Promoting integration in dual-eligible special needs plans

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Chapter summary

Individuals who qualify for both Medicare and Medicaid, known as dual-eligible beneficiaries or "dual eligibles," can receive care that is fragmented or poorly coordinated because of the challenges in dealing with two distinct and complex programs. Many observers have argued that the development of managed care plans that provide both Medicare and Medicaid services would improve quality and reduce spending for this population because integrated plans would have stronger incentives to coordinate care than either program does when acting on its own. These plans would provide all Medicare and Medicaid services and would feature extensive care coordination, a uniform provider network, and a single set of member materials. Integrated plans have shown some ability to reduce enrollees' use of inpatient and nursing home care, and CMS is testing the use of integrated plans on a broader scale through its financial alignment demonstration.

Given the importance of integrating Medicare and Medicaid benefits for the dual-eligible population, the Commission began an examination of integrated plans in its June 2018 report, reviewing the demonstration's progress and noting that Medicare has several types of integrated plans. This chapter continues our analysis by examining the integrated plan type with the largest enrollment, the Medicare Advantage (MA) dual-eligible special needs plan (D–SNP). This year, D–SNPs are available in 42 states and the District of

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Columbia and have 2.2 million enrollees, which accounts for between 15 percent and 20 percent of the dual-eligible population. This popularity is partly due to the extra benefits that D–SNPs provide using MA rebates. These benefits typically differ from those offered by traditional MA plans, with D–SNPs spending a much larger share of their rebates on supplemental benefits such as dental, hearing, and vision services. However, the level of integration between D–SNPs and Medicaid is generally low, and only about 18 percent of D–SNP enrollees are in plans with a significant degree of integration.

The low level of integration between D–SNPs and state Medicaid programs has three underlying causes:

- First, 27 percent of D–SNP enrollees are "partial-benefit" dual eligibles who have Medicaid coverage that is limited to payment of the Part B premium and, in some cases, Medicare cost sharing. D–SNPs provide little obvious benefit in these situations in terms of integrating Medicare and Medicaid coverage, and quality data for partial-benefit dual eligibles suggest that D–SNPs perform about the same as traditional MA plans. However, some partial-benefit dual eligibles may nonetheless benefit from enrolling because of the extra benefits that these plans provide using MA rebates.

- Second, 41 percent of D–SNP enrollees qualify for full Medicaid benefits but are enrolled in plans that do not have capitated Medicaid contracts for delivery of long-term services and supports (LTSS), such as nursing home care and community-based care. The delivery of these services is a key ingredient for integrated plans because LTSS accounts for about 80 percent of Medicaid spending on dual eligibles. However, a growing number of states can make capitated payments for these services because they have developed managed LTSS (MLTSS) programs. The plans in these programs typically provide primary care, acute care, and at least some behavioral health services in addition to LTSS, and thus provide an opportunity to develop integrated plans that serve a wide range of dual eligibles, including those who do not use LTSS.

- Third, 14 percent of enrollees qualify for full Medicaid benefits and are in D–SNPs that have a companion MLTSS plan run by the same parent company, but they are not enrolled in that MLTSS plan. Some enrollees may not be required to enroll in an MLTSS plan, but for those who are, these cases of misaligned enrollment are unlikely to lead to any meaningful integration given the inherent challenges of coordinating the efforts of two separate managed care companies.

Our analysis suggests that several policy changes could improve the level of Medicare–Medicaid integration in D–SNPs. Plan sponsors could be prohibited

from enrolling partial-benefit dual eligibles in D–SNPs or be required to establish separate D–SNPs for partial-benefit and full-benefit dual eligibles. Both options would make it easier to pursue greater levels of integration for dual eligibles who qualify for full Medicaid benefits (the group most likely to benefit from integrated plans), but the second option would enable partial-benefit dual eligibles to enroll in plans with the distinctive package of extra benefits that D–SNPs typically offer.

The other barriers to greater integration could be addressed by using a practice known as aligned enrollment, which would limit enrollment in D–SNPs to beneficiaries enrolled in a comprehensive Medicaid managed care plan offered by the same parent company. Under this approach, plan sponsors could not offer a D–SNP unless they had a companion Medicaid plan, and beneficiaries would not be able to enroll in D–SNPs and Medicaid plans from separate companies. These changes would ensure that D–SNP enrollees receive their Medicare and Medicaid benefits from the same parent company and would set the stage for greater integration in other important areas, such as the development of a single care coordination process and a unified process for handling grievances and appeals.

These policy changes would likely reduce overall enrollment in D–SNPs initially, but the number of beneficiaries enrolled in more highly integrated plans would increase. Since states vary greatly in their use of Medicaid managed care, policymakers could consider applying these changes only in states that have MLTSS programs.

Finally, some plan sponsors might try to circumvent these requirements by developing "look-alike" plans, which are traditional MA plans targeted at dual eligibles. Since look-alike plans operate as traditional MA plans instead of D–SNPs, they do not have to meet the additional requirements that apply to D–SNPs, such as having a Medicaid contract. The use of these plans has been growing; they are now available in 35 states and have about 220,000 enrollees. CMS may need new authority to prevent sponsors from using look-alike plans to undermine efforts to develop more highly integrated D–SNPs. ∎

Introduction

Individuals who qualify for both Medicare and Medicaid, known as dual-eligible beneficiaries or "dual eligibles," may receive care that is fragmented or poorly coordinated because of the challenges of navigating two distinct and complex programs. Many observers argue that managed care plans that provide both Medicare and Medicaid services would improve quality and reduce spending for this population because integrated plans would have stronger incentives to coordinate care than either program does when acting on its own. These plans would provide all Medicare and Medicaid services and would feature extensive care coordination, a uniform provider network, and a single set of member materials. However, these plans have been difficult to develop, and only 8 percent of dual eligibles who receive full Medicaid benefits are enrolled in plans with a high degree of Medicare–Medicaid integration.[1]

The first integrated plans for dual eligibles were developed in the 1990s and 2000s in Massachusetts, Minnesota, and Wisconsin. Researchers found that these plans had some ability to reduce enrollees' use of hospital services and redirect use of long-term services and supports (LTSS) from nursing home care to community-based care (JEN Associates 2015, Kane and Homyak 2004). The most positive findings come from a 2016 study of the Minnesota program, which is known as Minnesota Senior Health Options (MSHO) and serves beneficiaries who are 65 and older. The study compared MSHO enrollees with other dual eligibles in Minnesota who were mostly enrolled in a combination of fee-for-service (FFS) Medicare and Medicaid managed care. The study found that MSHO enrollees were 48 percent less likely to have an inpatient stay, 6 percent less likely to have an outpatient emergency room visit, 2.7 times more likely to have a visit with a primary care physician, and no more likely to have a visit with a specialist. As for LTSS use, MSHO enrollees were 13 percent more likely to receive home- and community-based services and no more likely to have a nursing home admission. The authors concluded that the integrated MSHO program was associated with desirable patterns of service use and "may have merit for other states" (Anderson et al. 2016).

