrated care program. Though this list is specifically targeted toward dual SNP contracts, the steps are transferable to developing an integrated care program through other methods. These steps include:

- 1) Engaging stakeholders;
- 2) Developing the program design;
- 3) Obtaining CMS approval; and
- 4) Contracting with dual SNPs.

### **1. Engaging Stakeholders**

State staff should not underestimate the importance of building strong support within all stakeholder groups, including consumers, policymakers, advocates, providers, and potential dual SNPs. Staff should engage stakeholders at the outset of the program design process and work with them to understand their goals for improving care for dual eligibles. In particular, state staff should seek out stakeholder concerns about changing service delivery for this population. This initial outreach also provides an opportunity to educate stakeholders about the benefits of integrated care and potential program options. Resulting consumer feedback can be used to develop a messaging strategy that will resonate with stakeholders. Stakeholders are likely to pose significant opposition to the use of managed care for LTSS and/or the dual eligible population. If state staff can convey the positive benefits of properly implemented integrated care, the state will have a higher likelihood of success.

Having an adequate provider network is essential to a successful program. Many states have a LTSS provider network (HCBS and facility) that exists almost exclusively to provide services to individuals in FFS Medicaid. These providers will likely be very anxious about transitioning from FFS to integrated care. Having providers and dual SNPs at the table together early will help alleviate provider contracting concerns and ensure access to experienced providers. Many provider groups are extremely powerful with state legislators and without their support an integrated care program will not be successful.

Stakeholder engagement extends beyond just working with policymakers, providers, and the advocacy community. States with integrated SNP programs, for example, realized that it is important to work with potential SNP contractors as early in the process as possible. In the development of its CoLTS program, New Mexico worked closely with interested contractors on many aspects of program design and implementation. This provided the state with additional staff support and ensured that the contractors understood the goals of the CoLTS program. In addition, the state may be looking to contract with dual SNPs that do not currently offer Medicaid managed care services in that state. If the state is considering including managed LTSS for Medicaid-only beneficiaries, the state should work with the dual SNP to be sure that it has the ability to develop the necessary medical service provider network.<sup>7</sup>

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<sup>7</sup> For more information on stakeholder engagement, see S. Gore and A. Lind. *Engaging Consumer Stakeholders to Improve Systems of Care for Dual Eligibles*, Center for Health Care Strategies, Inc., December 2010. Available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261210](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261210).

## 2. Developing the Program Design

Once stakeholder goals and state needs are established for the integrated program, the state should begin drafting a design document that addresses the following issues:

### *Covered Populations*

One of the first issues to consider in designing an integrated care program is what populations should be included. For example, does the state want to enroll:

- All dual eligibles or just those considered “full benefit dual eligibles”?
- Dual eligibles who spend down their income each month to eventually meet Medicaid eligibility requirements?
- A specific subset of dual eligibles such as: the elderly, people with disabilities, participants of a specific HCBS waiver program, or individuals who reside in an institution?
- Populations that require greater specialization of services such as individuals with traumatic brain injuries, intellectual disabilities, developmental disabilities, or who have significant behavioral health needs?
- Non-duals (Medicaid-only) beneficiaries in the program if LTSS is also provided?
- Children; if not, at what age should enrollment start?<sup>8</sup>
- Individuals who have other insurance in addition to Medicare and Medicaid?

### *Covered Services*

A second vital component in integrated care program design is determining what benefits to cover. Considerations include:

- What, if any, LTSS will be included?
  - Will the program only include State Plan HCBS or will it include HCBS waiver services – and if so, services for which populations? If the state offers HCBS through §1915(c) waivers, it may find it easier to include all of the services of a specific waiver program.
  - Will the program include nursing facility coverage? Will the program include coverage for an unlimited number of nursing facility days or will the individual be disenrolled if he or she exceeds a predetermined length of stay?
  - Will the program cover self-directed services or individualized budgeting?
- Will the program include community behavioral health services? If not, how will these services be coordinated?
- What Medicaid medical services should the program cover? If the program is just targeting dual eligibles, then at most, the program will only need to cover wrap-around services. If the program will include LTSS and cover Medicaid-only individuals, then the program will also need to offer the full range of Medicaid medical services. States with existing managed care programs may want to model their dual SNP medical services to their managed care benefit package.
- What Medicare services will the program cover? Although the state may not have a direct financial involvement with the Medicare-covered services, states should review the dual SNP Medicare benefit package to ensure that it is suitable to the state. While dual SNPs have the flexibility to offer additional benefits, they also have the ability to scale back Medicare benefits, as long as the actuarial value of their overall benefit package is not less than the value of the package under traditional Medicare.<sup>9</sup> This is often a benefit to healthier individuals who receive enhanced services such as hearing aids and eyeglasses, but can shortchange frailer individuals who need facility care since plans sometimes limit the number of days covered in a nursing facility.

