Promoting greater Medicare-Medicaid integration in dual-eligible special needs plans

Eric Rollins

November 1, 2018

MEDPAC

Overview of today's presentation

- Last year's work on managed care plans for dual eligibles
- Background on Medicare Advantage dual-eligible special needs plans (D-SNPs)
- Extra benefits provided by D-SNPs
- Factors that limit Medicaid integration in D-SNPs
- Potential policies to promote greater integration

Last year's work on managed care plans for dual eligibles

- Dual eligibles are a high-cost population that may receive fragmented care
- Integrated plans could be one way to improve quality and reduce costs for dual eligibles
  - Some evidence that they can improve care
  - Low enrollment in highly integrated plans
  - Medicare has several types of plans that serve dual eligibles
- Today's presentation focuses on D-SNPs, the most widely used type of plan

Key features of the D-SNP model

- Enrollment limited to dual eligibles
- Plans must follow an evidence-based model of care approved by NCQA
- Integration with Medicaid coverage
  - Plans must have state Medicaid contracts, but requirements for integration are fairly minimal
  - States do not have to make capitated payments for any Medicaid services
  - Fully integrated D-SNPs (FIDE SNPs) meet higher standards for integration

Note: NCQA is the National Committee for Quality Assurance

Overview of the D-SNP market

	Regular D-SNPs	FIDE SNPs	Total
States where plan is available	40	10	43
Number of plans	335	46	381
Enrollment (July 2018)	1,843,465	172,252	2,015,717
Integration with Medicaid	Varies but generally low	High	Varies but generally low

Note: Includes the District of Columbia but not Puerto Rico.

Extra benefits provided by D-SNPs

- Most MA plans receive rebates that are used to provide extra benefits to enrollees
  - Dual eligibles already receive many of these benefits through other programs
  - Limited enrollment allows D-SNPs to account for this coverage in their extra benefits
- D-SNPs more likely to use their rebates to cover supplemental benefits (such as dental, hearing, and vision benefits) than to reduce cost sharing

D-SNPs and regular MA plans use their rebates in different ways

	Regular MA plans	D-SNPs
Average monthly rebate, 2018	$94	$89
Average allocation of rebates:		
Part A/B cost sharing	53%	15%
Supplemental medical benefits	13	71
Supplemental drug benefits	16	3
Reduction in Part B premium	1	0
Reduction in Part D premium	16	10

Note: Figures are preliminary and subject to change. Components do not sum to 100 percent due to rounding.

Medicaid managed care is a key ingredient for greater integration

- Medicaid spending for dual eligibles is largely for long-term services and supports (LTSS)
- Ability to make capitated payments for LTSS makes greater integration more feasible
- Growing number of states use managed care to provide LTSS (managed LTSS programs)
  - Up from 8 states in 2004 to 24 states in 2018
  - States with programs account for ~75 percent of dual eligibles
  - Continued growth is likely

Comparing the D-SNP and Medicaid managed care markets

- Areas where markets overlap (same parent company offers both products in a state) are best positioned to achieve higher integration
- Only ~17 percent of enrollees are in plans with meaningful integration
  - FIDE SNPs (~8.5 percent)
  - “Aligned” D-SNP & MLTSS plans (~8.5 percent)

Three factors limit the level of Medicaid integration in D-SNPs

- Partial-benefit dual eligibles
  - 27 percent of enrollment
  - Limited Medicaid coverage; not much to integrate
- Plans without MLTSS contracts
  - 40 percent of enrollment (all full duals)
    - 14 percent in states without MLTSS programs
    - 26 percent in states with MLTSS programs
- Misaligned enrollment
  - 16 percent of enrollment (all full duals)
  - Plan sponsor has a companion MLTSS plan but beneficiary is only enrolled in the D-SNP

Should partial-benefit dual eligibles be allowed to enroll in D-SNPs?

- This population may not need a specialized MA plan like a D-SNP
- Two potential options to consider
  - Limit enrollment to full-benefit dual eligibles
  - Require plan sponsors to cover partial-benefit and full-benefit dual eligibles in separate plans
- Both options make it easier to pursue greater integration for full-benefit dual eligibles
- Second option preserves access to the distinctive extra benefits that D-SNPs offer

Should D-SNPs be required to have Medicaid MLTSS contracts?

- Integration in D-SNPs will remain low unless they can provide all / most Medicaid services
- This requirement could apply to all D-SNPs or just those in states with MLTSS programs
- Applying this requirement in states without MLTSS programs would probably lead most of these states to close their D-SNPs, but the impact on care coordination would be limited since these plans are not highly integrated

Should D-SNPs be required to use aligned enrollment?

- D-SNP eligibility would be limited to dual eligibles who are enrolled in the parent company's companion Medicaid plan
- All D-SNP enrollees would receive their Medicare & Medicaid benefits from the same parent company
- Lays groundwork for further integration in other areas

The potential for “look-alike” plans

- Some plan sponsors could try to circumvent limits on D-SNPs by developing regular MA plans that target dual eligibles
- Look-alike plans could undermine efforts to promote enrollment in integrated plans
- CMS could be given authority to prevent or limit entry of look-alike plans

Topics for discussion

- Should D-SNPs be required to meet higher standards for Medicaid integration?
  - Prohibit partial-benefit dual eligibles from enrolling or cover them in separate D-SNPs
  - Require D-SNPs to have MLTSS contracts
  - Require D-SNPs to use aligned enrollment
  - Should these higher standards apply only to plans in states that use Medicaid managed care?
- Should CMS have authority to prevent the use of look-alike plans?