In 2013, the Commission examined the performance of Medicare Advantage (MA) dual-eligible special needs plans, or D–SNPs. We found that these plans generally had average to below-average performance on quality measures compared with other types of special needs plans and traditional MA plans that are open to all enrollees, but some D–SNPs that were highly integrated with Medicaid performed well. The Commission recommended that D–SNPs be required to "assume clinical and financial responsibility for Medicare and Medicaid benefits" to encourage greater integration (Medicare Payment Advisory Commission 2013).

Given the potential benefits of integrated plans, the Commission began an examination of Medicare's managed care plans for dual eligibles in its June 2018 report to the Congress. We reviewed the progress of the financial alignment demonstration, where CMS and 10 states have been testing whether highly integrated plans known as Medicare–Medicaid Plans (MMPs) can improve quality and lower costs. While there were limited data available on the demonstration's effects on areas such as quality, service use, and cost, the information that was available was generally positive. Enrollment in the demonstration plans was stable, quality of care appeared to be improving, payment rates appeared adequate, plans had grown more confident about their ability to manage service use, and stakeholders remained supportive of the demonstration. We reported that Medicare has four types of integrated plans serving dual eligibles, and we described how these plans differed in key areas, such as their level of integration with Medicaid. Some states participating in the demonstration have found that operating multiple plan types in the same market has been problematic, and we noted that policy changes may be needed to better define the respective roles of each plan type or to consolidate these plans in some fashion (Medicare Payment Advisory Commission 2018a).

This chapter continues our examination of integrated plans by focusing on the most widely used type of integrated plan, the D–SNP. Although these plans are popular, their level of integration with Medicaid is generally low compared with other types of plans such as MMPs. We examine three issues:

- how the extra benefits that D–SNPs provide compare with those provided by traditional MA plans, which helps explain why many dual eligibles enroll in D–SNPs even though their integration with Medicaid is often limited;

- the overlap between the D–SNP and Medicaid managed care markets, which helps explain why the level of integration for many D–SNPs is low; and

TABLE
12–1

Dual eligibles had much higher per capita annual spending in 2013 than other Medicare beneficiaries

	Medicare	Medicaid	Total
Dual-eligible beneficiaries			
All dual eligibles	$18,112	$11,126	$29,238
Full-benefit dual eligibles	19,256	15,222	34,478
Partial-benefit dual eligibles	15,200	695	15,895
All other Medicare beneficiaries	8,593	N/A	8,593

Note: N/A (not applicable). Figures include all Medicare (Part A, Part B, and Part D) and Medicaid spending except Medicare or Medicaid spending on Part A, Part B, or Part D premiums. The Medicaid spending for partial-benefit dual eligibles is for coverage of Medicare cost sharing.

Source: MedPAC analysis of linked Medicare–Medicaid enrollment and spending data.

• the use of "look-alike" plans (traditional MA plans targeted at dual eligibles), which indicates that efforts to develop more highly integrated D–SNPs may need to account for potentially offsetting effects elsewhere in the MA program.

Background on dual eligibles

Individuals must separately qualify for both Medicare and Medicaid coverage to become dual-eligible beneficiaries. Roughly half of dual eligibles first qualify for Medicare based on disability (compared with the 17 percent of Medicare beneficiaries who qualify based on disability but are not dual eligibles) and roughly half qualify when they turn 65. Medicaid's eligibility rules vary somewhat across states, but most dual eligibles qualify because they receive Supplemental Security Income benefits; need nursing home care or have other high medical expenses; or meet the eligibility criteria for the Medicare Savings Programs, which provide assistance with Medicare premiums and cost sharing (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2018). In December 2017, about 10.7 million Medicare beneficiaries (18 percent of the total) were dually eligible.

Dual eligibles divide into two broad groups—"full benefit" and "partial benefit"—based on the Medicaid benefits

they receive. Full-benefit dual eligibles qualify for the full range of Medicaid services covered in their state, which generally includes a broad range of primary and acute care services, nursing home care, and other LTSS. In contrast, partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, assistance with cost sharing. In December 2017, there were 7.6 million full-benefit dual eligibles and 3.1 million partial-benefit dual eligibles.

As a group, dual eligibles are in poorer health than other Medicare beneficiaries and have noticeably higher costs (Table 12-1). Measured on a per capita basis, the average annual Medicare cost for dual eligibles in 2013 (the most recent year of linked Medicare and Medicaid enrollment and spending data available) was over $18,000, more than twice as high as that of other Medicare beneficiaries. Within the dual-eligible population, those eligible for full Medicaid benefits had higher Medicare costs and much higher Medicaid costs than those eligible only for partial Medicaid benefits.[2] In 2013, Medicare and Medicaid together spent more than $34,000 per capita, on average, on full-benefit dual eligibles.

Because of their high costs, dual eligibles account for a disproportionately large share of Medicare spending: In 2013, they represented about 20 percent of Medicare beneficiaries but accounted for about 34 percent of total Medicare spending. They were also costly for Medicaid,

representing about 15 percent of enrollment and about 32 percent of total spending in that program (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2018).

Medicare is the primary payer for services covered by both programs, such as inpatient care and physician services, so Medicaid spending for full-benefit dual eligibles is largely for LTSS, such as nursing home care and home- and community-based waiver programs. Less than half of full-benefit dual eligibles (42 percent) used LTSS in 2013, but spending on those services accounted for about 80 percent of this population's total Medicaid costs (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2018).

