KAISER FAMILY FOUNDATION

Medicare Policy

MEDICARE HEALTH PLANS AND DUALLY ELIGIBLE BENEFICIARIES:

Industry Perspectives on the Current and Future Market

MARCH 2013

THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE HEALTH PLANS AND DUALLY ELIGIBLE BENEFICIARIES:

Industry Perspectives on the Current and Future Market

MARCH 2013

Prepared by:

Marsha Gold, Sc.D. and Winnie Wang
Mathematica Policy Research

and

Gretchen Jacobson, Ph.D.
Kaiser Family Foundation

THE HENRY J. KAISER FAMILY FOUNDATION

EXECUTIVE SUMMARY

Policymakers are debating how to improve the efficiency and effectiveness of health care for beneficiaries dually eligible for Medicare and Medicaid. The federal government and states are beginning to test ways to financially align Medicare and Medicaid benefits for beneficiaries served by both programs; some of these demonstrations will enroll dually eligible beneficiaries into capitated managed care plans for both their Medicare and Medicaid benefits, and many will be managed by some of the firms that also offer Medicare Advantage plans. Over the past few years, these firms have also seen a growth in enrollment of dually eligible beneficiaries into Medicare Advantage plans, Special Needs Plans (SNPs) in particular, and this growth, as well as changes in policies and requirements for SNPs focused on dual-eligible beneficiaries (D-SNPs), has caused some firms to more closely manage the care of their dual-eligible enrollees. In addition, the future role of D-SNPs has been debated.

To inform these policy debates, we interviewed senior executives at 13 diverse insurance firms that contract with the Medicare and Medicaid programs to learn more about (1) how insurance firms view various proposals to better align the way Medicare and Medicaid work for individuals served by both programs, and (2) how dual-eligible beneficiaries are currently served by Medicare Advantage plans, particularly D-SNPs.

Perspectives on the Future with the Financial Alignment Initiatives

- Firms' perspectives on efforts to integrate Medicare and Medicaid for dual-eligible beneficiaries reflect the different backgrounds that have shaped the firms; some firms were developed from a largely commercial base, others began by managing Medicare benefits, and still others have a long history of managing Medicaid benefits and/or a mission and a vision of serving low-income individuals, including dual-eligible beneficiaries.
- The development of three-way contracts between the federal government, states, and health plans (a central feature of the Capitated Financial Alignment Initiatives) has been much more challenging than some initially expected. Some voiced concern that ultimately the contracts may "scotch tape" requirements across programs rather than provide true integration. The absence of critical details in the proposals and contracts, such as benefit specifications, rate levels, and risk adjustment methods, make it difficult to negotiate with providers or plan ahead.
- Experienced firms, in particular, perceive the needs of dual-eligible beneficiaries as varying substantially across the population—that is, the same product will not necessarily serve all well. The needs of the elderly, they said, typically differ from those under-65. Among under-65 dual-eligible beneficiaries, different provider networks and care management techniques are likely to be needed for key subgroups, such as those with severe mental illness, developmental disabilities, and physical disabilities. Few organizations are perceived as having all of the core competences they need to effectively manage the diversity of subgroups.
- Most interviewees see some savings potential from financially integrating Medicare and Medicaid services, but believe that capturing these savings likely will require time, organizational development, and work with providers to obtain their buy-in. They state that assumptions on savings need to be realistic and appreciate the positive role they see the Centers for Medicare & Medicaid Services (CMS) playing in setting realistic expectations of savings in negotiations with states.
- Firms' representatives also feel that the design of the Medicare-Medicaid Financial Alignment Initiatives is critical. Their primary concern is that highly visible failures could set back the initiatives and jeopardize their long-term success. Additionally, they think that a lengthy time frame is critical to the success of the

initiatives, noting that even three to five years could pass very quickly during the introduction of such a major change; however, they believe the financial integration and alignment of Medicare and Medicaid could improve care for beneficiaries and would like to see the initiatives get underway.

- Almost all firm interviewees think that dual-eligible beneficiaries will become more important to their business over time. Firms generally are highly supportive of efforts to integrate Medicare and Medicaid financing, and perceive the potential to improve care for dual-eligible beneficiaries and generate important new business opportunities.

Enrollment of Dual-Eligible Beneficiaries in Medicare Advantage Today

- The few firms that currently specialize in caring for dual-eligible beneficiaries say that effective care requires meeting both medical and social needs.
- Firms that offer D-SNPs see these plans as financially viable; however, they are concerned that some Medicare Advantage payment policies (e.g., risk adjustment, bonus payments) have been applied without being adapted to the special circumstances of dual-eligible beneficiaries. These financial issues are a growing concern as bonuses and risk adjustment become increasingly important components of plan payments.
- All interviewees state that their firms are taking a closer look at expanding future products for dual-eligible beneficiaries, including maintaining D-SNP products. It is unclear to firms how initiatives to improve care for dual-eligible beneficiaries will unfold. To position themselves, some are adding to their core competencies through acquisitions of both large and small firms, including firms with expertise in managing dual-eligible beneficiaries and those with skill sets that are important for effectively managing dual-eligible beneficiaries' care (e.g., behavioral health, data analytics).

Conclusions

The market to manage the care for dual-eligible beneficiaries, including D-SNPs, is evolving as firms line up to pursue new opportunities for financially integrating Medicare and Medicaid services. Such integration has proven more challenging than anticipated, as CMS and states work to reconcile the complex operational details.

Executives from experienced plans observe that the dual-eligible population is complex, with diverse needs, including subgroups such as the frail elderly, beneficiaries under the age of 65 with physical disabilities, and beneficiaries with chronic mental illnesses. Managing the care for each of these subgroups requires better integration of medical services, social services and long-term care than is generally available today. Yet, the same care management plan probably is not appropriate for every subgroup, especially those with specialized needs. Few firms have experience with all core competencies needed to manage the care of the different subgroups of dual-eligible beneficiaries.

Interviewees view the integration of Medicare and Medicaid services and financing as important to enhancing care for dual-eligible beneficiaries, who they believe are poorly served by the current system. They also state that the initiatives should be designed carefully and implemented thoughtfully due to high risks of failures and lengthy time required for full implementation. However, firms' experience with financial integration of Medicare and Medicaid is limited and few organizations have all core capabilities necessary for success. The long-term success of financially integrating the programs will be enhanced by the support and collaboration of all stakeholders.

Medicare Health Plans and Dually Eligible Beneficiaries:

Industry Perspectives on the Current and Future Market

Policymakers are debating how to improve the efficiency and effectiveness of health care for beneficiaries dually eligible for Medicare and Medicaid. The federal government and states are beginning to test ways to financially align Medicare and Medicaid benefits for beneficiaries served by both programs; some of these demonstrations will enroll dual-eligible beneficiaries into capitated managed care plans for both their Medicare and Medicaid benefits, and will be managed by some of the firms that also offer Medicare Advantage plans. Over the past few years, these firms have also seen a growth in enrollment of dual-eligible beneficiaries into Medicare Advantage plans, and Special Needs Plans (SNPs) in particular, and this growth, as well as changes in policies and requirements for SNPs focused on dual-eligible beneficiaries (D-SNPs), have caused some firms to more closely manage the care of their dual eligible enrollees. In addition, there has been some debate about the future role of D-SNPs.

To understand the various approaches Medicare Advantage plans use to manage the care for dual-eligible beneficiaries, and to understand the industry's views of initiatives to integrate Medicare and Medicaid financing and services for dual-eligible beneficiaries, we conducted a series of in-depth interviews with senior executives at 13 diverse firms that contract with the Medicare and/or Medicaid programs (see **Methods** text box). This issue brief describes the findings and core themes that resulted from the interviews.

