MEDICARE ADVANTAGE SPECIAL NEEDS PLANS FOR "INSTITUTIONALIZED INDIVIDUALS":[1] WHAT ADVANTAGE TO ENROLLMENT?

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I. INTRODUCTION

The cost of providing long-term care to all those who require it is immense.[2] While a significant majority of people who need long-term care services receive them from unpaid, informal caregivers, at costs that are not generally recognized in the economy,[3] the substantial costs for "formal" long-term care is borne largely by state and federal governments.[4]

1. The authors have chosen to put the term "institutionalized individuals" in quotation marks throughout the article because they find the term offensive and want to emphasize that they are using it only because it is a commonly recognized term to describe this population.

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2. In 2006, the average cost for nursing home care in a private room was $75,000 per year. HOWARD GLECKMAN, CTR. FOR RET. RESEARCH AT BOSTON COLL., MEDICAID AND LONG-TERM CARE: HOW WILL RISING COSTS AFFECT SERVICES FOR AN AGING POPULATION? 1-2 (Apr. 2007), *available at* http://crr.bc.edu/images/stories/Briefs/ib_2007-4.pdf (last visited Sept. 29, 2007). The average cost for long-term care at home was $34,000 per year. *Id.* at 2. Almost 70% of persons over age sixty-five are expected to need long-term care for at least three years at some point before they die. *Id.* at 1.

3. *See, e.g.*, LEE THOMPSON, GEORGETOWN UNIV. LONG-TERM CARE FIN. PROJECT, LONG-TERM CARE: SUPPORT FOR FAMILY CAREGIVERS (Mar. 2004) *available at* http://ltc.georgetown.edu/pdfs/caregivers.pdf (last visited Sept. 29, 2007) (describing monetary and other challenges faced by family caregivers).

4. In 2005, nearly 70% of long-term care (LTC) funding came from government dollars; 48.9% was from Medicaid dollars and 20.4% from Medicare dollars. GLECKMAN, *supra* note 2, at 2. This spending breakdown belies the common misperception that Medicare pays for LTC, which 59% of individuals surveyed believed to be the case. AM. ASS'N OF RETIRED PERS., THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY IN 2006 AARP FACT SHEET

Medicaid programs, jointly funded by the state and federal governments, primarily pay for long-term care,[5] with Medicare covering only post-hospitalization skilled- nursing facility care for a limited number of days and skilled home healthcare.[6] For years leading up to the extensive Medicare program changes of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[7], states had pressed Congress to shift the burden of long-term care costs for citizens eligible for both Medicare and Medicaid to the Medicare program.[8] Nevertheless, the MMA's provisions fell far short of this stated objective.

While the MMA is best known for adding prescription drug coverage to the Medicare program through a new Part D,[9] the Act made numerous other changes.[10] Many of the changes were designed to promote the privatization of Medicare.[11] Substantial changes were made to Medicare Part C, [12] which authorizes private health insurance plans to provide services covered by traditional Medicare. Among other amendments, the MMA created a new type of healthcare delivery vehicle called a Medicare Advantage Special Needs Plan (MA SNP).[13] An MA SNP must be a

(Dec. 2006), *available at* http://assets.aarp.org/rgcenter/health/ltc_costs_fs_2006.pdf (last visited Sept. 29, 2007).

5. *See generally* AM. ASS'N OF RETIRED PERS., THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY IN 2006 (Dec. 2006), *available at* http://assets.aarp.org/rgcenter/health/ltc_costs_2006.pdf (last visited Sept. 29, 2007). Medicaid spending for long-term care services was $94.5 billion or 31% of the Medicaid budget in 2005. GEORGETOWN UNIV. LONG-TERM CARE FIN. PROJECT, FACT SHEET: MEDICAID AND LONG-TERM CARE (Jan. 2007), *available at* http://ltc.georgetown.edu/pdfs/medicaid2006.pdf (last visited Sept. 29, 2007).

6. *See* 42 U.S.C. §§ 1395w-22(a), 1395w-131(a)(1) (2000 & Supp. IV 2004).

7. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 26 U.S.C. and 42 U.S.C.).

8. JOSHUA M. WIENER ET AL., CRS REPORT FOR CONGRESS: STATE COST CONTAINMENT INITIATIVES FOR LONG-TERM CARE SERVICES FOR OLDER PEOPLE CRS-15 (2000), *available at* http://urbaninstitute.org/UploadedPDF/1000056.pdf (last visited Nov. 28, 2007).

9. 42 U.S.C. §§ 1395w-101 to 1395w-152 (Supp. IV 2004).

10. The extensive changes the MMA made to the entire Medicare program are beyond the scope of this article.

11. *See* MARILYN MOON, MEDICARE: A POLICY PRIMER 99 (2006); BRIAN BILES ET AL., THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS—UPDATED AND REVISED 3-5 (Nov. 2006), *available at* www.cmwf.org/usr_doc/Biles_costprivatizationextrapayMAplans_970_ib.pdf (last visited Sept. 29, 2007) (discussing MA plan payments in 2005). For example, as part of the MMA, Congress once again changed the reimbursement mechanism to promote broader distribution of MA plans throughout the country. *See* 42 U.S.C. § 1395w-23. Analysts project that the changes will increase Medicare costs through 2013. *See* BILES ET AL., *supra*, at 1.

12. *See* 42 U.S.C. §§ 1395w-21 to 1395w-28 (2000 & Supp. IV 2004).

13. *See id.* § 1395w-21. The law authorizes plans for three different special needs populations: institutionalized individuals, dual eligibles, and individuals with severe or disabling chronic conditions. *Id.* § 1395w-28(b)(6)(B).

coordinated care plan—a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), not a private fee-for-service plan (PFFS) or Medical Savings Account (MSA)—and, unlike other MA plans, it must offer Part D drug coverage.[14]

An SNP is an MA plan established to enroll, exclusively or disproportionately, "special needs" populations.[15] The MMA defines *special needs individual* as

> an MA eligible individual who (i) is institutionalized (as defined by the Secretary); (ii) is entitled to medical assistance under a State plan under subchapter XIX of this chapter; or (iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.[16]

The authorization of SNPs is significant because prior to the MMA, an MA plan (then known as a Medicare+Choice plan) could not limit enrollment to subgroups of the Medicare population.[17] Medicare+Choice plans were required to enroll any eligible individuals during their available enrollment periods, unless the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare, had permitted the plan to limit total enrollments through a capacity waiver.[18] Under the MMA, only SNPs are authorized to limit enrollment to specific populations.[19]

SNPs, thus, can be designed to serve people who (1) are institutionalized, (2) are entitled to state medical assistance, or (3) have a severe or disabling chronic condition.[20] Beginning in contract year 2008, SNPs for dual eligibles will be permitted to limit enrollment to a subset of the dually eligible population if they make an agreement with state Medicaid programs that are serving a similar subset of dual eligibles.[21] To date, most

14. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL ch. 1 § 30.2.5 (Apr. 2007), *available at* www.cms.hhs.gov/manuals/downloads/mc86c01.pdf (last visited Sept. 29, 2007) [hereinafter CMS MANAGED CARE MANUAL].

15. "In the case of a specialized MA plan for special needs individuals . . . the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals." 42 U.S.C. § 1395w-28(f).

16. *Id.* § 1395w-28(b)(6)(B).

17. As a general rule, MA plans may not discriminate against any eligible individual. *Id.* § 1395w-22(b) (2000).

18. In limited circumstances, an MA plan may seek to cap or close enrollment. 42 C.F.R. § 422.60 (2007).

19. CHRISTINE PROVOST PETERS, NAT'L HEALTH POLICY FORUM, MEDICARE ADVANTAGE SNPS: A NEW OPPORTUNITY FOR INTEGRATED CARE? 2 (Nov. 2005), *available at* www.nhpf.org/pdfs_ib/IB808_SNP_11-11-05.pdf (last visited Sept. 29, 2007).

20. *Id.* at 10.

21. Memorandum from Anthony Culotta, Dir. Medicare Enrollment & Appeals Group, Ctrs. for Medicare & Medicaid Servs., to Medicare Advantage Orgs. (Aug. 10, 2006),

MA SNPs approved by Medicare have focused on the dually eligible population.[22] However, the number of SNPs in all three categories has increased rapidly each year of the program.[23]

While CMS and the insurance industry have broadly promoted, and some would say facilitated, the expansion of MA SNPs to all markets, SNPs are not wholly embraced by states or advocates.[24] Reluctance to support SNPs is largely due to the lack of standards established by CMS for what a plan must do to become an SNP and, once approved as an SNP, to, in fact, meet the needs of the special needs enrollees.[25] Congressional authorization for SNPs is due to sunset in December 2008.[26] Open discourse about the utility and worth of MA SNPs should occur and be considered as Congress decides whether to reauthorize them.

This article analyzes the MA SNPs for long-term care, generally referred to as institutional SNPs or I-SNPs. An MA I-SNP covers a person who is in a long-term care institution (such as a nursing home) for more than ninety days or who is living at home but is clinically eligible for institutional care.[27] It is a curious model because the Medicare SNP is not actually at risk for the cost of most of the long-term care services that the beneficiary needs since Medicare does not cover most long-term care services[28]—thus prompting

available at www.cms.hhs.gov/States/Downloads/SNPEnrollment.pdf (last visited Nov. 28, 2007).

22. *See* PETERS, *supra* note 19, at 3.