Background on integrated plans and D–SNPs

Policymakers have long been concerned that dual eligibles are vulnerable to receiving care that is fragmented or poorly coordinated. Medicare and Medicaid are separate programs—the first purely federal, the second largely operated by states with federal oversight and a mix of federal and state funding. Each program is complex, with its own distinct rules for eligibility, covered services, and administrative processes. Medicare and Medicaid also have relatively little incentive to engage in activities that might benefit the other program. For example, states have relatively little incentive to reduce the use of inpatient care by dual eligibles because Medicare would realize most of the savings. Similarly, Medicare has relatively little incentive to prevent dual eligibles from going into nursing homes, where Medicaid pays for most of their care.

Many observers have argued that the two programs could be better integrated by developing managed care plans that provide both Medicare and Medicaid services. Supporters argue that integrated plans, because of their responsibility for the full range of Medicare and Medicaid benefits, would not have the incentive that each program operating independently has to shift costs to the other program, and such plans would have stronger incentives to coordinate care across the programs. Dual eligibles would also find it easier to understand their coverage and obtain care because they would receive integrated materials (such as a single membership card and provider directory instead of separate Medicare and Medicaid versions) and have one point of contact for their care needs. Integrated plans, it has been argued, would thus improve the quality of care for dual eligibles and produce savings by reducing the use of high-cost services, such as inpatient hospital and nursing home care.

Over time, policymakers have developed four types of Medicare plans that serve dual eligibles and seek to integrate with Medicaid in some way (Table 12-2, p. 428). The most widely used integrated plan—and the focus of this chapter—is the Medicare Advantage D–SNP. These plans were first offered in 2006, although a small number were established before that as part of earlier CMS demonstrations aimed at developing integrated plans. (Interest in making these demonstration plans a permanent part of Medicare was one motivation for the creation of D–SNPs.) The legislative authority to offer D–SNPs was initially set to expire at the end of 2008 but was extended numerous times before the Congress permanently authorized them in the Bipartisan Budget Act of 2018. In 2019, D–SNPs are available in 42 states and the District of Columbia and have about 2.2 million enrollees.[3]

In many respects, D–SNPs are identical to traditional MA plans. For example, both are required to provide all Part A and Part B services except hospice and must meet the same adequacy standards for their provider networks. CMS also uses the same methodology to set the payment rates for both plan types. However, D–SNPs have several additional features that are not part of traditional MA plans.

Limited eligibility

MA plans are typically open to all beneficiaries in the plan's service area, but D–SNPs limit their enrollment to beneficiaries who are dually eligible. The rationale for the restriction is that limiting eligibility makes it easier for plan sponsors to tailor plans to meet the distinctive care needs of the dual-eligible population. The two other types of MA special needs plans, which cover beneficiaries with certain chronic conditions (known as C–SNPs) and beneficiaries living in long-term care institutions (known as I–SNPs), have similar eligibility limits.

Model of care

All special needs plans, including D–SNPs, must develop and follow an evidence-based model of care (MOC) that is designed to meet the specialized needs of their enrollees. The MOC must be approved by the National Committee

TABLE
12-2

Medicare has four types of plans that integrate with Medicaid in some way

| | D–SNP | | | | |
	Total	Regular	FIDE–SNP	MMP	PACE
Authorization	Permanent	Permanent	Permanent	Demonstration	Permanent
States where plan is available	43	40	10	9	31
Number of plans	445	400	45	46	126
Enrollment	2,162,127	1,977,848	184,279	388,098	44,440
Level of integration	Varies widely but generally low	Varies widely but generally low	High	High	High

Note: D–SNP (dual-eligible special needs plan), FIDE–SNP (fully integrated dual-eligible special needs plan), MMP (Medicare–Medicaid Plan), PACE (Program of All-Inclusive Care for the Elderly). The District of Columbia is treated as a state. Figures do not include Puerto Rico. Many states have more than one type of plan. Ten states have tested the use of MMPs, but one state (Virginia) has ended its demonstration. The numbers of regular D–SNPs and FIDE–SNPs are based on combinations of contract and plan number; the numbers of MMPs and PACE plans are based on contracts. Enrollment figures are for January 2019. Starting in 2021, regular D–SNPs that have a Medicaid contract to provide long-term services and supports, behavioral health, or both will be classified as highly integrated dual-eligible special needs plans (HIDE SNPs). CMS created this category to implement new requirements for D–SNPs that were enacted in the Bipartisan Budget Act of 2018. The number of plans that will qualify as HIDE SNPs is not yet known.

for Quality Assurance (NCQA) for the plan to participate in Medicare Advantage. CMS and NCQA require each plan's MOC to describe the plan's:

- target population,

- process for providing care coordination,

- provider network (for example, whether the network has the specialized expertise needed to serve the target population), and

- process for measuring quality and improving performance (National Committee for Quality Assurance 2018).

The NCQA gives each MOC a score; the MOCs with passing scores are approved for a period of one, two, or three years (those with higher scores receive longer approvals). The MOCs for most D–SNPs are approved for two or three years.

Requirements for Medicaid integration

When D–SNPs were first created, they did not have to have any formal relationship with state Medicaid programs, but the Congress has taken incremental steps since then to require the plans to be more highly integrated. Since 2010, each D–SNP has been required to have a state contract to "provide [Medicaid] benefits, or arrange for [such] benefits to be provided" (Section 1859(f)(3)(D) of the Social Security Act). These Medicaid contracts are sometimes known as "MIPPA contracts" because the requirement was enacted in the Medicare Improvements for Patients and Providers Act of 2008.[4] Although D–SNPs must have contracts with states, the reverse is not true. States are not required to sign MIPPA contracts with every plan sponsor that wants to offer a D–SNP; they can sign contracts with a limited number of plans or choose to have no D–SNPs at all.

The level of Medicaid integration required by these contracts is limited. For example, the contract must specify the plan's service area, which dual eligibles can enroll in the plan, and the process used to verify enrollees' Medicare and Medicaid eligibility. Consistent with the statutory provision, the contract must also specify the plan's responsibilities to provide or arrange for Medicaid benefits. However, states do not have to contract with

D–SNPs to provide any Medicaid services, let alone key services such as LTSS or behavioral health. Plans that do provide Medicaid services may cover only a limited subset, such as Medicare cost sharing or certain acute care services. At the same time, states that wish to achieve higher levels of integration have been able to do so by adding provisions to their D–SNP contracts. The net result of the contracting requirement has been that the level of integration between D–SNPs and Medicaid varies widely but is generally low.