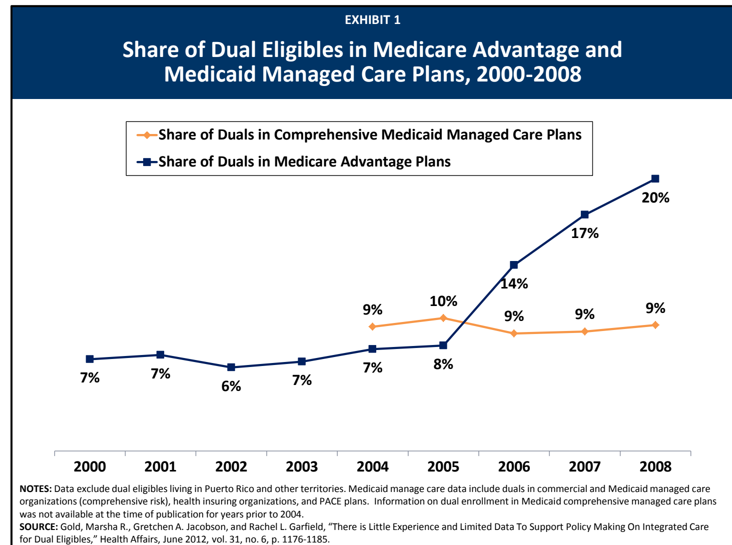
Organization of the brief. This brief is organized into two main sections. The first section describes firms' perspectives on the financial alignment initiatives that the Centers for Medicare & Medicaid Services (CMS) is pursuing, including operational issues and overall strategic concerns. We then summarize the insights gained on broader policy and delivery issues related to integration and alignment of programs serving dual-eligible beneficiaries, as reflected in the interviews.

The second section reviews the current Medicare Advantage landscape for dual eligible beneficiaries, and summarizes key findings from the interviews on the factors behind the enrollment of dual eligible beneficiaries in regular Medicare Advantage plans, how their care is managed within these plans, and firms' history with D-SNPs. We then discuss D-SNP products, including how they are structured, different models of care management, and associated policy issues, including risk adjustment and bonus metrics (star ratings).

BACKGROUND

Medicare beneficiaries who are dually eligible for Medicaid have complex health care needs that account for a disproportionate share of spending in both programs.[1] There is considerable interest in improving the alignment of care delivery for those dually eligible so that care is better coordinated in ways that enhance quality, improve outcomes, and reduce costs.[2] Yet, many questions remain about how to best structure such arrangements and what outcomes are reasonable to expect.[3]

Because Medicare is responsible for most acute care coverage, many managed care initiatives for the dually eligible build on this program. Most dual eligible beneficiaries are enrolled in traditional fee-for-service (FFS) Medicare, but some have enrolled in Medicare Advantage plans and their predecessors. The share of dual-eligible beneficiaries enrolled in Medicare Advantage plans increased beginning in 2006 with the introduction of SNPs (**Exhibit 1**). Historically, a smaller share of dual-eligible beneficiaries has been enrolled in Medicaid managed care.[4]



NOTES: Data exclude dual eligibles living in Puerto Rico and other territories. Medicaid manage care data include duals in commercial and Medicaid managed care organizations (comprehensive risk), health insuring organizations, and PACE plans. Information on dual enrollment in Medicaid comprehensive managed care plans was not available at the time of publication for years prior to 2004.
SOURCE: Gold, Marsha R., Gretchen A. Jacobson, and Rachel L. Garfield, "There is Little Experience and Limited Data To Support Policy Making On Integrated Care for Dual Eligibles," Health Affairs, June 2012, vol. 31, no. 6, p. 1176-1185.

In 2011, about 20 percent of dual-eligible beneficiaries were in a Medicare managed care plan of some type; about half (9 percent) were in specialized plans, mainly D-SNPs, and the rest in plans open to enrollment by all Medicare beneficiaries. Dual eligible beneficiaries under the age of 65 are less likely to be enrolled in a regular Medicare Advantage plan than in either a D-SNP or the traditional Medicare program.[5]

According to the Government Accountability Office (GAO), most dual-eligible beneficiaries (66 percent) who are enrolled in Medicare Advantage plans (other than SNPs) are *not* eligible for full Medicaid benefits, but rather only receive Medicaid coverage of Medicare premiums and/or cost-sharing.[6] The other third are "full" duals, eligible for their state's entire Medicaid benefits package as well as assistance with Medicare premiums and cost-sharing. When a dual eligible beneficiary is enrolled in a Medicare Advantage plan, the plan generally covers only Medicare (not Medicaid) benefits. Even among D-SNPs, only one-third of D-SNPs provided any coverage of Medicaid benefits in 2011, and only about one-fifth had any coverage of long-term care benefits.

With new authority granted by the Affordable Care Act (ACA) of 2010, CMS has been working to better align Medicare and Medicaid programs to meet the needs of dual-eligible beneficiaries.[7] Fifteen states received design contracts in 2011 to develop programs to enhance care for dual-eligible beneficiaries. In July 2011, CMS released a paper laying out a capitated model for such alignment, as well as a managed FFS model, for state-based alignment.[8] CMS offered all states, not just those receiving design contracts, the option to apply to participate in a financial alignment initiative; 26 states ultimately submitted proposals that were publicly reviewed. (A few states have subsequently withdrawn their applications.) While CMS initially expected to mount a broad-based initiative covering many states rapidly, progress on state initiatives to financially align Medicare and Medicaid benefits for dual-eligible beneficiaries has proceeded more slowly than originally anticipated.[9] Indeed, such a slow-down was evident over the time period of our interviews, as were some of the reasons it occurred.

METHODS

This brief is based primarily on telephone interviews with top executives responsible for the SNP/duals-line of business in 13 firms, conducted during the summer of 2012; some involved multiple executives with diverse responsibilities in a particular company. We explained to the interviewees that all interviews would be confidential and the resultant reports would not attribute comments to particular individuals or organizations.

The interviewees were selected to reflect a variety of types of firms:

- Five with large commercial payers having multiple lines of business and a history in different segments of the market. All of them participated in Medicare Advantage, although not all offered D-SNPs. Most had Medicaid products as well. They included publicly traded firms, large non-profit or community-based organizations, and companies affiliated with Blue Cross-Blue Shield.
- Five with predominantly Medicaid-oriented companies that had experience with higher-need populations. They included both publicly traded and non-profit firms.
- Two that specialized in chronic care management for Medicare.
- One whose business was primarily oriented around Medicare.

Together, these firms offer plans in all 50 states and the District of Columbia, and include more than 45 percent of Medicare Advantage enrollees and more than 45 percent of enrollees in D-SNPs. Diversity is important for gaining an industry-wide view, since Medicare Advantage firms approach products for dual-eligible beneficiaries from different backgrounds and perspectives. Some see the management of care for dual-eligible beneficiaries from the perspective of a largely commercial base, others from their start in Medicare, and still others from a long history of Medicaid involvement and/or a mission and vision of serving low-income individuals, including dual-eligible beneficiaries.

The interviews were guided by a semi-structured interview protocol (see **Appendix A**). Topics covered included 2012 Medicare Advantage and SNP products and arrangements used to manage care for dual-eligible beneficiaries; changes anticipated by 2013, including firms' responses to new policies; engagement in and perspectives on new initiatives for duals demonstration and alignment programs; and perceptions of the policy and market environment.

As with any project based on a limited number of interviews, the findings may not necessarily be representative of the industry as a whole; however, those we interviewed represent diverse members of that industry and include firms that enroll large numbers of dually eligible Medicare-Medicaid beneficiaries.

Operational Challenges

General dynamics and strategic concerns. As firms seem to perceive it, states' interests are driving the push for financial alignment initiatives, but CMS also is exerting an important influence through its focus on the realism of cost projections, the availability of beneficiary protections, and other features of the design for such initiatives.

Firm representatives said that in some cases, competing priorities or concerns have led states to back away. For example, a representative said that Pennsylvania decided not to pursue participating in a CMS demonstration to financially align Medicare and Medicaid at this time because the state perceives it as impossible to do as many things simultaneously as would be needed to meet a 2013 timeline, as initially called for by the schedule. In Minnesota, the requirement to share savings between Medicare and Medicaid was a concern to health plans because most dually eligible beneficiaries were in the Minneapolis-St Paul area, where Medicare Advantage payments already were on a path to being substantially reduced. Firms in Minnesota indicated that these and other fiscal concerns led the state to withdraw from pursuing the state's participation in the CMS Capitated Financial Alignment Initiative in the hope that alternative demonstration designs might be more supportive of the state's interests and health care context.