23. *See* CTR. FOR MEDICARE ADVOCACY, INC., MEDICARE ADVANTAGE SPECIAL NEEDS PLANS: WHAT CONGRESS NEEDS TO KNOW (July 18, 2007), *available at* www.medicareadvocacy.org/AlertPDFs/2007/07_07.19.SNPs.pdf (last visited Nov. 28, 2007); *see also* PETERS, *supra* note 19, at 11.

24. *See* Alissa Halperin et al., *What's so Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for "Dual Eligibles,"* 8 MARQ. ELDER'S ADVISOR 215, 249-50 (2007).

25. *Id.* at 232-34.

26. 42 U.S.C. § 1395w-28(f) (Supp. IV 2004).

> Not later than December 31, 2007, the Secretary shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the [M]edicare program as a result of amendments made [to 42 U.S.C. §§ 1395w-21 and w-28].

Pub. L. No. 108-173, 117 Stat. 2066, 2208 (2003) (42 U.S.C. § 1395w-21 note).

27. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., SPECIAL NEEDS PLAN – FACT SHEET & DATA SUMMARY (Feb. 14, 2006), *available at* www.cms.hhs.gov/SpecialNeedsPlans/Downloads/finalSNPfactsheetsum2-14-06.pdf (last visited Nov. 28, 2007).

28. Because Medicare coverage for nursing home care is limited to 100 days of skilled care per spell of illness or injury following three days of hospitalization, the Medicare SNP is not likely paying for the nursing home care. 42 U.S.C. § 1395d(a)(2)(A); CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL ch. 8 § 20.1 *available at*

inquiry into and the following discussion of what exactly an MA I-SNP is covering.

This article explores the premise behind I-SNPs; their regulatory framework; eligibility, marketing, and enrollment issues; benefits offered by I-SNPs and whether they differ from those mandated by traditional Medicare or other MA plans; I-SNP networks; required care coordination and what comprises good care coordination; insurance coordination; and the independent obligations of institutions in which I-SNP enrollees might reside.

CMS has approved eighty-five MA I-SNPs for 2007.[29] Growth and market penetration of all SNPs have been rapid. In fact, in 2004, there were only 11 SNPs of any kind.[30] By 2005, there were 125, with most of them focusing on dual eligible populations.[31] I-SNPs have increased from 37 in 2006[32] to 85 in 2007.[33] Increases are expected to continue as CMS actively encourages the spread of SNPs throughout the country.[34]

II. WHAT IS THE PREMISE OF I-SNPS?

A. Coordinated Care Efforts that Predate SNPs

The concept of coordinating care for individuals who are dually eligible for Medicare and Medicaid and/or who need significant long-term care services did not first arise under the MMA. For over thirty years, healthcare providers, social service agencies, states, and consumers have tried to develop models of care coordination for vulnerable populations, particularly with regard to long-term care services.[35] What distinguishes these earlier efforts from SNPs is that they approached the issues from a Medicaid, rather

www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf (last visited Nov. 28, 2007) [hereinafter CMS MEDICARE BENEFIT POLICY MANUAL].

29. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 27.

30. *See id.*

31. *Id.*

32. *Id.*

33. *See id.*

34. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: IMPROVING ACCESS TO INTEGRATED CARE FOR BENEFICIARIES WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID (July 27, 2006), *available at* www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=1912&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date (last visited Sept. 29, 2007); *see also* Ctrs. for Medicare & Medicaid Servs., Draft, State Guide to Integrating Medicare and Medicaid Models (Mar. 2006), *available at* www.cms.hhs.gov/DualEligible/Downloads/StateGuide.pdf (last visited Sept. 29, 2007) (aimed at encouraging the growth and expansion of reliance upon MA SNPs).

35. *See* PETERS, *supra* note 19, at 7-9 (illustrating various attempts by states to better integrate care).

than a Medicare, focus. As discussed earlier, this focus makes sense, given that Medicaid, not Medicare, is the primary payer for long-term care.

In 1974, the California Medicaid program began funding an adult day care program, developed by On Lok[36] Senior Health Services in San Francisco, to combine health and social services.[37] The On Lok program primarily served older people who were otherwise eligible for nursing home care.[38]

As both the number of services provided and the success of the program grew, On Lok looked for and received additional support beyond California Medicaid. In 1979, the United States Department of Health and Human Services gave On Lok a grant to develop an integrated healthcare delivery model for older people who required long-term care services.[39] The grant led to development of a risk-adjusted capitated payment rate for each On Lok enrollee in 1983.[40] Also in 1983 and again in 1985, Congress authorized a demonstration program based on the On Lok model that would provide intensive acute and long-term care management services to help frail, older people remain in the community.[41]

Significant to this discussion, the demonstration program authorized by Congress in the 1980s, known as the Program of All-Inclusive Care for the Elderly (PACE), involved both Medicare and Medicaid payments to provide a total package of services.[42] When PACE was made permanent in 1997, its enabling provisions were codified in both the Medicare and Medicaid titles of the Social Security Act.[43] PACE programs provide all Medicare and Medicaid covered services to individuals who generally need a skilled level of care[44] without imposing any cost-sharing on PACE beneficiaries.[45] The

36. On Lok means "peaceful, happy abode" in Cantonese. National PACE Association, What Is PACE?, www.npaonline.org/website/article.asp?id=12#History (last visited Sept. 29, 2007).

37. *Id.*

38. *Id.*

39. *Id.*

40. U.S. GEN. ACCT. OFFICE, MEDICARE AND MEDICAID: IMPLEMENTING STATE DEMONSTRATIONS FOR DUAL ELIGIBLES HAS PROVEN CHALLENGING 21-22, 22 n.23 (Aug. 2000), *available at* www.gao.gov/archive/2000/he00094.pdf (last visited Feb. 25, 2008).

41. Social Security Act of 1983, Pub. L. No. 98-21, § 603, 97 Stat. 64, 168 (codified at 42 U.S.C. §§ 1315, 1395, 1395b-1, 1396 (2000)); Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9220, 100 Stat. 183 (codified at 42 U.S.C. §§ 1315, 1395, 1395b-1, 1396); *see also* 42 C.F.R. § 460.4(b) (2007).

42. *See* KAREN TRITZ, CONG. RESEARCH SERV., CRS REPORT FOR CONGRESS: INTEGRATING MEDICARE AND MEDICAID SERVICES THROUGH MANAGED CARE, at CRS-12 (June 27, 2006), *available at* www.opencrs.com/rpts/RL33495_20060627.pdf (last visited Sept. 30, 2007).

43. *See* 42 U.S.C. §§ 1395eee (Medicare), 1396u-4 (Medicaid) (2000).

44. *Id.* §§ 1395eee(a)(5), 1396u-4(a)(5), 1396u-4(c)(2); 42 C.F.R. § 460.150(b).

45. 42 U.S.C. §§ 1395eee(b)(1)(A), 1396u-4(b)(1)(A).

comprehensive, multidisciplinary services are available twenty-four hours a day, seven days a week.[46] Like enrollees in an HMO-model I-SNP, PACE enrollees are restricted to using PACE providers.[47]

Several differences between PACE programs and SNPs, in addition to the authorizing statutes, are worth noting. First, PACE organizations, by statute, are generally non-profit organizations[48] that enter into a contract with CMS and/or a state Medicaid agency to provide comprehensive services to PACE-eligible individuals.[49] As non-profit organizations, they have less incentive than many for-profit SNP sponsors to choose service regions and enter into the market based on the increased Medicare capitation rate paid for vulnerable SNP populations in that market.[50]

Second, CMS gives PACE programs more structure and guidance than it gives to SNP programs. PACE programs operate under the federal statute and regulations as well as under a PACE Protocol published by On Lok.[51] The PACE protocol is based on the more than thirty years of experience On Lok has in providing both healthcare and social services to individuals who need an institutionalized level of care.[52] And, as indicated above, PACE programs contract with states when dual eligibles are enrolled in the program.

Third, because SNPs are MA plans, they have significant flexibility in developing their benefit package.[53] Although they must include all benefits available under Medicare Parts A and B, they have flexibility to develop the cost-sharing they charge for covered services as long as the cost-sharing is actuarially equivalent to that of Medicare Parts A and B.[54] They also have the flexibility to decide which, if any, supplemental benefits they want to include in their benefit package.[55] Thus, analysts have indicated that most

46. *Id.* §§ 1395eee(b)(1)(B), 1396u-4(b)(1)(B).

47. *Id.* §§ 1395eee(a)(1), 1396u-4(a)(1).

48. *Id.* §§ 1395eee(a)(3), 1396u-4(a)(3). The BBA also established certain conditions under which the Secretary of Health and Human Services has discretion to contract with private entities to serve as PACE providers. *Id.* §§ 1395eee(a)(3)(B), 1396u-4(a)(3)(B).

49. *Id.* §§ 1395eee(a)(2), 1396u-4(a).

50. Saucier and Burwell note that the "early market response from health plans for SNP certification has been higher than expected" and imply that the higher capitation rate may be an incentive. PAUL SAUCIER & BRIAN BURWELL, THE IMPACT OF MEDICARE SPECIAL NEEDS PLANS ON STATE PROCUREMENT STRATEGIES FOR DUALLY ELIGIBLE BENEFICIARIES IN LONG-TERM CARE: FINAL REPORT 2 (Jan. 2007), *available at* www.cms.hhs.gov/PromisingPractices/Downloads/SNP FinalReport.pdf (last visited Sept. 30, 2007).

51. 42 U.S.C. §§ 1395eee(a)(4) & (6), 1396u-4(a)(4) & (6).

52. *See id.* §§ 1395eee(a)(6), 1396u-4(a)(6); National PACE Association, *supra* note 36.

