



## Forum Session Meeting Announcement

**Friday, November 30, 2007**  
9:00–9:30am — Breakfast  
9:30–11:30am — Session

# Medicare Advantage Special Needs Plans Reauthorization: What Should Congress Consider?

### A Discussion Featuring:

**Jim Verdier, JD**

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Pennsylvania Health Law Project

### Location

**Reserve Officers Association  
of the United States**

One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor

*(Across from the Dirksen Senate  
Office Building)*

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# Medicare Advantage Special Needs Plans Reauthorization: What Should Congress Consider?

## OVERVIEW

*Medicare Advantage Special Needs Plans (SNPs) were created by Congress in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. These coordinated care plans are subject to all the same requirements as standard Medicare Advantage plans except (i) they must provide Part D benefits and (ii) they are authorized to limit their enrollment to targeted populations, namely beneficiaries dually eligible for Medicare and Medicaid; the institutionalized (or nursing home certifiable); and beneficiaries with severe or disabling chronic conditions. Designed to encourage greater access to Medicare Advantage (MA) plans for special needs individuals and to allow plans to tailor their benefits to meet unique needs, the SNP authority to limit enrollment has generated intense interest in the Medicare managed care market. The growth of the SNP market has far exceeded expectations. However, there are concerns that many plans are not experienced in working with special needs populations and that their benefit designs are not meaningfully different from standard MA plans. Many questions are being asked about SNPs, particularly about their added value, arrangements with states, and the extent to which truly integrated and specialized care is being delivered. In this Forum session, these questions and more will be explored in an examination of the current SNP market, its effect on Medicare and beneficiaries, plan interactions with states, and possible changes for the future as Congress considers extending the SNP authority to limit enrollment.*

## SESSION

Since 2004, the size of the Special Needs Plan (SNP) market has grown exponentially. The Centers for Medicare & Medicaid Services (CMS) approved 11 SNPs in 2004 and today there are 477 approved plans in operation. Enrollment in SNPs has grown substantially as well, reaching over 1 million beneficiaries this fall. With 320 plans and enrollment exceeding 750,000, dual eligible SNPs (that is, SNPs serving beneficiaries who are dually eligible for Medicare and Medicaid) represent over two-thirds of all SNP plans and three-quarters of enrollment (see table, next page).

The creation of SNPs brought with it the promise of coordinated, specialized care for special needs Medicare beneficiaries. Building on the experience of demonstration programs in several states, SNPs have been viewed as an opportunity to bring tailored managed care products to special needs beneficiaries as well as a means to integrate Medicare and Medicaid financing and benefits for dual eligibles. While all three types of SNP plans serve this population, the dual eligible plans present the greatest opportunity to coordinate care

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for beneficiaries because they can offer the full array of Medicare and Medicaid benefits—and supplement benefits—through a single plan with a single benefit package and one set of providers. Such plans could be an ideal vehicle for care coordination for low-income beneficiaries, who are generally in poorer health than others and as a result require more resources from both Medicare and Medicaid.

Despite this potential for a better coordinated system of care and the presence of a large number of dual eligible SNPs, there has not been as much coordination between plans and Medicaid programs as many anticipated.<sup>1</sup> The challenges in aligning different administrative, financial, marketing, and contracting requirements have contributed to the disconnect between SNPs and states, as has state experience with managed care. However, there are concerns about the actual interest in state-SNP coordination, particularly since coordination is voluntary for both stakeholders.

Although all three types of SNP plans have increased in number, the rate of growth in the number of chronic care SNPs from 2006 to 2007 has been the greatest. This is due in part to CMS' broad interpretation of "severely chronically ill and disabled" populations, which has allowed policymakers to see how the market develops. Another contributing factor to the growth is the full implementation of the risk-adjusted payment system in Medicare Advantage, which allows for more adequate payment for beneficiaries in poor health.

SNPs are paid like all other MA plans: they receive a capitated payment for each enrollee to cover Medicare Part A and Part B benefits.<sup>2</sup> SNPs receive the same payments other MA plans would have received for the same enrollees, but payments are risk-adjusted to reflect the potential costliness (based on health status) of each plan's enrollees. Therefore, CMS's per-enrollee MA payments to SNPs are generally higher than those for other MA plans in the same area.<sup>3</sup> This payment difference reflects the generally sicker, more at-risk (and therefore costlier) enrollment a SNP plan should have in comparison to a standard MA plan.