With limited resources, firms also indicated that states had to set priorities. For example, should they proceed first with a Medicaid-only long-term care initiative for the aged, blind, and disabled, or should they begin with the financial alignment for dually eligible beneficiaries? If duall eligible beneficiaries were to be the focus, should they first pursue initiatives for those under age 65, age 65 and older, or both?

Challenges in developing three-way contracts. A core feature of the CMS Financial Alignment Demonstration involves the development of a three-way contract between Medicare, Medicaid, and health plans (for states pursuing a capitated model). The goal is to integrate requirements and payments across Medicare and Medicaid via a single contract with a health plan. Health plans, instead of contracting directly with Medicare for a D-SNP and with Medicaid to provide either full Medicaid benefits, more limited benefits, or information sharing around dually eligible beneficiaries, instead would enter into a single contract that covers both programs.

How extensively such integration actually occurs remains to be determined. As one interviewee said:

> "… it looked easier than it is … the combination and integration of those funding streams, along with benefits, makes a lot of sense, but creating that three-part agreement is no easy task."

Some firms were concerned that the challenges would result in "scotch taping" requirements across the programs, rather than real integration. An example is a requirement for firms to make two welcome calls to beneficiaries—the scripted call required within 10 days for verification, and a separate call by a care coordinator that the firm uses to build a rapport. The requirements for each call differ, so they could not be combined effectively. From the firm perspective, operational challenges with integration arise across a range of areas. Firms indicated that marketing, eligibility, network adequacy, and data reporting are among the areas for which different sets of requirements need to be integrated, but where the process of achieving consensus on how to do so could be difficult.

From the firms' perspectives:

- **Marketing**: Under a three-way contract, there should be a single set of member materials and a single review process across the two programs. However, Medicare's readability requirements are generally less demanding than those for Medicaid. Firms' representatives felt that initial drafts were based more on Medicare requirements and likely would be problematic for states.

- **Eligibility**: Both Medicare and Medicaid have their own eligibility requirements and neither program is likely to cede the execution of these to the other or an integrated process. Firms were concerned that Medicare eligibility takes longer to ascertain, which might mean that they would be held liable for retroactive eligibility if they were notified first about Medicaid, followed by Medicare. Covering Medicaid benefits before Medicare benefits kick in also could complicate efforts to use an initial visit for comprehensive screening and risk stratification.

- **Network adequacy**: Each program has standards to assess network adequacy that may differ from one another. If the standards differ, should the more stringent standard apply to support integration? Since stringency also could vary by provider type, would this mean that any such test must be provided separately for each provider type? What if the provider groupings used for standards differ across the two programs?

- **Data reporting**: Since benefits are integrated, how should the submission of data applying to delivery of those benefits be handled? Plan interviewees' knowledge of CMS's original proposal was that CMS would acquire data to distribute to states, but states do not want to lose direct submission from plans. Thus, from the firm's perspective, *"Instead of having a single encounter process, we may still be creating two encounters and essentially pulling the benefits apart on the back side, which I think is an administrative burden that I don't think any of us want to necessarily take on."*

While our interviews involved firms that operate health plans, a recent survey of states indicates that they also see the development of financial alignment as challenging, particularly when they are taking on responsibilities for many other aspects of ACA implementation, including those related to the expansion of Medicaid and the creation of exchanges.[10] Like health plans, they are concerned about the many financial unknowns, including how savings and data will be shared and how differences in regulations and procedures will be resolved, and are concerned about the gaps in care that might emerge in the transition to aligning Medicare and Medicaid services.

These issues are complex and, over the period of our interviews, most activity related to financial alignment centered on work by CMS and states, to create a template or memorandum of understanding (MOU) laying out the general parameters of Medicare and Medicaid coordination that will be embedded in subsequent three-way contracts that add health plans to the mix. The first such MOU, for Massachusetts, was made public only in late August 2012, and many operational details, such as rates, were left blank and remained to be negotiated with health plans.[11] A second MOU, with Washington State—based on a managed FFS model—was announced on October 25, 2012;[12] no three-way contracts had been finalized as of November 2012.

Uncertainty about payments creates operational problems for plans. Because the MOUs are under development, and critical financial information still is not available, firms note that the states that are more actively engaged in pursuing contracts with plans often asked them to respond to Requests for Proposal (RFPs), in which critical and important fields, such as rates and responsibilities, are left blank. Such omissions make it difficult for firms to provide anything but a "soft" agreement. Uncertainty also trickles down to providers and networks if a key variable central to provider contracting is missing.

When asked about whether there were particular issues that complicated negotiations, "money" was a common response. As one firm representative said, "We're not doing a lot of negotiation at this point." One of the states with which this firm expected to work in 2013 was still involved in the RFP process and the other was awaiting approval from CMS. Until those discussions are complete, "We haven't really been talking about rates," according to an interviewee. In an uncertain environment, firms noted that they are trying to be accommodating. For example, one interviewee mentioned telling the firm's leadership: "We're just going to go without knowing [the answers to key issues] because we know everyone is doing as much as they can." Whether the three-way contract sets rates or allows for some negotiation with plans, firms want to know the amount they will receive and what their responsibilities will be so that they can assess product feasibility and negotiate contracts with providers in their networks.

State programs have limited resources. Firms indicated that many states' capacity to deal with complex program design and implementation issues has been affected adversely by the multiple demands on state staff and cascading effects of the economy on the state labor force. In at least two large states, for example, critical senior leaders have retired, limiting progress. The impact of resources is less of a barrier in certain states, however. For example, firms noted that Massachusetts leadership viewed integration as such a critical issue that it was given top priority for resources. Representatives said that in Minnesota, they have a long history of working closely with state staff to carry out implementation work, thus supplementing the available resources. States that have been awarded federal dual eligible design contracts also have the added flexibility of using those funds.

Broader Policy and Delivery Issues

These interviews with firms provide insight on major issues important to integrating care for dually eligible beneficiaries and aligning Medicare and Medicaid benefits. Using these insights, we have identified a number of points many firms perceive as relevant to shaping successful initiatives.

Needs vary and one product does not necessarily fit all. Firms, particularly those with more experience, stressed the diversity in needs across the dual eligible population. Those 65 and older typically have different needs from those under 65 who qualify for Medicare due to disability rather than age. For example, mental health needs for an older population may center predominately around depression and dementia, whereas psychosis and related conditions are more common in the younger population, a large share of whom may have persistent and severe mental illness. Within the under-65 disabled group, some qualify because they have specific medical conditions, while others may have physical or developmental disabilities, which also influence the age of initial eligibility. Across all subgroups, health status varies, so plans must accommodate the needs of the frailest members, while also recognizing that others may not have such needs.

Firms whose experience is predominately with Medicare typically are more experienced in working with the aged than other dual eligible subgroups. However, even among these firms, not all have experience in managing long-term care benefits, an expertise firms viewed as critical to success across the subgroups.

Scale also can be an issue. For example, those residing in nursing homes may be scattered in multiple locations, making care management complicated, particularly if enrollment is not of sufficient scale to support facility-specific programming.

Focusing on medical homes as one basic building block for plans serving dually eligible beneficiaries, one firm representative explained:

> "The more fragile, the more high-end the population, the bigger the challenge health homes are in general. We're much more comfortable today in knowing what health homes need to be for fragile seniors than what it needs to be for the other two segments of the population [people with serious mental illnesses and people with physical disabilities]. For example, for the seriously mentally ill, the health home will likely not be in a general medical setting … On the physical/developmental side, it is lack of general capacity to provide primary care to those members so they do not end up in the ER or with subspecialties [that determines success]. All too often, primary care physicians feel inadequate to deal with their issues."