53. *See* SAUCIER & BURWELL, *supra* note 50.

54. 42 U.S.C. § 1395w-22(a)(1)–(2).

55. *Id.* § 1395w-22(a)(3)(A).

SNPs will simply provide Medicare benefits without reaching out to states to incorporate their Medicaid programs.[56]

PACE programs, on the other hand, must cover all Medicare and Medicaid services.[57] Unlike with SNPs, dual eligibles are not charged a premium to enroll in a PACE program.[58] Most importantly, federal regulations concerning additional PACE services focus on the health needs of each individual PACE enrollee. The regulations require PACE programs to provide, as part of their benefit package, "[o]ther services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status."[59] SNPs, on the other hand, tend to offer supplemental benefits more because of their potential market value[60] than because of the health or social needs of their enrollees.

There are other crucial differences between PACE and SNPs that need to be considered when evaluating the ability of both programs to meet the needs of elderly or disabled dual eligibles. For example, PACE regulations articulate clear standards of performance and monitoring that are applicable only to PACE models.[61] No such standards exist for SNPs. PACE regulations, unlike MA regulations, address some of the difficult issues in coordination between Medicare and Medicaid, including payment under both programs,[62] co-payment issues,[63] and the differences in appeal rights available under both programs.[64]

At the same time that Congress was making the PACE demonstration programs a permanent part of the Medicare and Medicaid statutes, several states began looking for ways to use their Medicaid programs to provide more comprehensive and coordinated services for residents who needed long-term care and other high-cost services. Most notably, states that took

56. *See* SAUCIER & BURWELL, *supra* note 50.

57. *See id.* at 1 (describing attempts by policymakers to develop integrated care models that "combine Medicare- and Medicaid-covered benefits for dual eligibles under more unified administrative structures" through PACE).

58. 42 C.F.R. § 460.186(d) (2007). PACE enrollees who are eligible for only Medicaid pay no premiums. *Id.* Premiums for Medicare beneficiaries who are not eligible for Medicaid reflect the Medicaid capitation amount and vary, depending on whether the beneficiary is enrolled in Medicare Part A, Part B, or both Parts A and B. *Id.* § 460.186(a)–(c).

59. *Id.* § 460.92(q).

60. *See* PETERS, *supra* note 19, at 13.

61. *See* 42 C.F.R. §§ 460.130 – 460.140. Additionally, the PACE protocol is based on the On Lok model, which has proven successful in providing integrated Medicare and Medicaid services for over thirty years.

62. *Id.* §§ 460.180, 460.182.

63. *Id.* § 460.90.

64. *Id.* §§ 460.122, 460.124.

this approach spent years on developing proposals to provide integrated care and then on implementing the proposals once authority was granted.[65]

Minnesota and Wisconsin have had the most success with using the federal waiver process to develop programs of integrated care for their residents.[66] Federal law allows states to seek a waiver of federal Medicare and/or Medicaid requirements in order to demonstrate that alternative delivery models are effective while remaining budget neutral (in other words, they create no additional cost for the federal government).[67] The program that Minnesota operates under its waiver, Minnesota Senior Health Options (MSHO), is a managed care model that provides integrated Medicare and Medicaid services to elderly dual eligibles who live within limited geographic areas.[68] The Wisconsin Partnership Program provides services to dual eligibles who live at home but require a skilled level of care.[69] As part of the demonstration, Wisconsin includes younger people with physical disabilities who are either dual eligibles or Medicaid recipients.[70]

Several other states considered, but were unable to develop, waiver programs that integrate Medicare and Medicaid benefits and services for dual eligibles. The most successful of these other states, Massachusetts, created a voluntary managed care program, Massachusetts Senior Care Options (SCO), for dual eligibles aged sixty-five and older that combines Medicare and Medicaid benefits and allows Medicare payments to be made using a payment methodology similar to PACE's methodology.[71] Other states, such as Texas, ended up with approval only for a Medicaid waiver

65. For example, the state of Minnesota spent twenty-six months planning before submitting its proposal to the federal government. Federal review lasted an additional sixteen months and then the state spent another twenty-one months after approval fully developing the program before enrollment was initiated. U.S. GEN. ACCT. OFFICE, *supra* note 40, at 18 tbl.2.

66. In 1995, Minnesota became the first state to seek and receive approval to establish demonstration waiver programs. *Id.* at 11.

67. 42 U.S.C. §§ 1315(a), 1395b-1(b), 1396n(b) (2000).

68. MINN. DEP'T OF HUMAN SERVS., MINNESOTA SENIOR HEALTH OPTIONS (MSHO), *at* www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271#P9_236 (last visited Sept. 30, 2007).

69. U.S. GEN. ACCT. OFFICE, *supra* note 40, at 12-13 tbl.1. In December 2005, approximately 80% of participants in the Wisconsin Partnership Program lived at home. WIS. DEP'T OF HEALTH & FAMILY SERVS., SEMI ANNUAL NARRATIVE REPORT: WISCONSIN PARTNERSHIP PROGRAM 2 (July-Dec. 2005), *available at* http://dhfs.wisconsin.gov/WIpartnership/pdf-wpp/SemiAnnual05-2.pdf (last visited Sept. 30, 2007).

70. U.S. GEN. ACCT. OFFICE, *supra* note 40, at 12-13 tbl.1. The Total Partnership and PACE census as of September 30, 2006, was 2,894. WIS. DEP'T OF HEALTH & FAMILY SERVS., CLIENTS SERVED BY DHFS PROGRAMS 3, *available at* http://dhfs.wisconsin.gov/aboutDHFS/OPIB/policyresearch/clientsserved.pdf (last visited Feb. 25, 2008).

71. TRITZ, *supra* note 42, at CRS-14.

program.[72] Note that such states needed a waiver because Medicaid law specifically prohibits the mandatory enrollment of dual eligible individuals into Medicaid managed care plans.[73]

The relationship between MA SNPs and these state waiver programs is telling. A January 2007 report to CMS on the implications of SNPs on state strategies for dual eligibles in long-term care surveyed eight states, including Minnesota, Wisconsin, Massachusetts, and Texas, that had significant numbers of their dual eligible populations enrolled in Medicaid managed care before the MMA created SNPs.[74] The survey found that the Minnesota, Massachusetts, and some of the Wisconsin demonstration plans converted to SNP status.[75] New plans entering the Minnesota MSHO program pursued SNP contracts as part of becoming state contractors, as the state is requiring all new entrants to the program to do.[76] Significantly, county-based Wisconsin plans that previously bore risks only for long-term care services did not choose to become SNPs.[77] Medicaid contractors in Florida and New York that are sponsored by long-term care contractors also did not seek SNP status.[78] Some state officials also discussed the role of PACE programs as an option for states to effectively coordinate Medicare and Medicaid services for dual eligibles.[79]

The report concluded that some states may view SNPs as a new alternative for providing the Medicare portion of coordinated Medicare-Medicaid managed care services.[80] Such interest may be tempered by the failure of the MMA to address how states can share with the federal government in any savings that may result from improved coordination of Medicare and Medicaid.[81] The report did not discuss what improvement, if any, in quality and access to care for beneficiaries might be achieved if

72. U.S. GEN. ACCT. OFFICE, *supra* note 40, at 15-16. Texas could not use waiver authority to require a Medicare beneficiary to enroll in an HMO. *Id.* Thus, the Texas program mandated Medicaid managed care enrollment while keeping enrollment in the Medicare portion voluntary. TRITZ, *supra* note 42, at CRS-15–CRS-16.

73. 42 U.S.C. § 1396u-2(a)(2)(B) (2000). The prohibition applies to Medicare beneficiaries who are entitled to full Medicaid services as well as to those eligible for the Qualified Medicare Beneficiary Program (QMB). *Id.*

74. SAUCIER & BURWELL, *supra* note 50, at 3. The states are Arizona, Maryland, Massachusetts, Minnesota, New York, Florida, Wisconsin, and Texas. *Id.* Unlike the other states, Maryland does not have a current program but is in the process of developing one. *Id.*

75. *Id.*

76. *Id.* at 7.

77. *Id.* at 5.

78. *Id.*

79. SAUCIER & BURWELL, *supra* note 50, at 10.

80. *Id.* at 13.

81. *Id.*

SNPs worked directly with states. The authors did note, however, that not all SNPs want to join forces with states.[82]

B. An Alternative Premise for I-SNPs

Unlike PACE programs and state demonstration programs, I-SNPs are based on a Medicare, not a Medicaid, model; even though the services institutionalized SNP enrollees most need are Medicaid services.[83] I-SNPs are not required to coordinate with states to provide integrated Medicare and Medicaid services to affected populations and many SNPs are not interested in doing so.[84] Additionally, in developing standards and requirements for I-SNPs, CMS did not incorporate any of the requirements for PACE programs or look to the lessons learned from PACE and state demonstration programs regarding coordination of long-term care services for frail populations.[85] What, then, is the real premise behind SNPs?

SNPs must be viewed in the larger context of the MMA. It is likely that SNPs were created as part of Congress's broader goal of increasing beneficiary participation in private health insurance plans rather than in the traditional Medicare program.[86] The primary method Congress used to further this goal was to change the payment mechanisms for MA plans.[87] As a result, MA plans receive, on average, 112% of the amount that would be paid if the MA plan enrollee had remained in the traditional Medicare program.[88] The number of private plans that contracted with CMS to provide MA plans in June 2007 has more than doubled from the number of such contracts in 2003, when the MMA was enacted, primarily because of the favorable payment structure.[89]

SNPs, in particular, achieve the goal of expanded reliance on private health plans by extending MA options to populations (e.g., dual eligibles, long-term care residents, people with chronic conditions) that generally are not enrolled in Medicare managed care plans and that plans would

82. *See id.*

83. *See id.* at 2 (noting that SNPs are MA plans); Halperin et al., *supra* note 24, at 225 (noting that Medicaid pays for most long-term care services, and, perhaps consequently, that the market for I-SNPs has "not developed nearly to the extent of the market for SNPs for dual eligibles").