Concerns arise, however, when SNP and MA plans in the same area differ very little in services and benefits. The potential for inappropriate financial gain by targeting high-risk populations and not providing benefits to meet their special needs has raised questions about the marketing and enrollment practices as well as the benefit designs of some SNPs. In addition, some see the potential for an incentive for plans to "cream" by identifying the healthiest of the targeted populations, particularly the dual eligible population, thereby benefiting from the additional payment but not enrolling the sickest beneficiaries. These concerns lead some to question whether interest in financial gain is preventing investment in serving

### Aggregate Plan and Enrollment Data for SNPs, as of November 2007

SNP Type	Number of Plans	Enrollment
Chronic or Disabling Conditions	73	183,881
Dual Eligible	320	751,784
Institutional Care	84	144,928
<b>TOTAL</b>	<b>477</b>	<b>1,080,593</b>

*Note: Excludes plans with enrollment of 10 or less and employer-only group plans. Includes Puerto Rico.*

*Source: CMS Health Plan Management System, available at [www.cms.hhs.gov/MCRAdvPartD/enrolData/SNP/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1205177&intNumPerPage=10](http://www.cms.hhs.gov/MCRAdvPartD/enrolData/SNP/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=descending&itemID=CMS1205177&intNumPerPage=10).*

special populations. Are plans targeting the right populations? Are they providing the specialized services their high-risk enrollees need and for which they're being paid?

The authority allowing SNPs to limit their enrollment is scheduled to sunset in December 2008. Without extension of this authority, plans with the SNP designation will either revert to standard Medicare Advantage plans, seek demonstration approval, or leave the Medicare market altogether. As Congress considers extending this SNP authority, the development of the market to date and information on what SNPs offer Medicare beneficiaries will affect whether Congress finds that SNPs meet (or potentially can meet) the special needs of the medically complex populations they were envisioned to enroll.

## KEY QUESTIONS

- What expectations were inherent in the initial authorizing language regarding SNP coordination of care for special needs beneficiaries? How well is the current market meeting these expectations?
- What are the challenges to CMS, states, and SNPs in aligning Medicare and Medicaid benefits, care oversight, and financing for advancing integration?
- According to MedPAC's March 2007 report, SNPs are paid 18 percent more than Medicare fee-for-service would spend on the same beneficiaries. Is this too much?
- What are the incentives and disincentives for states to enter into contractual arrangements with dual eligible SNPs? Why don't more states have contracts with dual eligible SNPs? What effect does the presence of Medicaid managed care programs have on a state's interest or ability to pursue arrangements with SNPs?
- What do SNPs without state contracts—and therefore without integrated Medicaid services—offer dual eligible beneficiaries? How is beneficiary cost sharing addressed? Are low-income enrollees financially vulnerable in these plans?
- How will specific legislative proposals, such as requiring dual and institutional SNPs to have contracts with state Medicaid agencies, requiring chronic care SNPs to have an average risk score of 1.35 or greater, and requiring 90 percent of enrollees to be either dually eligible or institutionalized or to have a severe or disabling chronic condition, affect SNP viability? How might these proposals affect state-plan interactions?
- Will requiring more accountability for SNPs provide additional beneficiary protections?
- What should SNPs be required to provide, beyond what a standard Medicare Advantage plan provides, to meet beneficiaries' special needs? Are statutory changes necessary to ensure that SNPs are an appropriate choice for beneficiaries?

## SPEAKERS

**Jim Verdier, JD**, is a senior fellow at Mathematica Policy Research, Inc., in Washington, DC, where his work focuses on Medicaid, state health policy, and Medicare. He is also a senior program consultant for the Center for Health Care Strategies, a foundation-funded organization that helps states develop, purchase, and improve managed health care programs. He is a visiting lecturer at the Woodrow Wilson School at Princeton University, where he has co-taught courses on state health policy since 1998. He was the Indiana state Medicaid director from 1991 to 1997, and deputy director of the Michigan Department of Management and Budget from 1989 to 1990. He taught public management and policy analysis at the Kennedy School of Government at Harvard from 1983 to 1989, and he headed the Congressional Budget Office's Tax Analysis Division from 1979 to 1983. He is a graduate of Dartmouth College and Harvard Law School.