Representatives said that firms seeking to enter the dual eligible market should think carefully about the expertise needed for different populations of dual-eligible beneficiaries and develop appropriate strategies building on core strengths that exist or can be acquired, whether internally, through acquisition, or by partnership.

Medicaid experience is useful, but TANF experience with low-income parents and children is not enough. In some states, firms are building their dual eligible initiatives around those health plans with which they already contract for Medicaid managed care. Because of Medicaid's role in financing care for people with disabilities, Medicaid health plans often have more experience than do Medicare plans with care for under-65 populations with disabilities. These plans also are familiar with state requirements. However, Medicaid plans may not necessarily always have advantages. As one interviewee noted:

> "There's a world of difference between TANF and SSI population[s]. Those states that have not [managed the SSI population] have missed out on an opportunity to learn that skill set … But [at the same time] to assume you can do Medicare and also just combine it with the state with no Medicaid experience, I think is folly."

Compared to low-income parents and children, those who qualify for coverage under SSI require much more extensive care management. As one firm saw it:

> "What makes it different [from Medicare] is the other wrap services you provide. You can take care of diabetes and CHF [congestive heart failure], and so can many other Medicare plans. What makes it difficult is that these people are poor, they are very sick, they have multiple illnesses, they don't have transportation, they don't have a lot of family and social support services, and that's what you got to do to be successful in taking care of them … they require a lot of hand holding."

A firm that was gearing up to serve the dual eligible population noted that they expected its product to be very community based. It would be plugged into

> "… all the 501(c)(3) [organizations] that serve poor and disabled. [There would be] more emphasis on ambulatory care [and] coordination. [They would] get way upstream on morbidity to prevent unnecessary hospitalizations—[by caring for individuals as] outpatients, allowing early identification of disease, and targeted provider support, with more intensive pharmacy management."

Successful products need to align clinical and financial incentives, including those facing hospitals, according to the interviewees. Behavioral health, one interviewee said, is a huge challenge because it is an important comorbidity that is difficult to integrate with other services. Despite their experience, firms still are learning how best to manage the complex care needs of the dual eligible population.

These interviews showed that major national firms with multiple lines of business tend to place products for dually eligible beneficiaries within their Medicaid rather than Medicare product lines, suggesting that they see as vital the expertise in dealing with state Medicaid programs and the associated Medicaid populations with lower incomes and more complex needs. At least one interviewee anticipated that firms developing plans for dually eligible beneficiaries would ultimately encounter many of the same issues industry faced in operating both Medicaid and commercial lines of business. As one interviewee with a long history in the industry observed, plans "that try to initially mainstream their Medicaid business with the rest of the commercial business end up creating separate units over time because the population is so different."

Large firms with multiple lines of business seem to be positioning themselves to play diverse roles as initiatives start up. However, while these firms might sponsor plans, they also could act as vendors of specialized expertise for hire or managers of plans they do not own.

Potential savings exist, but appropriate scale and speed are unclear. Firms are tracking closely the financial expectations of rates for integrated products. Representatives of firms with Medicaid products anticipate more potential for savings with aged, blind, and disabled Medicaid beneficiaries—who cost more—than with the relatively healthy parents and children eligible for Medicaid based on their low incomes. Preventive care and avoiding readmissions were viewed as potentially large sources of savings. Reduced administrative costs also were possible, at least in theory, because of the integration but "the new model is a lot easier to think about than to pull off," commented one interviewee.

Provider buy-in is critical. Firms noted that the provider role in generating savings may be key and is underappreciated. For example, whether the long-term care industry buys into the expected sources for aligned savings could be critical if those savings are expected to come from reducing nursing home residents' use of emergency rooms and hospitals. As one firm representative told us, "[the] LTC industry has to buy into the financial model. It has to be negotiated. You can't just do it as a plan." Such firms indicated that these conversations with long-term care providers had not even begun yet. Instead, the focus still was on preliminary work with states and CMS on three-way contracts, and partners do not have sufficient detail as of yet to reach out and engage the needed providers.

Providers' attitudes also can be critical to how passive enrollment plays out. Firms contrasted California's earlier experience with passive enrollment of dually eligible beneficiaries in County Organized Health Systems. They noted the differences between San Mateo, where two-thirds of those passively enrolled stayed with the plan,

and Orange County, where only 20 percent stayed; the rest disenrolled within 60 to 90 days of enrollment—everyone left "en masse." Firms' interpretations of the reasons for those differences and their current relevance were explained as follows:

> "What people say as the difference between those two models was the degree to which the primary care physician community bought into the model. The doctors picked up on the dynamic and [have now] started shopping among health plans and say 'Do you want me in your program—it's going to cost you this,' and then you go across the street and they say 'It's going to cost you 10 percent more than the other guy.' It's launched a primary care contracting price battle."

Whereas California is known for its large provider groups, many of those participating in Medicaid—at least in southern California—are said to be small practices, some ethnically grounded, that often also provide ancillary services directly. Firms noted that these providers are concerned not just about the compensation they receive for visits and clinical care but also the impact on the revenue that ancillary services generate for their practices. While California's proposed six-month enrollment stabilization period for its financial alignment demonstration has been criticized and ultimately rejected by the federal government, at least one firm thought it might provide some advantages in allowing members to experience the new system and diminish "some of the clout physicians are exerting."

Realistic assumptions about savings will be important. Not surprisingly, firms were concerned about whether contracts for dual eligible products would include realistic assumptions regarding savings.

They said they understood the need for beneficiary protection but also felt the plan should have the flexibility to implement care management features that align with those goals. For example, some interviewees criticized California's proposed plan for its initial expectations of 15 percent savings while at the same time setting requirements that constrained plans in generating those savings. Firms criticized draft provisions that required plans to use the county mental health network as their only provider for serious mental illness and yet maintain the same level of in-home support services. As one firm representative put it:

> "They mandated the status quo in a number of areas where plans like us think we can make an impact and save money. The number one issue is the disjoint in opinion between the expected 15 percent savings and the maintenance of the status quo."

Firms also felt that the challenges in alignment could be complicated further if states first phase-in programs with Medicaid managed care. For example, one firm's care model revolves around a Healthy Start exam, but Medicaid might pay for this only to cover Medicaid services, delaying intake and coordination until Medicare benefits are integrated.

The firms' interviewees had different perspectives on financial risk. A few reported historically low medical loss ratios in SNP products, which they attributed to the effective care management models they had put in place. They were confident they could generate savings if given the flexibility to do so.

Most were more cautious, however, seeking rates close to the current traditional Medicare cost baseline because "You don't want to kill the plan at the outset." They saw CMS's proposal for initially smaller savings as more realistic than some of the higher figures that states had proposed. As one firm perceived it, "Financially it's a gamble. No one really knows what the appropriate assumptions are on day one around costs savings."

Safeguards, such as appropriate risk adjustment, were important to them. In some states, experience with previous unsuccessful introductions of products for dual-eligible beneficiaries was another factor contributing to caution, with firms wanting to avoid setting up a program that would not succeed.

Representatives said they thought policymakers needed to recognize the big investments their firms would be making in infrastructure. As one said, "Everyone believes in it, but there'll be a tremendous amount of work to ensure that the outcomes justify the investments."

Growth requires time. Firms said that short-term savings assumptions need to factor in an implementation time frame as well. Time lags associated with start-up apply to all models but are especially critical for those that depend on physical facilities and direct hires. Uncertainty over approval and start-up dates has impeded firms' ability to plan for and implement the infrastructure changes needed to support these products. Such growth is capital intensive and favors firms with access to the capital market (large, for-profit firms) — perhaps one reason smaller companies have been a focus of recent acquisition interest. Another concern, especially for those firms with the most specialized models, involves uncertainty about how rapidly they want to grow. As one representative noted, "There's a limit to how fast and how big we want to be quickly."

Start-ups that involved immediate enrollment of everyone, rather than phased enrollment (perhaps geared to eligibility dates or geographic region), also were a concern because it is harder for plans to employ effective ways of introducing members to the plan if a large number of new members enroll at the same time.