84. SAUCIER & BURWELL, *supra* note 50, at 10.

85. *See* Halperin et al., *supra* note 24, at 241-45.

86. *See* PETERS, *supra* note 19.

87. *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 243 (Mar. 2007), *available at* www.medpac.gov/documents/Mar07_EntireReport.pdf (last visited Sept. 30, 2007).

88. *Id.*

89. THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: MEDICARE ADVANTAGE (June 2007), *available at* www.kff.org/medicare/upload/2052-10.pdf (last visited Sept. 30, 2007).

generally not be interested in serving.[90] While in an ideal world the populations served by SNPs would seem to benefit most from managed care since they tend to be the highest users of healthcare,[91] the reality may be quite different since I-SNPs have no obligation or incentive to provide the costly care coordination services needed by their enrollees.

Instead, those beneficiaries who are eligible for enrollment in I-SNPs may be among the beneficiaries most adversely affected if Congress achieves its goal of providing Medicare coverage only through private health insurance plans such as SNPs. While the traditional Medicare program does not provide the care coordination and management services that these individuals need, there is no reason why it could not. Moreover, the traditional Medicare program provides a uniform, stable benefit so that high cost beneficiaries continue to receive Medicare benefits "regardless of where they live, their income, the services they require, or their health condition when they first become eligible for Medicare," and as they age.[92] Furthermore, traditional Medicare provides some coordination with state Medicaid programs in that Medicare is the primary payer, while Medicaid covers Medicare cost-sharing obligations and services, such as long-term care, that are not covered by Medicare.[93]

SNPs and other MA plans, on the other hand, are only obligated to provide Medicare-covered services for as long as they decide to enter into a contract with Medicare.[94] If and when private plans decide, for whatever business reason, not to renew their Medicare contract and to stop offering Medicare plans, they disrupt relationships with healthcare providers and access to healthcare in general. Disruption is particularly difficult for individuals with many healthcare needs.[95]

Additionally, the MA program is premised on SNPs and other MA plans being able to offer different additional benefits and cost-sharing, depending on the perceived market for such benefits in the particular geographic regions they serve.[96] The different benefit structures may have implications for those most in need of health services, as they may not be able to

90. *See id.* In fact, beneficiaries with end-stage renal disease (ESRD) are not eligible to enroll in an MA plan in most circumstances. *See* 42 U.S.C. § 1395w-21(a)(3)(B) (2000). Dual eligibles are ineligible to enroll in MA MSAs. *Id.* § 1395w-21(b)(3). Residents of long-term care facilities have greater flexibility to enroll in and disenroll from MA plans than other Medicare beneficiaries. 42 C.F.R. § 422.62(a)(6) (2007).

91. *See* PETERS, *supra* note 19, at 4.

92. Halperin et al., *supra* note 24, at 240.

93. U.S. GEN. ACCT. OFFICE, *supra* note 40, at 7-8.

94. *See* Halperin et al., *supra* note 24, at 240 (noting the concern that "turning to private markets to deliver Medicare benefits will undermine the security provided by Medicare").

95. *See id.*

96. *See* SAUCIER & BURWELL, *supra* note 50, at 13.

evaluate effectively the different benefit packages available to them, or if they need services that are not included in the available benefit. Some policy makers believe that such inequity in benefits among various plans and various regions may result in uneven care, threatening the reliability of the overall Medicare program.[97] Some states interviewed in the survey for CMS indicated that the variability of benefit packages offered by SNPs would make it difficult to design Medicaid wrap-around benefits and to ensure consistency throughout the state.[98]

III. WHAT IS THE REGULATORY FRAMEWORK FOR I-SNPS?

While the MMA requires regulations of SNPs to be implemented,[99] CMS has not yet promulgated any regulations delineating standards that MA plans must meet to be approved as SNPs or any requirements for approved SNPs to follow in meeting the special needs of their enrollees.[100] Instead, CMS has issued a few SNP "guidance documents."[101] While these documents largely relate to enrollment and marketing issues, it is only in

97. NAT'L ACAD. OF SOC. INS., THE ROLE OF PRIVATE HEALTH PLANS IN MEDICARE: LESSONS FROM THE PAST, LOOKING TO THE FUTURE (EXEC. SUMMARY) 1 (2003), *available at* www.nasi.org/ usr_doc/Medicare_and_Markets_Exec_Sum.pdf (last visited Sept. 30, 2007).

98. *See* SAUCIER & BURWELL, *supra* note 50, at 11.

99. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 223(b), 117 Stat. 2066, 2207 ("The Secretary shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act [42 U.S.C. §§ 1395w-21 to w-29] to carry out the provisions of this Act.").

100. The MMA calls for regulations to implement the changes to the MA program. *See id.* Furthermore, the MMA explicitly requires the promulgation of regulations for SNPs. *Id.* § 231(f)(2), 117 Stat. at 2208 ("No later than 1 year after the date of the enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act [subsec. (b)(6)(B)(iii) of this section], as added by subsection (b)."). While CMS has promulgated a handful of regulations that touch on eligibility and enrollment in SNPs, no regulations have been promulgated on what an SNP must do to be approved as such by CMS nor what it must do to meet the beneficiaries' needs. *See, e.g.*, 42 C.F.R. § 422.2 (2007) (definitions); § 422.4 (types of MA plans); § 422.50 (eligibility to elect MA plan); § 422.52 (eligibility to elect MA plan for special needs individuals); § 422.74 (disenrollment by the MA organization); § 422.254 (submission of bids); § 423.279 (national average monthly bid amount); § 423.855 (definitions regarding fallback prescription drug plans). Despite requirements and suggestions to the contrary, CMS has not promulgated any substantive operational rules for SNPs. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., RENEWAL AND NONRENEWAL INSTRUCTIONS FOR CONTRACT YEAR 2005 8, *available at* www.cms.hhs.gov/ACR/Downloads/CallLetter.pdf (last visited Oct. 1, 2007) [hereinafter CALL LETTER] (A sub-regulatory document regarding initial requirements for SNPs stating, "CMS intends to solicit comments on this provision of the MMA through rulemaking. Therefore, this interim guidance is subject to change in the future.").

101. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., MA SPECIAL NEEDS PLANS GUIDANCE (2006), *available at* www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FinalSNPGuidance1-19-06R1.pdf [hereinafter SNP GUIDANCE] (last visited Oct. 1, 2007).

these Guidance Documents that CMS elaborates on what it means to be an institutionalized individual.

A. Who May Join an I-SNP?

To enroll in any SNP,[102] the individual must (1) meet the definition of a special needs individual,[103] (2) meet the eligibility requirements for that specific SNP as approved by CMS, and (3) be eligible to participate in MA.[104]

In the Final SNP Guidance issued in January 2006, available only on CMS's Web site, CMS states that, for purposes of an I-SNP, an "institutionalized individual" is:

> a MA-eligible [individual] who resides or is expected to reside continuously for 90 days or longer in a long-term care facility that is either a skilled nursing facility (SNF), nursing facility (NF), SNF/NF, intermediate care facility for the mentally retarded (ICF/MR) or an inpatient psychiatric facility. In order for an SNP to enroll a special needs individual prior to 90 days of continuous residence, a CMS-approved assessment must show that the individual's condition makes it probable that the length of stay will be at least 90 days. It is the SNP's option to enroll those individuals expected to reside for 90 days or more, but the SNP must apply its policy consistently.
>
> In addition, individuals residing in a community setting but requiring an institutional level-of-care may also be considered long-term institutional residents for purposes of determining who can enroll in a [SNP], subject to CMS approval.[105]

CMS does not further define "individuals residing in a community setting but requiring an institutional level-of-care." Instead, the guidance notes that each state has a standard it typically uses in its Medicaid home- and community-based services (HCBS) programs.[106] CMS recommends that SNPs use the state's standard of eligibility for institutional level of care in determining who are "individuals residing in a community setting but requiring an institutional level-of-care" for the state in which the SNP is operating.[107] Since state standards for eligibility for community-based care differ, the eligibility for SNP long-term care for consumers residing in the community is likely to differ from state to state, undermining Medicare's character as a nationally uniform program.[108]

102. 42 C.F.R. § 422.52(b).
103. See *id.* § 422.2 for a definition of a special needs individual.
104. See *id.* § 422.50 for MA eligibility requirements.
105. SNP GUIDANCE, *supra* note 101, at 7-8.
106. *See id.* at 8.
107. *Id.*
108. *See* SAUCIER & BURWELL, *supra* note 50, at 11.

CMS also states that evaluations of whether a consumer in the community meets an institutional level of care standard cannot be completed by the SNP itself.[109] CMS recommends that SNPs rely on the state's designated agency to conduct their needs assessments for determining whether someone meets the standard for institutional level of care but is living in the community.[110] It is not clear that all assessment agencies would be available or willing to engage in needs assessments solely to establish a consumer's SNP long-term care eligibility. It is also not clear who is paying for such assessments, as there is no regulatory or guidance provisions addressing the relationship with the state assessment agency. With the assessments required to be done by the state assessment agency that is likely to find many I-SNP applicants eligible for Medicaid coverage of their institutional level of care, one wonders whether the requirements concerning assessment were intended to result in financial risk being spread across and beyond the I-SNP.