Since 2012, D–SNPs with high levels of Medicaid integration have the option of becoming what are known as fully integrated dual-eligible (FIDE) SNPs. D–SNPs must meet several additional requirements to qualify as FIDE–SNPs. For example, they must have a capitated Medicaid contract to provide a range of services that includes LTSS, provide both Medicare and Medicaid benefits through a single managed care plan, and take steps to integrate member materials. FIDE–SNPs can also receive higher payments if their enrollees have sufficiently high levels of functional impairment. (Since the integration requirements for "regular" D–SNPs and FIDE–SNPs differ significantly and FIDE–SNPs can receive higher payment rates than other D–SNPs for enrollees with sufficiently high levels of functional impairment, we show them as distinct plan types in Table 12-2.) The FIDE–SNP option has not been widely used. In 2019, only 10 percent of D–SNPs (45 of 445 plans) are FIDE–SNPs. They are available in 10 states and cover about 184,000 beneficiaries, with 3 states (Massachusetts, Minnesota, and New Jersey) accounting for about 75 percent of the overall enrollment.

Most recently, the Bipartisan Budget Act of 2018 requires D–SNPs to meet additional standards for integration starting in 2021.[5] Each D–SNP must satisfy one of the following requirements:

- The plan meets requirements (to be determined by the Secretary) aimed at improving the coordination of LTSS, behavioral health, or both.

- The plan is a FIDE–SNP or has a Medicaid contract to provide LTSS, behavioral health, or both on a capitated basis.[6]

- If the plan's parent company also has a Medicaid plan that provides LTSS or behavioral health, the D–SNP must assume "clinical and financial responsibility" for individuals enrolled in both plans.

Other integrated plans

Besides D–SNPs, the other types of integrated plans are MMPs and the Program of All-Inclusive Care for the Elderly (PACE). Nine states are currently testing the use of MMPs, and those plans have about 388,000 enrollees. MMPs are more highly integrated than D–SNPs, including FIDE–SNPs, because they provide all or almost all Medicaid-covered services and more of their administrative processes have been combined. CMS is conducting the demonstration using the authority of its Center for Medicare & Medicaid Innovation, so potentially CMS could expand the use of MMPs in the future. (See the Commission's June 2018 report for our most recent update on the financial alignment demonstration (Medicare Payment Advisory Commission 2018a).)

PACE plans are provider-sponsored plans that serve beneficiaries who are 55 and older and need the level of care provided in a nursing home. This program is not targeted specifically at dual eligibles, but in practice virtually all Medicare beneficiaries enrolled in PACE are full-benefit dual eligibles. The program aims to keep people living in the community instead of nursing homes and uses a distinctive model of care based on adult daycare centers that are staffed by an interdisciplinary team that provides therapy and medical services. PACE plans are fully integrated because they provide all Medicare-covered and Medicaid-covered services. The program started as a demonstration in the early 1980s and was permanently authorized in 1997. PACE plans are available in 31 states, but they are typically small, and overall enrollment has always been relatively low (currently about 44,000).

Finally, it is worth noting that dual eligibles can also remain in FFS Medicare or enroll in other types of plans, such as traditional MA plans and special needs plans for individuals who live in long-term care institutions or have certain chronic conditions (provided they meet the additional eligibility requirements for those types of SNPs).

D–SNPs offer extra benefits different from those offered by traditional MA plans

D–SNPs have been the most popular type of Medicare health plan for dual eligibles for many years. In 2017, the most recent year of data, 36 percent of dual eligibles were

	Traditional MA plans	D–SNPs
Average monthly rebate in 2019 (per beneficiary)	$106	$112
Average allocation of rebates:		
Cost sharing for Part A and Part B services	51%	11%
Supplemental medical benefits	16	78
Supplemental drug benefits	17	3
Reduction in Part B premium	1	<1
Reduction in Part D premium	15	8

Note: D–SNP (dual-eligible special needs plan), MA (Medicare Advantage). Figures do not include employer plans, other types of special needs plans, or plans in Puerto Rico. Components may not sum to 100 percent because of rounding.

Source: MedPAC analysis of MA bid data for 2019.

enrolled in some type of Medicare health plan, with about 17 percent in D–SNPs, 13 percent in traditional MA plans, and the rest in other plans such as MMPs. Since D–SNPs typically provide few, if any, Medicaid services, they have relatively little advantage over other plans in terms of greater integration and instead have other features that make them attractive to dual eligibles.

One of those features is likely the ability of D–SNPs to offer extra benefits that are not covered by FFS Medicare. Under the MA payment system, each plan submits a bid that indicates the amount of funding that the plan requires to provide the Part A and Part B benefit package in a given service area. CMS compares the bid with a benchmark amount for the area, which is determined administratively and equals a certain percentage of local FFS spending. Benchmarks for counties in the highest spending quartile (measured by FFS spending) equal 95 percent of FFS spending, while benchmarks for counties in the second, third, and fourth quartiles (with the fourth quartile having the lowest spending) equal 100 percent, 107.5 percent, and 115 percent of FFS spending, respectively. In addition, plans that have a rating of 4 stars or higher in the CMS star rating system for MA plans also have a bonus amount, usually 5 percent of FFS spending, added to their benchmark.

If the plan's bid is lower than the benchmark, the plan receives a payment that equals its bid plus a "rebate" that equals a percentage (between 50 percent and 70 percent,

depending on the plan's star rating) of the difference between the benchmark and the bid. Plans that receive rebates must use them to provide additional benefits to their enrollees, such as reduced cost sharing for Part A and Part B services or coverage of supplemental benefits. If the plan's bid is higher than the benchmark, the plan receives a payment that equals the benchmark and must charge beneficiaries a supplemental premium that equals the difference between the bid and the benchmark. (Almost all MA plans bid below their benchmarks.) Finally, the payment rates and rebate amounts are both adjusted for differences in beneficiaries' health status using CMS's hierarchical condition category model for risk adjustment.[7]

This payment system applies to all MA plans, so other products such as traditional MA plans can (and usually do) offer extra benefits. The key difference is that D–SNPs are limited to dual eligibles while traditional MA plans are open to all beneficiaries in the plans' service area. As a result, sponsors of D–SNPs can more easily customize extra benefits that meet the specific needs of dual eligibles compared with sponsors of traditional MA plans, who are typically trying to offer products that appeal to a broader Medicare population.