Few organizations possess all core competencies. All of the firm representatives with whom we spoke saw weaknesses in the way care currently is provided for dually eligible beneficiaries and felt that this care has the potential of being better under an integrated model. They also recognized, however, that few firms have all of the core competencies required to deliver care to dual-eligible beneficiaries. Medicare firms might lack Medicaid experience; those in Medicaid might lack experience with aged, blind, and disabled populations; and few firms have experience with the specialized services needed for critical subgroups of dual-eligible beneficiaries, such as chronic care for mental illness.

For many dually eligible beneficiaries, their care management needs require much more than medical care, as discussed previously. Few firms have experience in meeting social as well as medical needs and also integrating long-term care benefits. Further, those with the most experience often are small organizations offering "high-touch, intensive care models" that have proven successful, but it is unclear how easily or whether they can be scaled up.

Provider capacity is also an issue. Some firms are concerned about their ability to attract sufficient providers to their network who are willing to accept contracts consistent with Medicaid's low payment levels. While firms may have convinced providers to participate when they served smaller numbers of enrollees, "how well this math actually works when the population is significantly [increased] could be an issue." Developing an adequate network could be an even greater problem for plans whose populations have needs that may be unfamiliar to many of the practices already in the firm's network.

Early failures may jeopardize the long-term success. Firms expressed their concern that early failures might jeopardize the long-term success of efforts to improve care for dual-eligible beneficiaries. For example, many of the most experienced firms indicated that, from their perspective:

> "We've got to be very careful in how we handle this population. Only those who have the willingness to deal with complex members and who, particularly in the integrated world, have shown the capacity for both Medicaid and Medicare [should be in there], particularly in the early years."

Yet, while firms were concerned with moving too fast, they also were concerned that progress not be impeded by "an excess of caution." When asked directly whether these initiatives involved human experimentation in the context of limited experience, one interviewee observed that "we are experimenting with you but what you're getting is better care than what you're getting in FFS." They felt the principles of managed care could be applied successfully in this situation. They also described the positive reaction their members had when they were called by the plan, saying "no one in FFS does that."

Unintended effects are possible. National strategies that seek broad-based reform often struggle with reconciling the impetus for new initiatives with potential adverse effects of change that might inadvertently undercut current initiatives. While it is too soon to determine the ultimate effects, such unintended effects seem, not surprisingly, quite possible as states move forward with their dual eligible financial alignment initiatives.

In California, current plans call for building the dual eligible infrastructure based on current Medicaid managed care contractors. While California employs at least three managed care models, many counties have a two-plan model, involving a public and a private plan. At the time of our interviews, some firms with small but well respected D-SNPs were uncertain how their current members will be affected in 2014, when these initiatives are scheduled to be implemented. While some hold a private contract with the state (or have a parent company that does so), others do not. Even if they are able to negotiate a subcontract, they have concerns about the equity of the arrangement and the financial adequacy of payments, which may be lessened by subcontracting fees or a care management capacity weakened by arrangements that limit its flexibility. Unless they can successfully transition their products to this new environment, some of these plans were concerned about surviving or thriving, even though their mission is well aligned with the goals of state initiatives.

Minnesota plans stated that because of their long history with initiatives focused on dual eligibility, they are highly sensitive to issues that can arise inadvertently. For example, Minnesota's Senior Health Options (MSHO) program predated the SNPs and was built by the state under federal demonstration authority.[13] Firms in the state said that the program in many ways worked along the lines of what the three-way contract seeks to do today: one application form, coordinated processes for complaints and grievances, and integrated benefits. Many of those served were age 80 and older and needed a care coordinator and other supports, including culturally appropriate services. When SNP authority was added to the Medicare Advantage program, the state wanted to keep the authority to run its demonstration, but the federal government required that it transition to a SNP. As a result of this transition, the program no longer qualified for the Program of All-Inclusive Care for the Elderly (PACE) frailty adjuster.

Some very experienced firms expressed concern that their experience is no longer of interest. As one firm representative put it: "My concern right now is that there's absolutely phenomenal programs in some states that have been operating for years and it's like people are looking for the next bright shiny object and not embracing some of the learnings and values we have from existing programs." Similarly, they are concerned that not enough attention has been paid to "make sure existing programs continue to survive." From their point of view, it might be better to build on an existing foundation than start from scratch. The legitimacy of such concerns, or the extent to which the experience of leading states can be exported to others with different histories and contexts, could not assessed.

Variation across states is a concern for national firms. Federalism generates conflicts by allowing states flexibility and then generating inconsistencies in state policies that add to administrative costs or lead to inequities in benefits for individuals located in different states. While such issues long have existed in Medicaid, they have not been as critical for the managed care sector because many of its participating firms have developed with the Medicaid product as their central focus, or as local plans that function in only one or a few states.

With the exception of UnitedHealthcare, large national insurance companies with multiple lines of business currently are not involved extensively in Medicaid programs serving the duals, but this is likely to change as firms anticipate growing their products for dually eligible beneficiaries across all or most of the states with current Medicare Advantage products, and Medicaid-experienced firms expand to additional states. National firms perceive that CMS has been a good influence on the market, encouraging consistency in expectations across states that should translate into more consistency across state programs. Such firms hope that specialized delivery for lower-income beneficiaries will lead to more standardization across states, particularly if it can be shown that some models of care have better outcomes than others.

Uncertainty about the long-term horizon. Almost all of the firms saw dual-eligible beneficiaries as a more prominent and important part of their business in three to five years than it is today. However, they also viewed this time horizon as a short one. As one said:

> "Three to five years is a fairly short time period when you're talking about having to create new programs or expand … things like LTC, in-home supportive services, and extended behavioral health [services]."

Firms are focused on identifying their core competencies as they develop their strategies and seek to take advantage of new opportunities. However, they also want to protect their current enrollment base and set of products from harm as they pursue these opportunities.

Dual-Eligible Beneficiaries in Medicare Advantage Today

While the CMS demonstrations to integrate Medicare and Medicaid services for dual-eligible beneficiaries are being developed, many dual-eligible beneficiaries are currently enrolled in Medicare Advantage plans and receive Medicare-covered services from a managed care plan. In 2011, about 20 percent of dual eligible beneficiaries were in a Medicare Advantage plan, up from 14 percent in 2006. About half of dual-eligible beneficiaries in Medicare Advantage plans (9 percent of all dual-eligible beneficiaries) were in SNPs, mainly D-SNPs, and the rest in plans open to enrollment by all Medicare beneficiaries ("regular" Medicare Advantage plans). In the context of increases in enrollment of dual-eligible beneficiaries in Medicare Advantage plans and the development of CMS demonstrations, questions have arisen about how Medicare Advantage plans and D-SNPs manage the care for dual-eligible beneficiaries. This section summarizes the key findings from the interviews on the factors behind the enrollment of dual eligible beneficiaries in regular Medicare Advantage plans, how their care is managed within these plans, and firms' history with D-SNPs. We then discuss D-SNP products, including how they are structured, different models of care management, and associated policy issues, including risk adjustment and bonus metrics (star ratings).

Dual-Eligible Beneficiaries in Regular Medicare Advantage Plans

Dual-Eligible beneficiaries are not typically a marketing focus for regular Medicare Advantage plans. Even though half of dual-eligible beneficiaries in Medicare Advantage are in regular Medicare Advantage plans, most Medicare Advantage firms say they do not market their regular plans aggressively to the beneficiaries who are dually eligible for Medicare and Medicaid and do not necessarily track dual status when thinking about their enrollment in regular Medicare Advantage plans. As one interviewee characterized it:

> "If you are selling Medicare products, there is going to be a certain fraction of people in the community who you reach who are dual-eligible beneficiaries—even if they are not targeted."

Most of the dual-eligible beneficiaries in regular Medicare Advantage are "partial duals".

Firms say that they have limited financial incentives to enroll dual-eligible beneficiaries in regular Medicare Advantage plans. Firms indicated that, in many cases, they receive no state payments to compensate them for covering the Medicare cost-sharing for dual eligible enrollees. Firms also indicated that states have been reluctant to contract with them for Medicare's cost-sharing benefits alone, unless the firm's organization is a partner in a more comprehensive managed care plan (e.g., covering long-term care services).