Under 42 C.F.R. § 422.62(a)(6),

> an individual who is eligible to elect an MA plan and who is institutionalized, as defined by CMS, is not limited . . . in the number of elections or changes he or she may make. Subject to the MA plan being open to enrollees as provided under § 422.60(a)(2), an MA eligible institutionalized individual may at any time elect an MA plan or change his or her election from an MA plan to original Medicare, to a different MA plan, or from original Medicare to an MA plan.[111]

Accordingly, institutionalized individuals can enroll in an MA long-term care SNP at any time, effective the first of the month following the month in which they elected to enroll.[112] Enrollment requests are made directly to the plans, which may market to potential enrollees throughout the year.[113]

The opportunity for ongoing enrollment makes individuals who are eligible for I-SNPs especially attractive to plans and enrollment agents who

109. *See* SNP GUIDANCE, *supra* note 101, at 8.

110. *See id.* ("For Medicaid purposes, the State Medicaid agency has discretion as to which agency conducts the needs assessment and makes a level-of-care determination. Typically, these functions are completed by each State's Local Area Office of the Aging. In other instances, another State entity, such as the Department of Health, may perform these functions. In either case, we recommend that SNPs use those same agencies to conduct the needs assessment and make the level-of-care determination. [I-SNPs] proposing to cover individuals residing in a community setting but requiring an institutional level-of-care must indicate what instruments will be used for the needs assessment and level-of-care determination and obtain CMS approval. Evaluations conducted by the SNP are not acceptable.").

111. 42 C.F.R. § 422.62(a)(6) (2007).

112. *See* SAUCIER & BURWELL, *supra* note 50, at 11.

113. *See* CALL LETTER, *supra* note 100, at 15; SAUCIER & BURWELL, *supra* note 50, at 10-11.

are otherwise limited to enrolling beneficiaries during a few months of each year. Beginning in 2005, reports of MA plan marketing abuses abounded.[114] While most of the focus was on PFFS MA plans, SNPs engaged in their share of marketing to and enrollment of individuals who did not understand the concept of an MA plan, who lacked the capacity to enroll in an SNP, or for whom enrollment in the SNP doing the marketing might not have been the best option.[115]

B. What Benefits Are Provided by an I-SNP?

Numerous questions arise about the nature of I-SNPs, the benefits they offer, the added value to the enrollee, and the way, if any, in which all of these factors differ from traditional Medicare, other MA Plans, or preexisting guaranteed benefits.

1. What Must MA I-SNPs Cover?

As an MA plan, the I-SNP must cover the healthcare services that an MA plan must cover. MA plans are defined in Part C of the Medicare program.[116] Part C differs from Parts A,[117] B,[118] and D.[119] Instead of identifying benefits to be covered by Medicare, Part C establishes a different delivery mechanism for the benefits already identified in Parts A, B, and D. Most MA plans are managed care plans (also called coordinated care

114. Robert Pear, *Insurers' Tactics in Marketing Drug Plan Draw Complaints*, N.Y. Times, Nov. 27, 2005, at Section 1, 33. In June 2007, CMS announced the suspension of marketing activities by seven MA companies with respect to their PFFS plans. Press Release, Ctrs. for Medicare & Medicaid Servs., Plans Suspend PFFS Marketing (June 15, 2007), *available at* www.cms.hhs.gov/apps/media/press_releases.asp (go to page 4 of the results and follow the "June, 15 2007" hyperlink) (last visited Oct. 1, 2007).

115. The Center for Medicare Advocacy and the Pennsylvania Health Law Project have received such complaints from Medicare beneficiaries, their families, and their caregivers. *See* SAUCIER & BURWELL, *supra* note 50, at 10-11 ("In active SNP markets like Arizona, Florida and Texas, officials note that dual eligibles in Medicaid managed care plans are sometimes being actively marketed by 'unaffiliated' SNPs." Adoption by states of Medicaid marketing controls that are stricter than the federal MA marketing provisions "may cause disruptions in the memberships of fully integrated plans, because unaffiliated SNPs can market directly to their dually eligible beneficiaries enrolled in affiliated state plans.").

116. 42 U.S.C. § 1395w-21 (2000 & Supp. IV 2004).

117. *Id.* § 1395c (Part A covers hospital care, skilled-nursing facility care, hospice care, and some home healthcare provided after an in-patient hospital stay).

118. 42 U.S.C. § 1395j (2000) (referring to Medicare Part B as "Supplementary Medical Insurance Benefits for Aged and Disabled"). Part B provides coverage for doctor visits, durable medical equipment, some home healthcare coverage, and other coverage provided on an out-patient basis. *Id.* § 1395k.

119. *Id.* § 1395w-101 (Part D provides coverage for outpatient prescription drugs).

plans).[120] All SNPs must be coordinated care plans.[121] While all MA plans may choose whether to offer Part D coverage in addition to the mandated Parts A and B benefits, SNPs, as coordinated care plans, must cover Parts A, B, and D benefits.[122]

Medicare Part A generally covers limited skilled-nursing facility care, limited days of hospitalization, limited skilled home healthcare, and end of life hospice care.[123] Medicare Part B generally covers 80% of the cost of visits to the doctor for, primarily, health problems and not preventive visits, outpatient hospital services, the majority of home healthcare, and durable medical equipment (DME) for beneficiaries residing in the community.[124] Medicare Part D provides outpatient prescription drug coverage.[125] For I-SNP enrollees with lower-incomes or full Medicaid coverage, the Part D low-income subsidies help with drug costs.[126]

While I-SNPs are required to provide the services covered by Parts A, B, and D, it is important to remember that the I-SNP is an MA managed care plan that likely has the typical managed care model of limited networks of participating providers, complex referral processes, and cumbersome prior authorization requirements. Therefore, services are probably only available through network providers according to plan procedures.

Medicare Part A covers up to 100 days of skilled-nursing facility care for a given spell of illness.[127] To qualify for Medicare Part A coverage, the

120. *See* THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER (2007), *at* www.kff.org/medicare/healthplantracker/topicresults.jsp?i=7&rt=1 (last visited Oct. 2, 2007) (tracking enrollment in the various MA plans, including coordinated care plans).

121. *See* 42 C.F.R. §422.2 (2007); *see also* CMS MANAGED CARE MANUAL, *supra* note 14, at ch. 1, §§ 20, 30.2.5.

122. *See* 42 U.S.C. §§ 1395w-22(a), 1395w-131(a)(1) (2000 & Supp. IV 2004); CMS MANAGED CARE MANUAL, *supra* note 14, at ch. 1, § 20.

123. *See* 42 U.S.C. §§ 1395c, 1395d.

124. *See id.* §§ 1395j, 1395k.

125. *See* 42 U.S.C. § 1395w-101 (Supp. IV 2004).

126. The Part D low-income subsidy provides varying assistance for all individuals, regardless of health and institutionalization status, who meet strict income and eligibility criteria. The greatest assistance is provided to individuals living in qualifying institutions who are also eligible for Medicaid. *Id.* § 1395w-114. The subsidies cover an individual's prescription drug costs with no cost-sharing for those in institutions who are on Medicaid, with limited cost-sharing for those who receive an institutional level of care in the community and are on Medicaid or otherwise eligible for the Part D low-income subsidy, and with considerable cost-sharing for those who are institutionalized or in the community without Medicaid. *Id.*

127. *See* 42 U.S.C. § 1395d(a)(2)(A) (2000). A spell of illness begins the first day a Medicare beneficiary enters a hospital or skilled-nursing facility and ends when he or she has been at less than a skilled level of care, or outside a hospital or skilled-nursing facility, for sixty consecutive days. *Id.* § 1395x(a).

individual must have entered the skilled-nursing facility following three days of hospitalization and must have daily (or virtually daily) skilled care or rehabilitation needs that require a skilled medical professional.[128] Once a beneficiary is qualified, Medicare Part A pays for all goods and services, including room and board, nursing, therapy services, and prescription drugs.[129] The beneficiary pays no initial deductible or cost-sharing amount for the first 20 days of care; a co-payment, equal to 1/8 of the hospital deductible for that year, is imposed for days 21 through 100 of Medicare coverage.[130]

Few Medicare beneficiaries receive the full 100 days of Medicare Part A coverage in the skilled-nursing facility. The Medicare Payment Advisory Commission (MedPAC) reports that the average length of a Medicare Part A-covered stay in 2005 was twenty-six days, up slightly from 2003 and 2004.[131] MedPAC also reports that more residents are being admitted under Part A for rehabilitation services rather than for skilled-nursing care, with hip or knee replacements being the most frequent diagnosis for admission.[132]

The MA I-SNP, however, admits individuals who have resided or who are expected to reside in the institutional setting for ninety days or more,[133] most of whom have likely exhausted any Medicare Part A benefit for the given spell of illness that prompted their admission to the institution. As a consequence, by the time they are eligible to enroll in an MA I-SNP, most beneficiaries have likely transitioned into a private-pay, long-term care insurance, or Medicaid-funded nursing home stay. That is to say, Medicare Part A dollars would not cover either their room and board or the services they received after the 100th day.

It is for this reason that the I-SNP is not likely to be liable for most of the cost of its members' nursing facility care. The beneficiary, private long-term care insurance if available, or Medicaid, for those beneficiaries who are eligible, would pay for what amounts to the cost of room and board and attendant services provided by the facility. The SNP would pay for limited services received while in the institution that might be covered under Part B of Medicare, for example doctor's visits and possibly some therapy services, assuming the plan agrees that they were medically necessary and that they

128. *See id.* § 1395x(i); *see also* 42 C.F.R. § 409.33(b)(1) (2007).