In particular, D–SNPs can account for the fact that many out-of-pocket costs for dual eligibles are already covered by other programs. Medicaid covers the cost sharing for Part A and Part B services for all full-benefit dual eligibles and for about half of the partial-benefit dual

eligibles.[8] Medicaid also pays the Part B premium for many dual eligibles and covers the Part A premium for many beneficiaries who do not qualify for premium-free coverage. Dual eligibles also qualify automatically for the Part D low-income subsidy (LIS), which covers the premium and all or most beneficiary cost sharing for prescription drug coverage. D–SNPs thus have less reason than traditional MA plans to use their rebates to cover these costs.

The comparison of bids that traditional MA plans and D–SNPs submitted for 2019 illustrates this difference between the plan types (Table 12-3). As part of the bid process, plans indicate how much of their rebate will be used for extra benefits in five categories:

- coverage of cost sharing for Part A and Part B services;

- supplemental medical benefits (services that FFS Medicare does not cover, such as dental benefits or eyeglasses);

- supplemental drug benefits, such as benefits in the Part D coverage gap;

- lowering the Part B premium; and

- lowering the plan's Part D premium.[9]

For 2019, the rebate amounts for traditional MA plans and D–SNPs are comparable ($106 and $112, respectively, on a per member per month basis). However, D–SNPs spend a much larger share of their rebates on supplemental medical benefits (78 percent of their rebate compared with traditional MA plans' expenditure of 16 percent), while traditional MA plans spend more of their rebates on Part A and Part B cost sharing (51 percent of their rebate compared with D–SNPs' expenditure of 11 percent) and supplemental drug benefits (17 percent of their rebate vs. 3 percent of D–SNPs'). D–SNPs use a somewhat smaller share of their rebates to lower the Part D premium, and both types of plans spend very little to reduce the Part B premium.

We examined data from the Medicare Plan Finder website and MA plan benefit package files to better understand the types of supplemental medical benefits that D–SNPs and regular plans cover. Both data sources have standardized information about each MA plan's benefits. CMS has traditionally defined supplemental benefits as services that are not covered by FFS Medicare and are "primarily health related" (Centers for Medicare & Medicaid Services 2018b). CMS and the Congress have both recently given MA plans more flexibility to cover benefits that are not primarily health related, but these changes are still being implemented, and it is unclear how plans will ultimately use this new flexibility.[10]

We found that D–SNPs are more likely than traditional MA plans to offer several types of supplemental benefits (Table 12-4, p. 432). The most prominent are dental, hearing, and vision services, but D–SNPs are also more likely to cover over-the-counter items and transportation. In each benefit category, more than 80 percent of D–SNP enrollees are in plans that cover at least some services in 2019, compared with roughly two-thirds of enrollees in traditional MA plans. The biggest areas of difference are (1) comprehensive dental services, such as extractions or root canals, with 88 percent of D–SNP enrollees and 43 percent of traditional MA enrollees in plans that cover at least one service, and (2) transportation, for which 84 percent of D–SNP enrollees and 30 percent of traditional MA enrollees have coverage.

The MA program allows plans to offer three types of supplemental benefits: basic supplemental benefits that plans provide to all enrollees using their MA rebates, mandatory supplemental benefits that all enrollees are required to purchase by paying an additional premium that covers their full cost, and optional supplemental benefits that beneficiaries can purchase at their discretion by paying an additional premium that covers the full cost of the benefits. (The supplemental benefits shown in Table 12-4 (p. 432) are either basic or mandatory.) More than half of traditional MA enrollees are in plans that offer optional supplemental benefits, while almost no D–SNP enrollees are in plans that offer these optional benefits.

D–SNPs also tend to have more generous coverage of supplemental benefits than traditional MA plans. MA plans typically control their spending on supplemental benefits by limiting the number of services an enrollee can use, limiting the total amount that the plan will spend on a service, or both. We used the MA plan benefit package files to calculate the average maximum amount that plans will spend on supplemental benefits. The coverage of dental, hearing, and vision benefits can vary substantially across plans, so we have provided figures for some common benefit packages in Table 12-4 (p. 432) instead of a single overall figure. For example, the most common arrangement for plans that cover both preventive and

**TABLE
12–4**

D–SNPs have more generous coverage of supplemental medical benefits than traditional MA plans in 2019

	Traditional MA plans	D–SNPs
Share of enrollees in plans with the following coverage:		
Supplemental benefits in basic package		
Preventive dental services (one or more)	68%	85%
Comprehensive dental services (one or more)	43	88
Hearing aids	77	81
Eyeglasses	76	91
Over-the-counter items	60	97
Transportation	30	84
Optional supplemental benefits	52	<1
Average annual maximum coverage amounts:		
Dental services (based on plans that cover both preventive and comprehensive services subject to an overall dollar limit)	$1,140	$2,140
Hearing aids (based on plans that have an overall dollar limit on their coverage but no quantity limits)	$1,610	$1,960
Eyewear (based on plans that have an overall dollar limit on their coverage but no quantity limits)	$140	$270
Over-the-counter items	$260	$940
Transportation (number of one-way rides)	24	41

Note: D–SNP (dual-eligible special needs plan), MA (Medicare Advantage). All figures are weighted using January 2019 enrollment. Figures do not include employer plans, other types of special needs plans, or plans in Puerto Rico. "Preventive dental services" are defined as cleanings, dental X-rays, fluoride treatment, office visits, and office exams. "Comprehensive dental services" are defined as diagnostic services, endodontics, extractions, nonroutine services, periodontics, prosthodontics, and restorative services.

Source: MedPAC analysis of Medicare Plan Finder data and Medicare Advantage plan benefit package data for 2019.

comprehensive dental services is to use a single dollar limit that covers all dental services. About 43 percent of traditional plan enrollees and 47 percent of D–SNP enrollees have this type of coverage (figures not shown in table), and the average maximum coverage amount for D–SNPs is about a thousand dollars higher than the amount for traditional MA plans ($2,140 vs. $1,140). The maximum coverage amounts for other services were also higher for D–SNPs than for traditional MA plans, although the percentage difference between the two figures varied from service to service.