Regular Medicare Advantage plans manage the care for dual-eligible beneficiaries as they do for all other enrollees. Our interviews suggest that dual eligible enrollees in a regular Medicare Advantage plan are managed in the same way as any other Medicare Advantage enrollee. The benefit package in these plans is built around the Medicare benefit package, with a focus on acute care. Interviewees said that all of their Medicare Advantage plans have some care management infrastructure, often aided by risk stratification, which helps identify high risk individuals (including dual-eligible beneficiaries with special needs) for more intensive management. However, many of those with whom we spoke said that such care management systems probably are not as well developed or resourced in regular Medicare Advantage plans as in more specialized plans, including the D-SNPs their firms offer. Thus, regular Medicare Advantage plans could offer more coordination than traditional Medicare, but not necessarily as much as might be offered in a D-SNP or other specialized plan.

Special Needs Plans (SNPs) for Dual-Eligible Beneficiaries

Most firms' knowledge of how to tailor managed care systems to dual-eligible beneficiaries is based on their experience with SNPs, particularly D-SNPs. Firms suggested in interviews that they have developed their models of care for dual-eligible beneficiaries by building on their current networks of providers and core competencies. However, few firms have developed D-SNPs that fully integrate both Medicare and Medicaid benefits for dual-eligible beneficiaries.

Not all firms pursued D-SNPs initially, although more are doing so now. Not all firms pursued D-SNPs after they were granted authority to do so by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. For example, a large regional company said that its base was in commercial Preferred Provider Organizations (PPOs), making the requirements for HMOs (which it felt were better suited to caring for dual-eligible beneficiaries) challenging to its corporate culture. Medicaid experts from another large commercial firm said that originally they viewed D-SNPs as "clunky" because they achieved little integration of Medicare and Medicaid. Another firm said they had decided not to pursue SNPs as a "core competence issue" at first, perceiving their network of providers as not being sufficiently well structured to serve a needy and frail population; the firm felt that the plan had good preventive services and chronic disease management but, for example, did not have specialized programs to serve the homebound who have multiple chronic conditions. Since then, the firm's care model has evolved, and they are actively pursuing products for the dual eligible market.

With the potential growth in enrollment of dual-eligible beneficiaries in private plans, all of the company representatives with whom we spoke said that they either are currently engaged in the D-SNP market, actively pursuing this market, or considering the implications of such a pursuit for their programming. Firms' representatives generally viewed D-SNPs as important to their mission. Current CMS policies allow these products to generate a margin and contribute to a firm's bottom line.

Provider networks in D-SNPs reflect the different backgrounds that shaped the firms. Firms with a commercial insurance and Medicare background tend to build their provider networks for their D-SNPs using the providers from their regular Medicare Advantage plans. Firms with a heavy background in providing care to both Medicaid beneficiaries and Medicare beneficiaries often see low-income dual-eligible beneficiaries as their focus, and the plans' provider networks tend to resemble Medicaid provider networks that serve adult disabled populations.

Firms view CMS's model of care requirements as helpful. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) required SNPs to articulate and submit a model of care to CMS.[14] Firms that we interviewed said that the requirements helped them to articulate their existing model of care or, to the extent they did not have one, develop a model of care. Firms stated that care models are important to their operations. As one interviewee commented:

> "Model of care requirements … do a good job of capturing our care model; federal requirements around SNPs are appropriate."

Another executive said, "Model of care [requirements] helped separate the weak from strong plans" and eliminated some of the early entrants, whose interests were driven by marketing.

The historical roots of each firm (Medicare versus Medicaid), and the share of enrollment comprised of individuals with high needs, influenced the models of care they adopted. Generally speaking, the strategies firms described fell into three main types, varying by the historical focus of the firm. (For illustrative examples, see **Box 1**.)

Medicare focused firms tend to use risk stratification. Many large firms based in the Medicare market have evolved their model of care for their D-SNP from the model of care for their regular Medicare Advantage plan, often investing substantial resources in what they regard as relatively sophisticated and robust risk stratification tools. They use these tools to identify who should be receiving additional care management resources, such as care managers. They say that they leverage their large system-wide investments in clinical care guidelines and electronic care management tools, and employ these tools within the existing provider network and delivery system constructed for Medicare Advantage plans.

Firms focused on frail elders tend to prioritize addressing both the medical and social needs of dual-eligible beneficiaries. Interviewees from firms with extensive experience caring for frail elders and similar subgroups said that to serve dual-eligible beneficiaries well, addressing both medical and social needs is critical. Such firms have built infrastructures to complement the medical management of provider groups with more integrated care management resources, staffed by multidisciplinary teams of nurses, social workers, and other personnel. These teams serve as a bridge between what the medical system provides and what frail elders need, while coordinating the care with the medical providers. Often these teams go to where the patient either resides or seeks care and strive to provide the support and services needed to keep patients in the community, including air conditioners or other products not typically perceived as medical care services.

One of the interviewees said that their firm houses its support in actual physical facilities, such as outpatient clinics, that patients can visit, which helps to more fully incorporate social supports, condition-appropriate physical activity, and care management services. This firm feels that such facilities are visible sources of support that are popular with enrollees and also effective sources of word-of-mouth marketing that further builds its membership.

Firms with such expertise currently tend to be small but have increasingly become attractive to outside investors and have been acquisition targets by large Medicare Advantage firms. Many such firms that remain independent are considering expansion, but how scalable such models may be, and how fast they can expand, remain outstanding questions for firms.

SSI Medicaid focused firms have created D-SNPs around Medicaid providers and waiver experience. Firms that have built D-SNPs around Medicaid managed care for the aged, blind, and disabled typically describe growing their Medicare- and Medicaid-dominated business in synergy as they expand in different states. These firms see their focus aimed more extensively at the low-income population than do other types of firms. These firms often hold substantial responsibilities for Medicaid enrollees and are typically responsible for at least some components of long-term care. Often they have evolved from state efforts to better serve those in their Medicaid programs who are under age 65. Interviewees said their firms are supported by a variety of Medicaid waivers that target various subgroups, such as the people with physical disabilities or those with severe and persistent mental illness.

Firms involved in this market indicated that integrating Medicare and Medicaid may be only part of the challenge. As one representative saw it:

> "One of the challenges for states is that these waiver populations are often distributed across multiple [state] departments, so none of them see the whole picture."

The point was that effective product design (and, from the firm's perspective, financing) requires all of these funding streams to be understood and aligned in a product that integrates Medicare and Medicaid for dual-eligible beneficiaries.

Few D-SNPs offer integrated benefits with Medicaid. Integration of Medicare with Medicaid benefits (especially those beyond Medicaid cost-sharing) is rare among D-SNPs. Those companies with a history of involvement in Medicaid managed care for states' aged, blind, and disabled populations were more likely to integrate Medicare and Medicaid benefits. However, enrollment in such fully integrated plans amounts to only a small share of total D-SNP enrollment. By law, SNPs, like any other Medicare Advantage plans, must apply the rebates they receive (which equal a share of any positive difference between benchmarks and the plan's bid for providing Medicare A and B services) to reduce premiums or enhance benefits. Firms varied in how they used rebates to strengthen the benefits in D-SNPs. Medicaid benefits are viewed by firms as relatively comprehensive in all states because of federal minimum requirements, so there are few extra benefits that D-SNPs could offer that would not be covered by Medicaid.

Some D-SNP firm representatives said that they covered adult dental care, transportation to providers' offices (which some firms said is more extensive than anything Medicaid might cover), and vision care. Most firms used at least some of the rebate dollars to fund care management infrastructure, including what some of them viewed as a care management benefit, perhaps based on needs identified in a face-to-face visit.