129. *See* 42 U.S.C. §§ 1395d(a), 1395x(h).

130. 42 C.F.R. § 409.85(a).

131. *See* MEDICARE PAYMENT ADVISORY COMM'N, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM 126, chart 9-4 (June 2007), *available at* www.medpac.gov/documents/Jun07DataBook_Entire_report.pdf (last visited Oct. 2, 2007).

132. *See id.* at 125, 128.

133. *See* 42 C.F.R. § 422.2.

were provided by a network provider according to plan procedures. The SNP would also be responsible for covering prescriptions under the Part D component of its benefit package, assuming the medications prescribed were on the I-SNP's formulary (or were obtained through an exception) and were provided by a participating pharmacy. The SNP would be responsible for hospitalizations covered under Medicare Part A should such become necessary, assuming the I-SNP agreed that the hospitalization was medically necessary and the hospital was in the I-SNP's network. The SNP would not be responsible for DME because Medicare Part B does not pay for DME for institutionalized beneficiaries.[134]

The SNP would only be liable for the cost of skilled-nursing facility coverage if the enrollee entered a new Medicare Part A spell of illness following a hospitalization of at least three days.[135] However, the SNP might be financially motivated to have its enrollees discharged from the hospital in fewer than three days to avoid Medicare skilled-nursing facility coverage or it might be motivated to encourage avoidance of hospitalizations altogether. This latter goal would be beneficial to the enrollee if hospital avoidance was achieved by the provision of good care in the facility.

An I-SNP serving beneficiaries in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) is likely to be liable for even less of the individual's healthcare needs. While the SNP would be liable for the regular Medicare Parts A, B, and D services used by an enrollee residing in such a facility, ICFs/MR are not certified to participate in Medicare and so are not eligible for Medicare reimbursement for room, board, or any of the active treatment services they are required to provide.[136]

Similarly, little risk would be involved for an I-SNP enrolling an individual needing an institutional level of care but residing in the community, as the greatest needs of such individuals are for non-skilled services that are not covered by Medicare. Services often used by such persons, and paid for under a Medicaid home and community-based services waiver, include case management, homemaker/home-health aide, personal care, adult day health, habilitation, respite care, and other services determined by the state and approved by the Secretary of Health and Human Services.[137] Note also that I-SNPs are responsible for those Parts A, B, and D services that the I-SNP deems medically necessary and are provided according to the I-SNP's access rules by appropriate providers.[138]

134. *See* 42 C.F.R. § 410.38(a) – (b).

135. *See* CMS MEDICARE BENEFIT POLICY MANUAL, *supra* note 28.

136. *See* 42 C.F.R. § 483.440.

137. *See, e.g.*, 42 U.S.C. § 1396n(c)(4)(B) (2000).

138. *See id.* § 1395w-22(a)(1)(A); CMS MANAGED CARE MANUAL, *supra* note 14, at ch. 1, §20.

It is important to note that there are no additional benefits that SNPs must provide to enrollees. SNPs are not required as an MA plan generally or as an SNP specifically to offer any specific benefits that would facilitate meeting their enrollees' special needs. Any such benefits are optional.[139] Anything other than the Parts A, B, and D covered services falls under this optional category that SNPs may elect to offer as supplemental benefits. Thus, the design of the supplemental benefit package to be offered and coordination with state Medicaid programs is voluntary for each SNP, just as it is for any other type of MA plan.

2. What Supplemental Benefits May I-SNPs Cover?

In addition to the basic benefits of Parts A, B, and D that all SNPs must cover, MA SNPs, like all MA plans, are permitted to offer supplemental benefits.[140] MA plans may include in their benefit package mandatory supplemental benefits that all enrollees must purchase or optional supplemental benefits that enrollees may choose to add to their coverage at additional cost.[141]

The federal rules governing supplemental benefits are no different for SNPs than for non-SNP MA plans. SNPs, like all MA plans, must submit an application, make a bid, and sign a contract each year to continue participating in the Medicare program.[142] The application for organizations

139. *See* 42 U.S.C § 1395w-22(a)(3).

140. *See* 42 C.F.R. § 422.102.

141. The regulations outline supplemental benefits.

§ 422.102 Supplemental Benefits.

(a) Mandatory supplemental benefits.

(1) Subject to CMS approval, an MA organization may require Medicare enrollees of an MA plan (other than an MSA plan) to accept or pay for services in addition to Medicare-covered services described in § 422.101.

(2) If the MA organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the MA plan.

(3) CMS approves mandatory supplemental benefits if the benefits are designed in accordance with CMS' guidelines and requirements as stated in this part and other written instructions.

(4) Beginning in 2006, an MA plan may reduce cost sharing below the actuarial value specified in section 1854(e)(4)(A) of the Act only as a mandatory supplemental benefit.

(b) Optional supplemental benefits. Except as provided in § 422.104 in the case of MSA plans, each MA organization may offer (for election by the enrollee and without regard to health status) services that are not included in the basic benefits as described in § 422.100(c) and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits are purchased at the discretion of the enrollee and must be offered to all Medicare beneficiaries enrolled in the MA plan.

Id.

142. *See generally* 42 U.S.C. § 1395w-27(a), (c) (2000 & Supp. IV 2004).

that want to operate an SNP in 2008 adds a requirement that the SNP craft a "model of care."[143] While plan sponsors are required to articulate a model of care that "describes the applicant's proposed approach to providing specialized care to the SNP's targeted population, including a statement of goals and specific processes and outcome objectives for the targeted population to be managed under the SNP,"[144] CMS has not articulated standards for accepting, rejecting, or enforcing these models of care. The SNP's chosen model of care need not include any supplemental services that would assist in meeting the care needs of their special needs enrollees.

One additional benefit that SNPs should be required to provide is coordination of an enrollee's Medicare and Medicaid coverage. States are permitted to coordinate their Medicaid benefits with the benefits provided by any MA plan to ensure a "continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for" both Medicaid and benefits under the MA plan.[145] But even though I-SNPs are likely to serve primarily poor elderly or disabled individuals who are likely to be dually eligible, no coordination with state Medicaid programs by MA plans (SNP or otherwise) is actually required.

CMS has not set standards for SNPs that are different from the standards for other MA plans that do not serve a special population. CMS imposes no requirements for offering supplemental benefits targeted to the particular population and does not require coordination with the appropriate state Medicaid program even when the majority of SNP enrollees are Medicaid eligible. Additionally, CMS provides no guidance on an appropriate plan model of care that would incorporate supplemental benefits or Medicaid coordination. As a consequence, an I-SNP's model of care may or may not provide any benefits that meaningfully address their enrollees' special needs.

A cursory review of the 2007 benefits summaries for a sampling of I-SNPs suggests that some supplemental benefits such as health status monitoring, skin specialists, or pain assessments specifically tailored to the special needs of the institutionalized enrollees, are being offered.[146] However, I-SNP enrollees have no particularly greater need for vision

143. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ADVANTAGE INITIAL APPLICATION FOR COORDINATED CARE PLANS 33 (Jan. 2007) [hereinafter CCP APPLICATION].

144. *Id.*

145. *See* 42 U.S.C. § 1395w-28(d) (2000).

146. The authors reviewed the publicly available benefits summaries of fourteen I-SNP plan sponsors (summaries on file with authors). Of them, four offer care coordinators, one offers pain assessments, and one offers skin specialists.

services, an example of a commonly offered extra benefit, than do other persons with Medicare.

C. How Are Medicare Advantage I-SNP Networks Composed?

Network composition requirements are important to I-SNP enrollees for many reasons. Imagine an I-SNP enrollee who is "institutionalized" but living in the community. If the I-SNP is allowed to serve a larger proportion of such individuals living in the community but does not have any greater proportion of home health agencies to serve those larger numbers of individuals who will need home healthcare, network composition would, arguably, be inadequate.

CMS may approve an MA plan with a limited network of providers as an I-SNP as long as it has at least one long-term care facility under contract.[147] There is no requirement that all the doctors, laboratories, pharmacies, service providers, or other facilities relied upon by the long-term care facility be part of the network before the I-SNP can be authorized. No written documents through the 2007 contract year articulate any special requirements for SNP network composition that differ from those for all MA plans. In 42 C.F.R. § 422.112, CMS lays out network composition details for MA plans generally. These requirements are:

> (a) *Rules for coordinated care plans*. An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:
>
> > (1) *Provider network*. (i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.
> >
> > > (ii) *Exception*: MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.
> >
> > (2) *PCP panel*. Establish a panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the

147. *See* SNP GUIDANCE, *supra* note 101, at 8.

> needed referral or make other arrangements to ensure access to medically necessary specialty care.
>
> (3) *Specialty care*. Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The MA organization arranges for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.[148]

In short, the regulations allow each plan to determine and ensure that it maintains the network it needs to serve its members' needs.

As the regulations require no minimum number of providers, looking to the guidance and contract language for standards is important. Sub-regulatory guidance, however, is not helpful in ascertaining what an adequate network of providers for an I-SNP must include. The Coordinated Care Plan Application for Contract Year 2008, for example, requires the I-SNP sponsor to (1) state whether its SNP provider and pharmacy network is different from its other MA plan networks, (2) "describe the pertinent clinical expertise" the plan will include in its network to meet the enrollees' special needs, and (3) describe "if the network does not include sufficient specialists to meet the special needs of the target population . . . how access to non-contracted specialists will be arranged."[149]

In sum, network composition decisions are wholly left to the plan. Consequently, the consumer entering the I-SNP has no way of knowing its adequacy or capacity to meet her needs or what access problems she might face.