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<sup>8</sup> Dual eligible children typically have end stage renal disease (ESRD).

<sup>9</sup> E. Park. “Informing the Debate about Curbing Medicare Advantage Overpayments.” Center on Budget and Policy Priorities. July 2007. Available at [http://www.cbpp.org/cms/index.cfm?fa=view&id=513#\\_ftn15](http://www.cbpp.org/cms/index.cfm?fa=view&id=513#_ftn15).

- What services does the state expect to include in care coordination? Should it include conducting initial assessments and annual functional assessments and how will this impact continued Medicaid eligibility? What level of care coordination is expected for relatively healthy dual eligibles who do not receive LTSS? What staffing ratios, if any, will the state require for care coordinators?

Decisions about covered services will shape the extent to which an integrated care program can facilitate more coordinated service delivery. In general, if the state is planning to pursue integration through dual SNPs, it is important (though often tempting due to stakeholder pushback) not to exclude services from the dual SNP contract through FFS carve-outs. Doing so can result in the unintended incentive for plans to shift care and costs back to the Medicaid FFS system. This is especially true regarding the extent of risk that plans take on for institutional placements. There is a perception that plans can do very little to manage care for a resident in a nursing facility. However, if plans are not at-risk for any portion of a facility placement, they will have no incentive to avoid such placements (thus undermining the ability of dual SNPs to increase the role of HCBS).

### **Geographic area**

State staff members need to determine whether they will operate the integrated care program statewide or limit it to specific regions of the state. If a state has had a difficult time implementing a Medicaid managed care program for its TANF population statewide, it will likely run into the same obstacles when implementing an integrated care program across the state. States such as Arizona that have had the most success with statewide integrated care had a strong Medicaid managed care program across the state on which to build their program. Other states such as Texas have had success targeting their programs in certain regions. A regional program, however, still requires the same steps that a statewide program requires, but the impact is not as broad. Also, regional programs still require substantial upfront investments from dual SNPs. If the population is not large enough for the dual SNP to recoup its initial investment, most plans will not be interested in the program. Nonetheless, regional programs can offer states and stakeholders the chance to slowly transition to integrated care and allow for a higher level of attention and scrutiny to program monitoring.

### **Authority**

Most likely, a state will need to obtain new authority or amend existing authority from CMS to operate an integrated care program. States such as, Texas developed integrated care programs through concurrent §1915(b) and §1915(c) waivers. If a state already operates a managed care program under §1915(b) waiver authority and uses §1915(c) authority to provide HCBS, concurrent §1915(b) and (c) waivers may be the state's best option. While Minnesota also has a concurrent 1915 (b)and (c) program for a separate managed care program for seniors, Minnesota operates its integrated care programs through separate waiver authority. It operates Minnesota Senior Health Options (MSHO) through §1915(a) and §1915(c) waivers and Special Needs Basic Care (SNBC), a voluntary program for dual eligibles with disabilities, through a §1915(a) waiver. States such as Arizona and Tennessee implemented integrated care programs through an §1115 demonstration waiver. Since section 1115 authority provides greater flexibility for states, an increasing number of states are using this authority to tailor programs to their specific needs. In addition, new authority may also be available in the near future. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) and the Federal Coordinated Health Care Office to assist states with developing new innovative and cost-effective service delivery models. New authority for integrated care may be available through these offices; however, this may not be the best route for a state if it could implement a program using existing authority, such as an §1115 waiver or §1915(b) and §1915(c) waivers. States that plan to develop an integrated care program using a new payment structure are encouraged to explore opportunities through CMMI such as the *State Demonstrations to Integrate Care for Dual Eligible Individuals* contracting opportunity.<sup>10</sup>

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<sup>10</sup> Applications for this demonstration are due on February 1, 2011. More information about this opportunity and other CMMI initiatives can be found at [www.innovations.cms.gov](http://www.innovations.cms.gov).