Concerns in Applying Policies for Regular Medicare Advantage Plans to D-SNPs

Firms' policy concerns related to D-SNPs stem largely from the fact that the policies affecting their payment and rewards were developed for the broader Medicare population, not the specific subgroup of individuals enrolled in SNPs. The most commonly expressed concerns center around risk adjustment and the star ratings used to generate bonus payments.

Risk adjustment. While firms have many concerns about risk adjustment for SNPs, the most broadly relevant concern stems from the fact that many of the individuals they serve are frail and have social circumstances that complicate and make care delivery more expensive. For example, an executive told us:

> "It certainly is tougher to deal with this [SNP] population than the Medicare Advantage [population], in general. One, how do you make sure you do preventive medicine in a population that has [a] more significant presence of behavioral health/substance abuse conditions and a much higher degree of residential and social instability than the general [Medicare Advantage] population … You have a population that historically has been less likely to have a well-functioning health home and also one where the health homes that would meet their demanding needs are harder to come by as well."[15]

For the most part, according to interviewees, Medicare Advantage rates provide for no adjustment pertaining to this set of social risk factors. Such issues are likely to become more important as fiscal alignment proceeds.

CMS has experience in using frailty as an adjuster for selected programs, such as the PACE program. In 2013, this adjustment will be available to SNPs having an average acuity level in their D-SNP enrollment that is at least equal to that of PACE programs. A few firms expected to qualify for these adjustments, but most did not; they see the test for eligibility for such payments as too demanding.

Bonus metrics. The other, related policy concern of firms is the structure of the star metrics used to generate bonus payments.[16] Firm representatives noted that:

> "The quality bonuses have become so important to the payment model because of the ACA payment cuts."

While such concerns are common across Medicare Advantage, those with D-SNPs are especially concerned because of a perception that they face more challenges in improving scores. One firm representative explained:

> "We're at 3.5 [stars] and working very hard to get to 4. In a D-SNP environment, the ability to go from 3.5 to 4 is as challenging as anything we've ever done in quality … it isn't so much being a D-SNP. I just think that the measures and requirements are extremely stiff."

Others expressed concern that the star ratings essentially encompass measures developed for the general Medicare population and might not always be appropriate for dual-eligible beneficiaries. One experienced plan representative provided this example:

> "[We have] this amazing provider who services individuals who are predominately in nursing homes and assisted living. [With a very small panel of patients] he has to make sure tests [are] done or he looks like he's not providing good care on the star ratings. [But] when he goes to find them [his patients], there's 5 of the 15 [individuals] that shouldn't really be having the tests at all because it would be detrimental to them."

While star ratings are assessed across plans, not providers, these types of situations make it difficult for firms to align incentives with their providers. Cumulatively, their impact across providers in a network also can disadvantage firms whose plans serve the most challenging enrollees.

Firms' Future Outlook for Products Serving Dual-Eligible Beneficiaries

In light of ACA and CMS initiatives, all firm representatives said their firms were taking a closer look at expanding products for dual-eligible beneficiaries in the future. They perceive the market for such products as potentially large. They also said that the focus on integration provides an opportunity to improve care for beneficiaries whose needs are not well met now. HMOs in particular view D-SNPs as good vehicles for illustrating the value of managed care.

2013 state contract requirements were not perceived to be a big issue. In general, firms indicated that the requirement to have some form of Medicaid agreement with states for D-SNPs in 2013 was not a large barrier to continuation. With work underway on state alignment initiatives, it appeared from our interviews that CMS was not demanding a great deal from these agreements. However, at least one firm indicated that it dropped its D-SNP in a few states that were not interested in negotiating an agreement, perhaps because the states preferred plans with an existing Medicaid contract. While CMS hopes that states will contract with Medicare Advantage D-SNPs, states are not required to do so.

Mergers and acquisitions were planned to position for financial alignment. Firms that were considering extensive changes in their future product lines appeared to be motivated by the potential major federal-state initiatives around financial alignment of Medicare and Medicaid for dual-eligible beneficiaries. To position themselves, some Medicare Advantage firms are acquiring core competencies that they lack through purchases, both large and small. For example, the trade press has publicized the acquisitions of CareMore and Amerigroup by WellPoint and Cigna's acquisition of HealthSpring, to enhance its expertise in caring for frail elders and the disabled. While less visible, firms also are making targeted acquisitions to acquire or enhance particular competencies. Examples include acquiring firms or lining up consultants specializing in behavioral health or data analytics. Organizations with expertise in Medicaid products for under-65 disabled adults also appear to be highly valued potential acquisition targets.

From our interviews, it appears that firms currently are acquiring firms or individuals they believe to be relatively sophisticated managers in the care of selected subgroups of dual-eligible beneficiaries and so far are letting them operate with a good deal of independence. The small specialized companies acquired by larger firms gain access to capital and the ability to leverage the parent firms' strengths (such as provider networks or existing payer contracts) to help them expand. Expertise makes such small niche players very valuable.

Some firms still on the fence. While some representatives said their firms were committed to expanding in the market to manage the care for dual-eligible beneficiaries, others were proceeding more cautiously. They said that such decisions would take into account the firms' current experience with complex populations and the implications of expansion for their overall business strategy as they move forward. Such firms want to learn more about how care for dual-eligible beneficiaries might challenge their current systems so they can decide whether to move forward and, if so, how. Should they, for example, acquire expertise or build it? They also are seeking to understand which segments of the market might be incorporated most easily into their existing skill sets and which might require more than their organization can currently offer. Because the duals market is large, firms are hesitant to write it off but they also are looking at new products as long-term propositions that might require sequential testing and capacity development. For example, one firm that in the past has had only Medicare PPOs now feels it might make more sense to expand to a Medicare Advantage HMO and then a D-SNP, before developing products that also include integrated Medicaid benefits.

Potential "pushback" from some existing SNPs. A number of firms indicated that there always will be "a role for regular pure vanilla duals SNPs." Firms that have invested in this product were concerned that new initiatives may erode current efforts. They also were pragmatic—"hedging their bets"—because they were unsure how extensive state efforts at financial alignment would be—or how successful. Interviewees said that even if initiatives are developed, they expected their firms to maintain enrollment in D-SNPs because some beneficiaries like their current SNPs and prefer to stay with them. Thus, firms see and want a role for D-SNPs and believe these products will remain viable as long as beneficiaries retain the right to opt-out of integrated plans in states pursuing financial alignment demonstrations.

CONCLUSIONS

The market to manage the care for dual-eligible beneficiaries, including D-SNPs, is evolving as firms line up to pursue new opportunities for financially integrating Medicare and Medicaid services. Such integration has proven more challenging than anticipated, as Medicare and Medicaid work to reconcile the complex operational details.

Executives from experienced plans observe that the dual eligible population is complex, with diverse needs, including subgroups such as the frail elderly, beneficiaries under the age of 65 with physical disabilities, and beneficiaries with chronic mental illnesses. Managing the care for each of these subgroups requires better integration of medical services, social services and long-term care than is generally available today. Yet, the same care management plan probably is not appropriate for every subgroup, especially those with specialized needs. Few firms have experience with all core competencies needed to manage the care of the different types of dual-eligible beneficiaries.

Interviewees view the integration of Medicare and Medicaid services and financing as important to enhancing care for dual-eligible beneficiaries, who they believe are poorly served by the current system. However, they also state that the initiatives should be designed carefully and implemented thoughtfully due to high risks of failures and lengthy time required for full implementation. While such initiatives are perceived as having the potential to improve care coordination for vulnerable populations with extensive needs, firms' experience with financial integration of Medicare and Medicaid is limited and few organizations have all core capabilities necessary for success. The long term success of financially integrating the programs will be enhanced by the support and collaboration of all stakeholders.

Box 1: Illustrative Care Approaches for D-SNPs

Medicare /commercial plans' approaches:

- Build on the sophistication of firms to develop robust risk stratification tools. Pair those at highest risk with a care manager and providing disease-specific or more comprehensive support.
- Differentiate enrollees more by need than by payment source. Employ a delivery system to manage a team of people that provides optimal outcomes for patients with diverse needs, complementing it with guidelines, electronic tools, etc.