These supplemental benefits may be particularly appealing to dual eligibles because Medicaid's coverage of those services is often limited. For example, Medicaid classifies dental, hearing, and vision services as "optional" services, which means that states can cover them if they wish but are not required to do so (Centers for Medicare & Medicaid Services 2018d). One study found that, in 2012, 4 states did not cover any dental services for adults and 20 states limited coverage for some or all adults to emergency treatment or trauma care (Kaiser Family Foundation 2018). Another study found that 22 states did not cover hearing aids in 2016 and that only 8 states had excellent coverage (Arnold et al. 2017). Even when a state covers a particular service, individuals may have difficulty obtaining care because the number

MEDPAC

TABLE
12–5

D–SNPs and traditional MA plans have different benefit structures and premiums in 2019

	Traditional MA plans	D–SNPs
Share of enrollees in plans with the following features:		
Plan benefit structure		
Maximum out-of-pocket limit ($6,700)	31%	68%
No Part D deductible	46	2
Maximum Part D deductible ($415)	3	92
Monthly plan premium (includes any Part D premium but does not include the Part B premium)		
$0	55	<1
$1 to $10	1	2
$11 to $20	5	8
$21 to $30	7	48
$31 to $40	6	42
$41 to $50	5	1
Over $50	22	<1
Premium is at or below Part D LIS subsidy amount	70	99

Note: D–SNP (dual-eligible special needs plan), MA (Medicare Advantage), LIS (low-income subsidy). All figures are weighted using January 2019 enrollment. The figures do not include employer plans, other types of special needs plans, or plans in Puerto Rico. Components may not sum to 100 percent because of rounding.

Source: MedPAC analysis of Medicare Advantage landscape files for 2019.

of providers (particularly dentists) who accept Medicaid may be limited.

There are also notable differences between D–SNPs and traditional MA plans in their benefit structures and premiums (Table 12-5):

- CMS requires all MA plans to have an annual cap on beneficiary out-of-pocket costs that does not exceed a specified dollar amount ($6,700 in 2019). One way for plans to use their rebates to cover Part A and Part B cost sharing is by having a lower cap. D–SNPs tend to have higher caps than traditional MA plans, likely because a lower cap provides little benefit to most dual eligibles.

- The Part D benefit has a deductible ($415 in 2019), but plans can lower or eliminate it by using an alternative cost-sharing structure or offering supplemental drug coverage. A significant share of beneficiaries enrolled

in traditional MA plans (46 percent) have no deductible for drug coverage, and very few (3 percent) have the maximum deductible of $415. In contrast, more than 90 percent of D–SNP enrollees are in plans that use the maximum deductible, which is covered by the Part D low-income subsidy that all dual eligibles receive.

- The premiums charged by traditional MA plans vary significantly. More than half of the beneficiaries enrolled in these plans (55 percent) are in "zero-premium" plans that use their rebates to cover the Part D premium that enrollees would otherwise pay. These plans are popular with many beneficiaries, but about 45 percent of traditional MA enrollees are in plans that do have premiums, and 22 percent are in plans that have premiums of more than $50 per month. (The plan's premium is separate from the standard Part B premium and includes any amount that enrollees are required to pay for mandatory supplemental benefits.) D–SNPs have different incentives. There is

no advantage to offering a zero-premium plan because the Part D premiums for dual eligibles are covered by the LIS. Using rebates to fully cover the plan's Part D premium thus provides no real benefit to dual eligibles and reduces the amount that the plan can use in other areas such as supplemental benefits. At the same time, the LIS premium subsidy is capped at a specific dollar amount, so D–SNPs have a strong incentive to keep their premiums below the LIS subsidy amount (generally between $21 and $40 per month, depending on the state). As a result, almost no D–SNP enrollees are in zero-premium plans, and almost all enrollees are in plans with premiums that are fully covered by the LIS. About 40 percent of D–SNP enrollees are in plans that have premiums that are within $1 of the LIS subsidy amount (data not shown in Table 12-5 p. 433).

The behavior of dual eligibles who receive partial Medicaid benefits demonstrates the relative appeal of D–SNPs and traditional MA plans. These beneficiaries generally have income between 75 percent and 135 percent of the federal poverty level, but the extent of their Medicaid coverage varies.[11] The key difference is that Medicaid covers Part A and Part B cost sharing for beneficiaries with income between 75 percent and 100 percent of the federal poverty level but not for those with income between 100 percent and 135 percent of the federal poverty level.

Both groups of beneficiaries have the option of enrolling in a D–SNP or traditional MA plan in most states, but they prefer different types of plans (Figure 12-1). In 2017, those who had Medicaid coverage of their cost sharing were more likely to enroll in D–SNPs than traditional MA plans, by a margin of 56 percent to 41 percent, and the share enrolled in D–SNPs has been rising steadily, up from 42 percent in 2012. In contrast, beneficiaries who did not have Medicaid coverage of their cost sharing strongly preferred traditional MA plans, by a margin of 79 percent to 17 percent in 2017, a pattern that has changed relatively little in recent years.

This difference in preferences suggests that the presence (or lack) of Medicaid coverage of cost sharing is an important factor in plan selection. Those who already have their cost sharing covered by Medicaid appear to prefer the richer coverage of supplemental medical benefits that D–SNPs typically offer, while those who do not have their cost sharing covered by Medicaid appear to prefer plans that use more of their MA rebates to cover cost sharing.

The differences in the extra benefits for D–SNPs and traditional MA plans will be an important consideration later in the chapter, when we examine whether partial-benefit dual eligibles should be allowed to enroll in D–SNPs and whether some MA plan sponsors might try to circumvent efforts to increase the level of Medicaid integration in D–SNPs.

## Comparing the D–SNP and Medicaid managed care markets

The generally low level of Medicare and Medicaid integration in D–SNPs is a concern because plans will not have the proper incentives to coordinate care unless they are responsible for providing both Medicare and Medicaid services. As we have seen, there is relatively robust interest in serving dual eligibles in the Medicare managed care sector. However, the development of integrated plans also depends on whether states use capitated managed care to provide Medicaid services to dual eligibles.

For many years, states were much less likely to use Medicaid managed care for their aged and disabled enrollees, many of whom are dual eligibles, than for other enrollees such as children and pregnant women. This discrepancy was largely due to a lack of experience with using managed care to provide LTSS, which presents distinct challenges for health plans because its services and providers can differ greatly from traditional medical services. As recently as 2004, only eight states had programs that used managed care plans to deliver LTSS to at least some beneficiaries (Saucier et al. 2012). But there has been rapid growth since then, and today 24 states have what are known as managed LTSS (MLTSS) programs (Lewis et al. 2018). (North Carolina is one of those states, but its MLTSS plans are quasi-governmental entities that provide a limited set of benefits—behavioral health and substance abuse treatment services—and do not operate other health plans. We decided to exclude it from our analysis and thus have 23 states with MLTSS programs in the material below.) The use of MLTSS will likely grow in the future as more states develop programs and the states that already have programs expand them.