In addition, some states may need to obtain authority from the state legislature to proceed with program implementation. If states have adequately laid the groundwork with stakeholders, obtaining legislative authority should be a relatively smooth process. However, if administrative funding is needed for start-up costs, the program may still encounter opposition due to budget constraints. States should allow ample time to develop and submit waiver and legislative proposals since the process often requires significant staff time.

### ***Financing***

Establishing rates for a new population is always a daunting task. States may find that setting rates for integrated care programs is a new territory for everyone -- including their actuaries. Beyond determining the new populations and services that will be covered, states will need to decide how much risk the SNP will be responsible for and whether there will be any limits on this risk, such as inclusion of a risk corridor. In addition, states may consider developing a rate structure that has different rate cells for different levels of service. For example, individuals using LTSS may have a higher reimbursement rate than those who do not. In this case, states may want to use an independent assessor to determine who qualifies for LTSS since there would be an incentive for the dual SNP to move individuals into this category to obtain the higher reimbursement rate. If the state does use an independent assessor, however, it will need a process to share this assessment information with the dual SNP care coordination team.

### ***Enrollment***

In general, states may enroll participants in an integrated care program for their Medicaid services in one of two ways: either through *mandatory* enrollment where individuals follow the standard Medicaid managed care enrollment rules and may select the dual SNP from which they would like to receive their Medicaid services or through *voluntary* enrollment where individuals are given the *option* to participate in the dual SNP for Medicaid services and must proactively enroll in the program. It is important to make the distinction, that at this time, CMS requires that individuals **voluntarily** enroll to receive **Medicare** services through the SNP. “Passive enrollment” with the opportunity to opt-out of the dual SNP is considered mandatory enrollment and not currently allowed. In addition, individuals may enroll or disenroll from receiving Medicare services through the dual SNP at any time.

Voluntary enrollment can serve to mitigate negative reactions to integrated care from stakeholders. However, as many states have realized, it can also result in low enrollment. In addition, generating interest from dual SNPs is more difficult in a voluntary program, since it is hard for state staff to predict the number of participants. Dual SNPs require a critical mass of covered lives to recoup investments in infrastructure needs, such as hiring care managers and developing an adequate network. On the other hand, mandatory enrollment will ensure a favorable number of participants, but may be politically difficult if there is a negative reaction by stakeholders.

### ***Data Systems***

Currently information on service utilization and expenditures for dual eligibles does not reside within a single entity. Thus, identifying ways to link Medicare and Medicaid data is a critical component to successfully achieving integrated care for dual eligibles. Without access to Medicare data, Medicaid agencies have only a limited picture of the dual eligible population. This lack of information inhibits a state’s ability to address the needs of the population and the misalignments in care that result from the current fragmented system. States generally have two ways of obtaining Medicare data:

- 1) Requesting Medicare data files from CMS and the Research Data Assistance Center; or
- 2) Seeking CMS approval to reuse the Medicare Parts A and B data provided through the Coordination of Benefits Agreement for quality improvement activities and/or to re-release the data to make treatment disclosures to providers.

The options for accessing Medicare data each have pros and cons associated with them, both in terms of the data available and methods for obtaining them.<sup>11</sup> CMS is optimistic, however, that a better process for states requesting Medicare data will be available soon.<sup>12</sup> Regardless of the source, Medicare data, when linked with a state's Medicaid data, can provide the state with valuable information about dual eligible beneficiaries, including basic cost and utilization data, diagnostic snapshots, and opportunities for improving care. For this data to be useful states must have a process in place and the resources available to analyze the data, make recommendations, and implement new courses of action based on data findings.

### **Claims Process**

Stakeholders and outside experts are often surprised to realize how little many states know about their dual eligibles. This is especially true when it comes to covered services for this population. Because reimbursement rules are different for dual eligibles than for other Medicaid beneficiaries—since Medicare is the primary payer—and Medicare data is difficult to obtain, states often are not familiar with service utilization for this population. Also, since Medicare is the primary payer, historically, many states have not been as concerned about this population and therefore did not closely monitor their service utilization or claims.