D. What Coordination of Care or Care Management Must Medicare Advantage I-SNPs Provide?

To be eligible for an institutional level of care, consumers must have established complex care needs.[150] Most individuals who need this level of care are frail, medically involved, and high users of healthcare and other support services. Ensuring that these individuals are able to access the full extent of services prescribed for them often involves negotiation among different healthcare providers and even different healthcare systems or coverage.

148. 42 C.F.R. § 422.112(a) (2007).
149. CCP APPLICATION, *supra* note 143, at 45.
150. *See id.* at 33.

As described by the American Academy of Pediatrics (AAP) in an article focusing on services for children with special needs,[151] care coordination comprises an array of services that may involve:

> planning treatment strategies; monitoring outcomes and resource use; coordinating visits with subspecialists; organizing care to avoid duplication of diagnostic tests and services; sharing information among health care professionals, other program personnel, and family; facilitating access to services; planning a hospital discharge; and notification, advanced planning, training of caregivers, education of local emergency medical services when a child with special health care needs lives in their community, and, finally, ongoing reassessment and refinement of the care plan.[152]

Even more considerations must be taken into account in the home setting, as it adds an extra layer of technology and service adaptation because the patient is not in a centralized institution.[153]

Additionally, no two patients are alike, and care coordination inevitably varies with a patient's particular needs and strengths. The ability to pay for certain healthcare services, the availability of such services, and the goals of the patient and provider must all be taken into account when determining an individual's plan.[154] Due to the complexities involved in caring for special needs individuals, it is crucial for the care coordinator to keep track of services provided and determine when it is necessary to deviate from the plan originally laid out for a patient.[155] The plan's "goals, role of the family and other supports, locus of implementation, methodology, intensity, and duration" all need to be considered to develop a workable coordinated care plan.[156] Finally, the need for prior approval from third party payers should be assessed when devising a plan.[157] According to the AAP, the ultimate goals of a successful care coordination plan should include "(1) gain[ing] access to and integrat[ing] services and resources, (2) link[ing] service systems with the family, (3) avoid[ing] duplication and unnecessary cost, and (4) advocat[ing] for improved individual outcomes."[158]

151. Am. Acad. of Pediatrics, Comm. on Children with Disabilities, *Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs*, 104 PEDIATRICS 978 (1999), *available at* http://aappolicy.aappublications.org/cgi/content/full/pediatrics;104/4/978 (last visited Oct. 5, 2007).

152. *Id.* at 979.

153. *Id.*

154. *Id.*

155. *Id.*

156. Am. Acad. of Pediatrics, *supra* note 151, at 979.

157. *Id.*

158. *Id.*

An I-SNP is only responsible for providing or arranging for all medically necessary Medicare-covered services the enrollee requires.[159] No requirement is placed on the plan to provide or arrange all medically necessary healthcare the enrollee needs. Interestingly, the federal Nursing Home Reform Law[160] requires both skilled-nursing facilities and nursing facilities[161] to ensure that each resident receives all healthcare and other services[162] determined to be required by a "comprehensive, accurate, standardized, reproducible," and individualized assessment[163] that is completed when the beneficiary is admitted to the facility and revised and updated periodically and as needed. This requirement is imposed regardless of payment source.[164] Regulations governing ICFs/MR require that each resident's active treatment program be "integrated, coordinated and monitored by a qualified mental retardation professional."[165] The active treatment program includes, among other aspects, "health services and related services."[166]

Both the Medicare statutes and regulations are silent on what steps MA plans generally are expected to take to coordinate the care of their members. Nor are there such requirements that apply specifically to MA SNPs to ensure availability and delivery of all medically necessary healthcare and other services to their special-needs enrollees. The I-SNP's participating facilities are required by federal law to do this;[167] yet, the I-SNP is not required to pay for it. In other words, it is the facilities in which the MA SNP enrollees reside, rather than the MA SNP itself, that are required to coordinate necessary care.

E. What Coordination of Insurance or Benefits Must MA I-SNPs Provide?

The regulations articulate how MA plans must coordinate insurance when an MA plan enrollee has other insurance in addition to Medicare. These rules, known as the Medicare Secondary Payer procedures, focus on

159. *See* SNP GUIDANCE, *supra* note 101.

160. Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Pub. L. No. 100-203, §§ 4201 – 4218, 101 Stat. 161(1986) (This section of OBRA '87 is often referred to as the Nursing Home Reform Act.).

161. 42 U.S.C. § 1395i-3(a)(2000) (defining "skilled nursing facility" as used in Medicare); § 1396r(a) (defining "nursing facility" as used in Medicaid).

162. *Id.* § 1395i-3(b)(2) (scope of services and activities under a Medicare plan of care); § 1396r(b)(2) (scope of services and activities under a Medicaid plan of care).

163. *Id.* § 1396r(b)(3) (residents' assessment in the Medicaid statute); § 1395i-3(b)(3) (residents' assessment in the Medicare statute).

164. *See id.* § 1395i-3(c)(4).

165. 42 C.F.R. § 483.430 (2007).

166. *Id.* § 483.440(a).

167. *See supra* text accompanying notes 160-165.

ensuring that Medicare is the payer of last resort in appropriate circumstances.[168] The regulations also articulate minimum requirements for MA plans' obligations to coordinate insurance coverage or benefits when the MA plan holds the contract for both the Medicare coverage and any other coverage an enrollee might have through Medicaid, Employer-Based Insurance, or Retiree Insurance.[169] This provision focuses on ensuring that the MA plans provide enrollees with all of the benefits that Medicare is paying the plan to provide.[170] However, there is no requirement that the MA plan ensure that the enrollee receive all of the benefits available under the other health insurance coverage with which it coordinates payment for Medicare-covered services.

As stated above, the Medicare secondary payer requirements focus on payment for services when other insurance is available, primarily to protect the Medicare fisc. There are no clear statutory or regulatory requirements, however, for coordination of Medicare and other insurance coverage to protect or improve access to the full array of benefits that an individual is entitled to under both the MA plan and the other insurance. The problems created by the lack of such requirements generally are manifest when plan enrollees endeavor to obtain coverage for prescribed services.[171] Contrary to what may be expected, many individuals with two different sources of health insurance coverage find that they have less access to healthcare or that they have to pay more out-of-pocket for the care they receive. This occurs especially if providers believe the primary insurance amount is insufficient and find it difficult to secure coverage from the secondary insurer.[172]

168. 42 C.F.R. § 422.108. Generally, Medicare pays first before retiree health plans and Medicaid. Medicare may be secondary to group health insurance obtained as a result of active employment, depending on the size of the employer and the circumstances under which the beneficiary became eligible for Medicare.

169. *Id.* § 422.106.

170. *See id.*

171. *See* NAT'L ASS'N OF LETTER CARRIERS, NALC HEALTH BENEFIT PLAN: DOUBLE COVERAGE AND COB (Nov. 16, 2004), *at* www.nalc.org/depart/hbp/News/Forms/Medicare/Double%20Coverage.html (the "double coverage" clause and "coordination of benefits" explanation illustrate the complexities involved in determining who covers what benefits, and for how much, when an individual is enrolled in two or more health plans).

172. *See* Charpentier v. Belshe, No. S-90-758 JG/PAN, 1994 WL 792591 (E.D. Cal. Dec. 21, 1994) (holding that policies resulting in no access to certain Medicaid services for categorically needy individuals who were also eligible for Medicare, where such access was not so limited for individuals not "dually eligible," violated comparability requirements). *But see* Ralabate v. Wing, No. 93-CV-0035E(H), 1996 WL 377204, at *4 (W.D.N.Y. June 27, 1996) (dual-eligibles deemed to be primarily Medicare beneficiaries; therefore the fact that Medicaid-only beneficiaries could receive custom wheelchairs at a lower cost due to the

Medically complex special needs populations often have more than one payment source (generally Medicare and Medicaid).[173] For them, navigating the course to obtaining coverage and payment for medically necessary prescribed services is particularly challenging and they often need help in doing so. An MA plan specially designed to meet the challenges of serving this population would be expected to engage in steps necessary to coordinate benefits and ensure access to prescribed care.

Nonetheless, instead of imposing an affirmative obligation on MA SNPs to coordinate their special needs populations' coverage and benefits, CMS has actively pressed for this responsibility to fall to the state Medicaid programs. CMS has widely encouraged states to enter into contracts with insurers who offer MA SNPs to also provide the state's Medicaid benefits through a complementary Medicaid managed care plan.[174] In its guidance materials, CMS suggests states can use contract requirements to regulate areas otherwise lacking regulation. Coordination of benefits is one such area.[175]

This theme of encouraging but not requiring MA SNPs to coordinate beneficiary care is still evident in the 2008 application SNPs use. All SNP sponsors must only articulate whether they have a contract with their state Medicaid plan; they are not required to have such a contract.[176] In fact, the Coordinated Care Plan (CCP)[177] application for contract year 2008 asks the I-SNP that has a contract with the state Medicaid program to articulate how it will coordinate benefits between the Medicare and Medicaid program.[178] The CCP application asks the I-SNP that does not have a contract with the state Medicaid program to articulate whether it "intends to work with the State Medicaid agency to assist dual eligible beneficiaries enrolled in the . . . [I-SNP] with accessing Medicaid benefits and with coordination of Medicare and Medicaid covered services."[179]

differences between the two programs does "not violate the Medicaid comparability-of-services requirement").