Although these programs are often referred to as MLTSS programs, their scope is usually broader than LTSS, and many could also be described as comprehensive Medicaid managed care programs. In these cases, the MLTSS

FIGURE
12–1

Partial-benefit dual eligibles are more likely to enroll in D–SNPs if Medicaid covers their Medicare cost sharing

Medicaid covers cost sharing (QMBs)

Medicaid does not cover cost sharing (SLMBs and QIs)
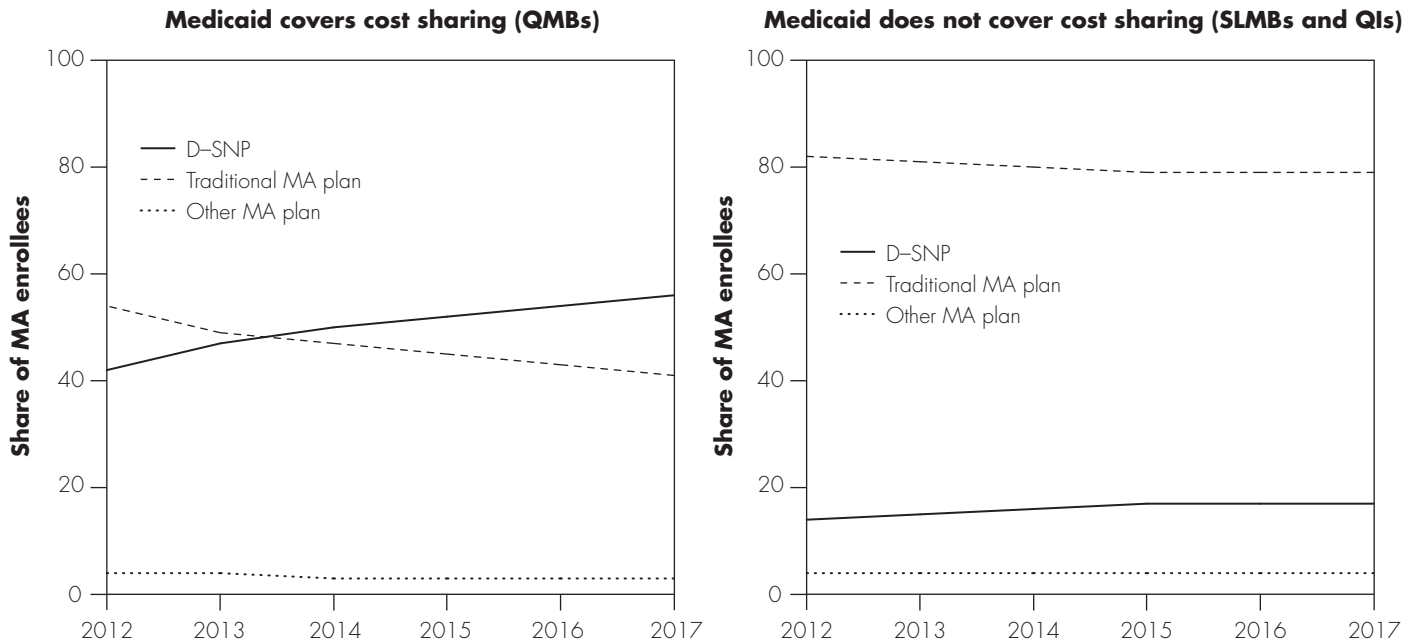
Note: D–SNP (dual-eligible special needs plan), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), MA (Medicare Advantage). QMBs have income below 100 percent of the federal poverty level; Medicaid covers their Part A and Part B cost sharing, Part B premiums, and Part A premiums if necessary. SLMBs and QIs have income between 100 percent and 135 percent of the federal poverty level; Medicaid covers their Part B premiums only. Figure does not include plans in Puerto Rico. The figures for traditional MA plans do not include employer plans. The beneficiaries in the "Other MA plan" category are largely enrolled in special needs plans for individuals with chronic conditions.

Source: MedPAC analysis of common Medicare environment and denominator files and MA cross-walk files.

component is just part of a larger effort to use managed care to integrate the delivery of all or most Medicaid-covered services. The health plans in these programs thus typically provide primary care, acute care, and at least some behavioral health services in addition to LTSS. As a result, even though more than half of dual eligibles do not use LTSS in any given year, the growth in MLTSS programs provides an opportunity to develop integrated plans that serve a wide range of dual eligibles, including those who do not use LTSS.

States can be divided into three broad groups based on their use of MLTSS:

• **States with full MLTSS programs** (15 states) have developed programs that operate statewide and require at least some dual eligibles to enroll in MLTSS plans

to receive their Medicaid-covered services.[12] These programs nonetheless vary in terms of the recipients who are affected (most states have initially developed MLTSS programs for individuals who are elderly or have physical disabilities but have been slower to enroll individuals with intellectual or developmental disabilities, so a program may not cover all dual eligibles) and the plans' responsibility to provide services other than LTSS (plans typically provide medical services such as primary care and acute care but often do not provide all Medicaid-covered behavioral health services).

• **States with limited MLTSS programs** (8 states) have programs that operate in only certain parts of the state, do not require recipients to enroll in plans (i.e., enrollment is voluntary), or both. Many of these states

TABLE
12–6

Overlap between D–SNPs and Medicaid MLTSS plans, January 2019

	Full MLTSS program	Limited MLTSS program	No MLTSS program	Total
Number of states	15	8	28	51
Number of D–SNPs	253	85	113	451
D–SNP enrollment				
Full-benefit dual eligibles	970,000	289,000	307,000	1,566,000
Partial-benefit dual eligibles	344,000	33,000	201,000	578,000
Total	1,314,000	322,000	508,000	2,144,000
For full-benefit dual eligibles:				
Parent company of D–SNP operates an MLTSS plan in the same state				
Yes	812,000	155,000	N/A	967,000
No	158,000	134,000	307,000	599,000
Total	970,000	289,000	307,000	1,566,000
Beneficiary lives within the service area of the companion MLTSS plan				
Yes	585,000	105,000	N/A	690,000
No	227,000	50,000	N/A	277,000
Total	812,000	155,000	N/A	967,000
Beneficiary is also enrolled in the parent company's MLTSS plan				
Yes	282,000	104,000	N/A	386,000
No	303,000	1,000	N/A	304,000
Total	585,000	105,000	N/A	690,000

Note: D–SNP (dual-eligible special needs plan), MLTSS (managed long-term services and supports), N/A (not applicable). The District of Columbia is treated as a state. Table does not include Puerto Rico. The numbers of D–SNPs are based on combinations of state, contract number, and plan number; a small number of D–SNPs operate in multiple states and are counted more than once.