This lack of understanding becomes even more challenging for states implementing a fully integrated dual SNP. Because of states' inability to mandate dual SNP enrollment for Medicare services, some individuals will be in the same dual SNP for both their Medicaid and Medicare services (the ideal situation); some individuals will be in one dual SNP for their Medicaid services and another dual SNP or MA plan for Medicare services (thereby missing out on the benefits of integrated care); and some will be in one dual SNP for their Medicaid services and in FFS for their Medicare services (again missing out on the benefits of integrated care). Furthermore, since dual eligibles can enroll and disenroll from a dual SNP at any time, their coverage can change from month to month, so one month they can receive integrated care and the next month, they can disenroll into a different plan. In addition, some states may be tempted to carve out certain Medicaid services from inclusion in the dual SNP due to stakeholder pressure, thus making the claims process even more difficult. Many dual eligibles also have additional third-party coverage, which must be factored into the claims process. States will want to provide for adequate time and funding to design and implement the necessary changes to their Medicaid Management Information Systems. States will also want to ensure that the claims process will not be over burdensome to providers.

### **Quality**

Monitoring the quality of services for dual eligibles is very important, yet often difficult for states. Since Medicare is the primary payer for most medical services, states do not have easy access to medical claims information, much less the ability to mandate reporting on quality measures from providers. Ideally, fully integrated dual SNPs alleviate this challenge since one health plan is responsible for all services. However, without the ability to mandate enrollment into the dual SNP, enrollees are often not enrolled in the SNP for both Medicare and Medicaid services. In such cases, the dual SNP would not have access to both programs' data. Improving the quality of services for high-risk individuals is a primary goal of SNPs. Congress seeks to address this quality dilemma through provision §3205 of the ACA, which mandates that SNPs are NCQA approved by 2012.

States that include LTSS in their program will want to include quality measures for these services. States developing their integrated care programs through §1915(b)/(c) waivers also need to ensure that the dual SNP can meet the often extensive quality reporting requirements of the §1915(c) HCBS waiver(s). This can be challenging for states because many states will need to rework protocols for LTSS data collection and CMS reporting. In addition, some SNPs may find these reporting requirements excessive and seek additional funding to fulfill this requirement.

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<sup>11</sup> For more information see L. Barnette. "Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles." Center for Health Care Strategies, Inc. July 2010. Available at [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261140](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261140).

<sup>12</sup> CMS Pre-Proposal Call on January 5, 2011, Discuss the State Demonstrations to Integrate Care for Dual Eligible Individuals. <http://www.innovations.cms.gov/events/events.shtml>.

### ***Consumer Protections: Marketing, Grievances, and Appeals***

Ideally, integrated care should simplify navigating medical services and LTSS. Due to differences in state and federal rules for Medicaid managed care and dual SNPs, it is virtually impossible to develop a single system of consumer protections for dual eligibles enrolled in dual SNPs. State Medicaid programs must require that dual SNPs meet the Medicaid marketing, grievance, and appeal rules found in 42 CFR 438 et seq. and CMS requires that dual SNPs also meet the rules for MA plans set out in 42 CFR 422 et seq. These rules do not always overlap. In addition, many states have state consumer protection regulations that dual SNPs must also follow.

### ***Provider Networks***

If a state chooses to work with national plans that have experience with managed LTSS, behavioral health, or integrated care, these organizations will likely have established protocols for network development and provider enrollment. If a state, however, chooses to work with plans that are new to integrated care, then the state will likely have to spend a fair amount of time educating the dual SNPs and providers about the new program. In addition, dual SNPs new to LTSS and community behavioral health services may initially be surprised at the limited licensing and credentialing standards for most of these services. This is especially true if the state plans to include self-directed services (where the individual hires and trains his or her own attendant) in its program. States new to managed LTSS and behavioral health will also need to develop network adequacy standards for providers to ensure that there is ample access to services. States may want to facilitate initial conversations between the dual SNP and LTSS and behavioral health providers, and may also need to educate the dual SNP on self-directed care.

## **3. Obtaining CMS Approval**

The state should keep CMS abreast of its program design elements, but the program will not be able to draw down federal matching funds until CMS grants final approval for the program. If the state is developing its program under §1915(b) and §1915(c) authority, CMS requires that all rules for the two waiver programs are met. Several states encountered difficulty with the CMS approval process for these waivers since each waiver was reviewed independently and both CMS review teams were reluctant to approve the waiver until the other waiver was approved. Hopefully, the new Office of the Duals will help eliminate this type of challenge.