Frail elders focused firms' approaches:

- Create a layer of clinical services between the primary care physician and specialists that is focused on managing chronic illnesses, frailty, and cognitive and mental impairments. Such physically based care centers provide services that complement acute medical care and create a physical presence in the neighborhood that the plan believes is attractive to the older population and targeted to their needs. Staff includes nurse practitioners (with some MD support), dieticians, podiatrists, nutritionists, physical therapists, mental health staff, and social workers, along with ancillary clinical services such as vision care, skin care, dermatology, and elder-focused exercise programs. This model also can support chronic and institutional SNPs and allow "pseudo-coordination with Medicaid," although it is financed solely with Medicare funds.
- Involve a geriatric health management benefit to complement the medical management provided by contracted provider groups. The benefit uses teams of nurses and social workers that do the more integrated care management utilizing both social and medical models, and working closely and coordinating with medical groups. At enrollment, the plan identifies those with medical or social problems; care managers then refer them to a medical group for some of their medical management. Special attention also is paid to care transitions.

SSI Medicaid based approaches:

- Build Medicare D-SNP around Medicaid managed care for Medicaid's aged, blind, and disabled beneficiaries, first with passive enrollment when the Part D benefit is added, and then on a voluntary basis. The plan is responsible for all Medicaid benefits except behavioral health, which (in the state where the plan was located) is provided through the counties. The Medicaid network is enhanced to serve the population. Primary care physicians receive a capitated fee, which is higher than Medicaid would pay in FFS but below Medicare; they are expected to incorporate many medical home features in ways suitable for a small practice. Medicare rebate dollars are used to address gaps in the Medicaid benefit, including transportation, home/bathroom fixtures, and hearing aids. This is a prospective care management model that looks not only at medical needs, but also behavioral, economic, environmental, medical, social, and even spiritual needs in a holistic way, and develops a treatment plan with primary care physicians and any specialists needed. An important goal is to reduce the use of hospital services.
- Build D-SNP around Medicaid managed care for the aged, blind, and disabled in Medicaid. The care model is based on categorizing people by how many chronic care illnesses they have and the likelihood they will end up in a nursing home. It triages those with the most chronic illness or those who are most frail. This model is limited when long-term care and behavioral health are not aligned with the D-SNP. As this plan moved to aged, blind and disabled from the TANF population, the network had to be rescaled to better serve individuals with different levels of needs. The model includes teams of care managers, doctors, nurses, dieticians, and social workers to maintain people in the community. Community connectors manage enrollees as they move from hospital to home to help avoid preventable readmissions.

Appendix A: List of Topics to be Discussed (Tailored for Specific Types of Firms)

Current Role and Form of 2012 products

- Where D-SNPs now fit in product line, future changes expected, and why
- 2012 (current) arrangement with states if offering a D-SNP plan

General Approach Towards Care for Dual-eligible beneficiaries

- Network development and similarity of network to other MA plans
- Provider payment relative to general MA, Medicare, private payers
- Care management strategy for duals and how it compares to general MA
- Extra benefits financed with rebates/bonuses and how they differ from general MA

Anticipating 2013 and Transition

- Projected increase/decrease in enrollment and number of states
- Acquisitions made or being considered in anticipation of dual expansion
- Operational changes anticipated to better serve dual-eligible beneficiaries and ease implementation
- Perspectives on CMS's model-of-care requirements and how they capture the care model

Nature of 2013 Formal Agreements with States (excluding new demos)

- Strategy firm has taken in developing formal agreements with states, and why
- Current status of the agreements reached for 2013 with the states, and any states dropped
- Ease of negotiation and particular issues that were sticking points
- Scope of benefits for 2013 (e.g., Medicare only versus some Medicaid primary) versus 2012

Other Policy Changes in 2013

- Perceptions on risk adjustment for duals and expectations for a PACE frailty adjuster for D-SNPs in 2013
- Plans to take advantage of the D-SNP "Benefits Flexibility Initiative"
- Perspectives on streamlined marketing for duals plans now under consideration for 2014

Involvement in State Demo/Alignment Planning

- Relevance to the states you now operate in (or hope to operate in the future)
- Whether separate 2013 MA bids submitted in any state related to such demonstrations
- Expected timing for any demonstrations firm is involved in (2013, later in 2013, 2014)
- What would be different under the 2013 SNP contract compared to 2012
- Anticipated firm competitiveness versus state-based Medicaid managed care plans
- Issues most relevant to firm regarding initiatives: (probe: eligibility, enrollment, benefit, financial risk, risk adjustment)
- Perceived impact of limited state fiscal and staff resources on effective initiatives

General Policy Environment/Future Plans (to the extent not covered above)

- Issues of greatest concern
- Issues with risk adjustment for duals
- Perceived constraints on ability to develop effective arrangements for duals, and how to address them
- Whether the post-2013 phase-out of SNP authority is a concern in planning
- How different are expectations for firms' role with duals in 3-5 years
- Source of biggest uncertainty

Anything else important we should have asked about or that you want to add?

REFERENCES

[1] Jacobson, G., T. Neuman, and A. Damico. "Medicare's Role for Dual Eligible Beneficiaries." Kaiser Family Foundation, 2012, Issue Brief No. 8138-02; and Young, K., R. Garfield, M. Musumeci, L. Clemans-Cope, and E. Lawton. "Medicaid's Role for Dual Eligibles." Kaiser Commission on Medicine and the Uninsured, April 2012, Issue Brief No. 7846-03.
[2] Kaiser Family Foundation. "Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries." Washington, DC: Kaiser Family Foundation, October 2012.
[3] Neuman, P., B. Lyons, J. Rentas, and D. Rowland. "Dx for a Careful Approach to Moving Dual Eligible Beneficiaries into Managed Care Plans." *Health Affairs*, vol. 31, no. 6, June 2012, pp. 1186–1194; and Brown, R., and D.R. Mann. "Best Bests for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence." Washington, DC: Kaiser Family Foundation, October 2012.
[4] Gold, M.R., G.A. Jacobson, and R.L. Garfield. "There is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles." *Health Affairs*, vol. 31, no. 6, June 2012, pp. 1176–1185.
[5] Only 26 percent of dual eligibles in regular MA plans are under 65, versus 38 percent in D-SNPs and 44 percent in traditional Medicare. See Government Accountability Office. "Medicare Special Needs Plans." GAO Report 12-864, September 2012.
[6] While only 34 percent of dual eligible enrollees in MA plans available for general enrollment were eligible for full Medicaid benefits, 80 percent of those in D-SNPs were so eligible, as were 75 percent in traditional FFS Medicare. Government Accountability Office. "Medicare Special Needs Plans." GAO Report 12-864, September 2012.
[7] See [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicaidAnnouncement4_11.pdf].
[8] See [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf].
[9] For additional information on CMS's Financial Alignment Initiatives, see [http://www.integratedcareresourcecenter.com/icmresources.aspx].
[10] Smith, V., R. Rudowitz, and L. Snyder. "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment, and Policy Trends." Kaiser Commission on Medicaid and the Uninsured, October 2012.
[11] CMS. "Massachusetts MOU for Integrated Care Demonstration." Available at [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf].
[12] CMS. "CMS and Washington State Partner to Coordinate Care for Medicare Enrollees." October 25, 2012. Available at [www.cms.gov/apps/media/press/factsheet./] and [http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf].
[13] Verdier, J., J. Libersky, and J. Gillooly. "Integrating Care for Dual Eligibles in New York: Issues and Options." New York: New York State Health Foundation, February 2012.
[14] See [http://www.ncqa.org/Programs/OtherPrograms/SPecialNeedsPlans.aspx]. Accessed November 18, 2012.
[15] We believe that interviewees referring to "health homes" were not necessarily referring to the technical definition of health home benefits laid out in the ACA but were using this term interchangeably with "medical homes."
[16] Jacobson, G., A. Damico, J. Huang, and T. Neuman. "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011." Washington, DC: Kaiser Family Foundation, February 2011.

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This report (#8427) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.