**Abby L. Block** is the director of the Center for Beneficiary Choices at the Centers for Medicare & Medicaid Services (CMS). Before that she was a senior advisor to the CMS Administrator and played a leading role in implementing the Title I and Title II provisions of the Medicare Modernization Act. She worked extensively with health plans and beneficiary advocacy groups to ensure an effective transition to the new Medicare Advantage and prescription drug programs in 2006. Before transferring to CMS, Ms. Block was deputy associate director at the U.S. Office of Personnel Management (OPM), where she was considered the expert on federal health and life insurance programs, as well as federal retirement systems. She has served as a technical expert to the Bush administration, Congress, employee organizations and associations, the insurance industry, and others on related issues. Ms. Block has MA, MSW, and MBA degrees from Columbia University.

**Pamela J. Parker** is manager of special needs purchasing within the Health Care Administration Purchasing and Service Delivery Division in the Minnesota Department of Human Services. She directs the Minnesota Senior Health Options (MSHO) and the Minnesota Disability Health Options (MnDHO) Medicare payment demonstrations, and she is responsible for contracting with 17 Medicare Special Needs Plans for dually eligible enrollees. MSHO/MnDHO programs provide integrated primary, acute and long-term care Medicaid and Medicare services to about 37,000 elderly and people with disabilities through specialized managed care delivery systems. She also manages Minnesota Senior Care and Minnesota Senior Care Plus for seniors required to enroll in Medicaid managed care, as well as Special Needs BasicCare, a new integrated program for people with disabilities. Ms. Parker has a master of public administration degree from Harvard's Kennedy School of Government.

**Robb A. Cohen** is chief government affairs officer for XLHealth. He has worked with XLHealth since 1998, starting with working on the business plan as a consultant and becoming a full-time employee in 2003. Most

recently, Mr. Cohen has been responsible for the company's Medicare Advantage Chronic Care Special Needs Plan strategy, development, and implementation activities; for beneficiaries with diabetes, heart conditions, and end-stage renal disease; and for what are now the largest Chronic Care Special Needs Plans in the United States. He graduated from The Wharton School with an MBA degree in finance and health care management.

**Alissa E. Halperin, JD**, is managing attorney with the Pennsylvania Health Law Project, a statewide public interest organization that provides free legal services to lower income people, seniors, and individuals with disabilities on health care coverage and access issues relating to Medicaid, Medicare, Program for All-inclusive Care for the Elderly (PACE), State Children's Health Insurance Program, and other programs. Ms. Halperin's work has focused on health care and long-term care access and coverage issues for lower income seniors and adults with disabilities. She is an appointee to the Intra-Governmental Council on Long-Term Care, the Department of Public Welfare's "Olmstead" Stakeholder Planning Team, the Governor's Office of Health Care Reform Stakeholder Advisory Taskforce, and the Department of Aging End of Life Taskforce. Ms. Halperin received her BA degree from the University of Washington in Seattle and JD degree from Villanova University School of Law.

## ENDNOTES

1. Charles J. Milligan and Cynthia H. Woodcock, "Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer," Center for Medicare Advocacy, Inc., October 8, 2007; available at [www.medicareadvocacy.org/SNP%20Conference/BackgroundInfo/ConferencePapers/MilliganAndWoodcock\\_10.15.2007.PrimerOnSNPs.pdf](http://www.medicareadvocacy.org/SNP%20Conference/BackgroundInfo/ConferencePapers/MilliganAndWoodcock_10.15.2007.PrimerOnSNPs.pdf).
2. Payment for Part D prescription drugs services is calculated separately.
3. James 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., October 2006; available at [www.chcs.org/usr\\_doc/Medicare\\_Advantage\\_State\\_Primer.pdf](http://www.chcs.org/usr_doc/Medicare_Advantage_State_Primer.pdf).



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