The §1115 waiver approval process often requires a significant amount of time for states to work through provisions with CMS. States seeking new authority or renewed authority under these sections, however, should benefit from §2601 of the ACA. This provision establishes a five-year approval period for waivers that provide Medicaid services to dual eligibles. Furthermore, states seeking approval from the newly established CMMI should be prepared to devote extra due diligence since this is a new authority and the approval process is unprecedented.

## **4. Contracting with Dual SNPs**

By now, states should have a good idea which dual SNPs are interested in contracting with the state. States may choose to release a competitive procurement document where the state expects to pick a limited number of dual SNPs or the state may choose to open up the procurement to an “all qualified bidders” approach. The all qualified bidders approach may be attractive to some plans that do not want to invest the effort into responding to a procurement request and developing a preliminary network if they are not certain they will be awarded the contract. This process, however, may also dissuade some dual SNPs, since without a cap on the number of plans, there is no way to guarantee a minimum number of enrollees.

Depending on the state’s procurement rules, state staff may want to meet with interested plans prior to the proposal release to discuss the final program design. Coverage for dual eligibles is likely to be new to some

plans, so taking the time to meet with them to ensure that they understand the services for which they are bidding is important. Also, this gives the state the opportunity to confirm that it is not including anything in the program design that results in complete disinterest from dual SNPs.

Prior to the bidding process, state staff members also need to finalize reimbursement rates for the program. Over the past few years, reimbursement rates from CMS for SNP-covered Medicare services gave some plans ample cushion to absorb initial losses on the Medicaid side. The ACA establishes a schedule that decreases Medicare reimbursement for SNPs, so states looking to develop programs with dual SNPs over the next few years should be prepared for an extensive rate negotiation process.

## Conclusion

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To date, SNP-based programs are the most successful and frequently used model to integrate Medicaid and Medicare services for dual eligibles. States and health plans, however, are still in the early stages of feeling the impact of Medicare rate cuts mandated in the Reconciliation Act for these plans. In addition, if enrollment for Medicare services remains voluntary, SNPs may not be as attractive to potential enrollees if enhanced benefits such as vision and hearing services are cut.

The ACA sets the stage for state innovation in integrated care, but the extent to which this provision will generate the desired flexibility for states is yet to be seen. A number of states that participated in *TCDE* are hoping the new ACA authority will enable them to develop state-based integrated care programs, in which the state serves as the integrated care entity. The state would provide the full range of Medicare and Medicaid services by combining the funding streams for both programs. Such initiatives seem promising and offer innovative options for states.

The next 18–24 months will be very revealing for the future of integrated care. Improved care for this high-need population is imperative. Though this technical assistance brief is focused on developing an integrated care program with dual SNPs, many of the steps and decisions included herein are applicable to alternative models of integrated care. Through continued support from organizations such as The Commonwealth Fund and ongoing commitment to this population from forward-thinking stakeholders, the states and the federal government will continue to make strides in improving the quality, access, and cost-effectiveness of services for dual eligibles.

### ***Transforming Care for Dual Eligibles – Resources at [www.chcs.org](http://www.chcs.org)***

Under *Transforming Care for Dual Eligibles*, the Center for Health Care Strategies (CHCS) is working with seven states -- **Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont** -- to develop and implement innovative strategies for integrating care. This national initiative, made possible by The Commonwealth Fund, is seeking to develop a range of integrated delivery models for dual eligibles that can be implemented by other states across the country. Participating states are receiving in-depth technical assistance covering program design, care models, financing mechanisms and contracting strategies and CHCS is also facilitating linkages with the Centers for Medicare & Medicaid Services to identify new avenues for Medicare-Medicaid integration.

To learn about CHCS' *Transforming Care for Dual Eligibles* initiative or to download related resources, including policy briefs, hands-on tools, and templates to help guide state integration efforts, access *Integrating Care for Dual Eligibles: An Online Toolkit* at [www.chcs.org](http://www.chcs.org).

### **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. Visit [www.chcs.org](http://www.chcs.org) for more information.