173. For example, 40% of people who are eligible for Medicare based on disability are also eligible for Medicaid. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: A PRIMER 3 (Mar. 2007), *available at* www.kff.org/medicare/upload/7615.pdf (last visited Sept. 22, 2007).

174. *See* SAUCIER & BURWELL, *supra* note 50, at 1 ("CMS has recently taken a more proactive role in working with states to promote greater integration of Medicare and Medicaid benefits for the dually eligible population.").

175. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., STATE GUIDE TO INTEGRATED MEDICARE & MEDICAID MODELS 17 (Mar. 2006), *available at* www.cms.hhs.gov/DualEligible/Downloads/StateGuide.pdf (last visited Sept. 22, 2007) [hereinafter CMS STATE GUIDE].

176. *See* SAUCIER & BURWELL, *supra* note 50, at 2.

177. A coordinated care plan is an MA plan that includes any kind of network provider. All SNPs are coordinated care plans. 42 C.F.R. § 422.4(a)(1) (2007).

178. CCP APPLICATION, *supra* note 143, at 36-37

179. *Id.* at 42.

IV. HOW DO MA I-SNPS ADD TO WHAT INSTITUTIONS ARE ALREADY REQUIRED TO PROVIDE UNDER THE NURSING HOME REFORM ACT AND OTHER PRE-EXISTING LAWS?

The Nursing Home Reform Act requires skilled-nursing facilities and nursing facilities to conduct a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity" and needs.[180] The individualized assessment must be conducted by a multi-disciplinary team, using a uniform data set specified by the Secretary and an instrument specified by the state.[181] Each individual who completes part of the assessment must sign and certify its accuracy[182] and a registered nurse must sign and certify completion of the assessment.[183] Assessments must be conducted within fourteen days of admission and updated at a minimum, quarterly, promptly after a significant change, and annually.[184] Facilities must base each resident's written plan of care on the comprehensive assessment.[185] The plan of care must describe the resident's medical, nursing, and psychosocial needs and how these needs will be met to enable the resident to achieve his or her "highest practicable physical, mental, and psychosocial well-being."[186] Facilities are required to provide all services identified in the Reform Act that are needed by residents, with the exception of routine dental services under Medicaid, without regard to the availability of program funding.[187]

The 2008 Call Letter requires that the I-SNP have a contract with long-term care facilities.[188] As one of eight mandatory provisions, the contract, or other provider materials, must require the SNP "to provide protocols to the facility for serving the beneficiaries enrolled in the SNP in accordance with the SNP Model of Care;" must delineate which specific services are provided by the SNP and the facility, "in accordance with the protocols and payment;" and must include a "training plan to ensure that the LTC facility staff understand their responsibilities in accordance with the SNP Model of

180. 42 U.S.C. §§ 1395i-3(b)(3), 1396r(b)(3) (2000) (Medicare and Medicaid, respectively); 42 C.F.R. § 483.20 (2006).

181. 42 U.S.C. §§ 1395i-3(b)(3), 1396r(b)(3); 42 C.F.R. § 483.20.

182. 42 U.S.C. §§ 1395i-3(b)(3)(B)(i), 1396r(b)(3)(B)(i) (Medicare and Medicaid, respectively); 42 C.F.R. § 483.20(i)(2).

183. 42 U.S.C. §§ 1395i-3(b)(3)(B)(i), 1396r(b)(3)(B)(i); 42 C.F.R. § 483.20(i)(1).

184. 42 U.S.C. §§ 1395i-3(b)(3)(C), 1396r(b)(3)(C); 42 C.F.R. § 483.20(b),(c). Additional assessments are required for purposes of Medicare reimbursement.

185. 42 U.S.C. §§ 1395i-3(b)(2), (b)(3)(D), 1396r(b)(2); 42 C.F.R. § 483.20(d).

186. 42 U.S.C. §§ 1395i-3(b)(2), 1396r(b)(2); 42 C.F.R. § 483.20(k).

187. Medicare and Medicaid; Requirements for Long Term Care Facilities, 56 Fed. Reg. 48,826, 48,850-51 (Sept. 26, 1991) (preamble to the final Requirements of Participation).

188. CTR. FOR BENEFICIARY CHOICES, CTRS. FOR MEDICARE & MEDICAID SERVS., 2008 CALL LETTER 48 (Apr. 19, 2007).

Care, protocols and contract."[189] The Call Letter does not elaborate on these requirements.

CMS has not provided definitions of the SNP Model of Care or protocols or guidance on how I-SNPs are expected to coordinate with the skilled nursing facilities and nursing facilities in which their enrollees reside. Facilities have a legal obligation under the Nursing Home Reform Act to conduct resident assessments on a regular basis and to implement care plans based on these assessments,[190] but SNPs have no legal obligation to honor these assessments or care plans. Moreover, conflicts may occur if an SNP conducts an evaluation and recommends treatment under its Model of Care that does not comport with the care plan developed by the facility. If a facility follows the SNP's Model of Care for a beneficiary, rather than the plan of care it developed pursuant to the Reform Act, the facility runs the risk of being sanctioned for failing to follow through on its assessment.[191] This possibility could cause facilities to avoid contracting with the SNP and could eventually narrow the SNP's facility network.

V. DO MA I-SNP BENEFITS ADD VALUE TO WHAT IS AVAILABLE THROUGH OTHER MEDICARE OPTIONS, INCLUDING TRADITIONAL MEDICARE AND OTHER MA OPTIONS? WHAT DOES THE ENROLLEE REALLY GAIN FROM PARTICIPATING IN THE I-SNP?

From a beneficiary perspective, the simple answer to the question of whether I-SNPs add value to traditional Medicare or other MA options is no. As this article has demonstrated repeatedly, SNPs are MA plans. The only statutory and regulatory difference between SNPs and other MA coordinated care plans is the ability of SNPs to limit the populations they can market and enroll in the plan.

MA I-SNPs are not required to take any discreet steps to actually meet the needs of their medically complex enrollees. They are in the strange position of having limited Medicare risk[192] and no obligation to coordinate care or benefits for their enrollees. They are able to enroll new members continuously throughout the year and, yet, are not required to provide complete and accurate information as to what care or services they cover and what is covered by other sources. They offer the same "supplemental" benefits that MA plans offer, none of which are specifically targeted to their

189. *Id.* at 48-49.

190. 42 U.S.C. §§ 1395i-3(b)(3), 1396r(b)(3); 42 C.F.R. §483.20.

191. The Nursing Home Reform Act authorizes the imposition of remedies for non-compliance with any of the Federal Requirements of Participation, including assessment and care planning. 42 U.S.C. §§ 1395i-3(h), 1396r(h).

192. Halperin et al., *supra* note 24, at 237.

enrollees' special needs. The Medicare statute and regulations do not impose any additional requirements on SNPs:

- To provide a benefit package designed to meet the healthcare needs of the limited populations they serve;
- To ensure an adequate network of providers appropriate to meet the enrollees' needs;
- To provide Medicaid services or to coordinate with state Medicaid programs; or
- To coordinate with the long-term care facilities in their network to avoid duplication of requirements under the Nursing Home Reform Law or under laws regulating other institutional facilities such as ICFs/MR.

CMS identifies Medicare and Medicaid contractual arrangements, integration of benefits under both programs, accounting and tracking funding sources, managing data reporting requirements, coordinating Medicare and Medicaid appeals processes, and coordinating quality oversight requirements as some of the issues to be considered when developing an integrated program for dual eligibles.[193] However, SNPs generally have not entered into contracts with state Medicaid programs to provide and coordinate coverage of Medicaid-covered benefits as part of their supplemental benefit package. Indeed, as this article has already stated, the majority of SNP plans only offer Medicare-covered goods and services as part of their benefit packages. The supplemental benefits they offer may or may not have relevance to the populations they serve and may duplicate Medicaid services already available to their dual eligible enrollees.

From a beneficiary perspective, integration would include true coordination of benefits to ensure that individuals receive all the services they are entitled to under Medicare and Medicaid or other secondary insurance available to them. Cost-sharing for dual eligibles should be limited to cost-sharing under the state Medicaid programs. All network providers should accept Medicaid and should be precluded from billing beneficiaries for cost-sharing that will be absorbed by the Medicaid program.

States would like a greater role in the regulation of SNPs to ensure proper coordination with state programs. For example, states want a role in certifying SNP programs, including reviewing an SNP applying to provide Medicaid wrap-around benefits.[194] States might also want to apply their more stringent marketing requirements, quality controls, and data-sharing requirements. Additionally, states want a say in the development of the SNP

193. CMS STATE GUIDE, *supra* note 175, at 19-20, tbl.4.

194. *See* SAUCIER & BURWELL, *supra* note 50, at 10.

supplemental benefit package to ensure consistency throughout the state and to avoid duplication of existing Medicaid benefits.[195]

VI. CONCLUSION

As Congress considers whether to reauthorize MA SNPs for "institutionalized individuals," it must look to the actual value I-SNPs are providing and the beneficiary outcomes being achieved. In theory, SNPs appear full of potential. In practice, SNPs appear to be a moving target of *maybes*. CMS has yet to articulate requirements for any of the SNPs to ensure that enrollees' needs are being met. For I-SNPs specifically, CMS must establish requirements for how to reconcile conflicts between the institution or HCBS provider operating under its state and federal obligations to provide all necessary care with the SNP's internal procedures for medical necessity and prior authorizations, composition of network, methods for coordination of care and benefits, and array of supplemental benefits. Only then will consumers even be able to fairly evaluate what value I-SNPs can add to their care or the care of their loved ones.

195. *Id.* at 10-12.