Source: MedPAC analysis of Medicaid MLTSS plans and D–SNP landscape and enrollment data.

have developed their MLTSS programs as part of the financial alignment demonstration and are thus using MMPs instead of D–SNPs as their vehicle for greater Medicare–Medicaid integration. For some states, the demonstration will likely be an interim step in the development of statewide, mandatory programs. For example, Virginia has transitioned from the demonstration to a statewide, mandatory program that uses D–SNPs, and Ohio has discussed expanding its MLTSS program to cover the entire state.

- **States without MLTSS programs** (27 states and the District of Columbia) currently provide LTSS on a fee-for-service basis. Given the shift underway in

Medicaid toward greater use of managed care for aged and disabled enrollees, some states in this group will likely develop MLTSS programs in the future and migrate to one of the categories described above.

To better understand the overlap between the D–SNP and MLTSS markets, we developed an inventory of the MLTSS plans that were operating in January 2019. This inventory had information for 153 plans in 23 states and included the state where the plan was offered, the associated MLTSS program (some states have more than one), service area, and parent company. We matched these plans to a corresponding inventory of D–SNPs by

looking for instances in which a parent company offers both an MLTSS plan and a D–SNP in a given state. The areas where the two markets overlap are best positioned to achieve higher levels of integration. We then used this linked plan landscape to break down D–SNP enrollment as of January 2019 for the 50 states and the District of Columbia based on each state's use of MLTSS and whether the D–SNP's parent company also offers an MLTSS product (Table 12-6).

Looking at the two markets in tandem suggests that the lack of integration in many D–SNPs stems from three features of the D–SNP model:

- partial-benefit dual eligibles can enroll in most D–SNPs,

- D–SNPs are not required to have capitated Medicaid contracts for the delivery of major services such as LTSS, and

- most states with MLTSS programs allow dual eligibles to enroll in D–SNPs and MLTSS plans offered by different parent companies.

Enrollment of partial-benefit dual eligibles

Partial-benefit dual eligibles can enroll in a D–SNP if the state authorizes it in its Medicaid contract with the plan; 36 of the 43 states with D–SNPs currently allow it.[13] As shown in Table 12-6, about 578,000 D–SNP enrollees, or 27 percent of the total, qualify for partial Medicaid benefits only. However, only about a third of the partial-benefit dual eligibles enrolled in MA plans have selected D–SNPs; most of these beneficiaries (about 60 percent) are in traditional MA plans (data not shown).

The enrollment of partial-benefit dual eligibles in D–SNPs makes greater integration more difficult because their Medicaid coverage is so limited compared with dual eligibles who qualify for full benefits. Simply put, there is not much to integrate. About half of partial-benefit dual eligibles receive assistance with the Part B premium only, which does not involve the plan at all. The other half receives assistance with both the Part B premium and Part A and Part B cost sharing, so that Medicaid functions somewhat like a medigap plan. Some states provide a monthly capitated payment to D–SNPs to cover this cost sharing, but even in these situations, the plan itself plays a very limited role and D–SNPs provide little obvious benefit over other MA plans in terms of integrating Medicare and Medicaid coverage. States also routinely

exclude partial-benefit dual eligibles from Medicaid managed care programs because they are not eligible for full benefits. However, some partial-benefit dual eligibles may nonetheless benefit from enrolling in D–SNPs because of the extra benefits they offer.

The presence of partial-benefit dual eligibles is also an obstacle to greater integration for full-benefit dual eligibles. For example, enrolling both groups in the same plan makes it difficult to develop a single care coordination process that oversees all Medicare and Medicaid service needs (states have little incentive to help finance the costs of care coordination for partial-benefit dual eligibles) or use a single set of integrated member materials (each group needs its own version of documents such as the summary of benefits). As a result, every state with FIDE–SNPs—the D–SNPs with the highest levels of integration—limits enrollment in those plans to full-benefit dual eligibles.

One potential argument for allowing partial-benefit dual eligibles to enroll in D–SNPs is that some will ultimately become full-benefit dual eligibles and then could benefit from the greater care coordination that D–SNPs provide compared with traditional MA plans. However, as we noted in our June 2018 report to the Congress, the share of partial-benefit dual eligibles who later qualify for full Medicaid benefits is relatively small (Medicare Payment Advisory Commission 2018a).[14]

Another potential argument for allowing partial-benefit dual eligibles to enroll in D–SNPs is that they have greater health needs than other Medicare beneficiaries. As shown in Table 12-1 (p. 426), average per capita spending for partial-benefit dual eligibles is about 75 percent higher than for beneficiaries who are not dually eligible. Along this line of argument, partial-benefit dual eligibles might receive better care in D–SNPs than in traditional MA plans since D–SNPs are designed to serve a high-cost population and must follow an evidence-based model of care.

We tested this hypothesis using data from the Healthcare Effectiveness Data and Information Set® (HEDIS®), a set of clinical quality measures that MA plans submit annually. We used HEDIS person-level data for 2016 (the most recent data available) to compare partial-benefit dual eligibles enrolled in D–SNPs with those enrolled in traditional MA plans. We limited our analysis to beneficiaries who had no months of full dual eligibility and were enrolled in the same plan for the entire year to maximize the amount of time beneficiaries were enrolled

TABLE 12–7	D–SNPs and traditional MA plans had similar performance on most HEDIS® measures for partial-benefit dual eligibles, measurement year 2016	
	Enrollees under age 65	**Enrollees age 65 and older**
Number of HEDIS measures evaluated	39	42
Number of measures where:		
D–SNP and traditional MA performance was similar	35	36
Traditional MA plans performed better than D–SNPs	2	2
D–SNPs performed better than traditional MA plans	2	4

Note: D–SNP (dual-eligible special needs plan), MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set®). Better performance means that the average measure value for one type of plan was at least 5 percentage points greater than the average measure value for the other type of plan and that the difference between the average measure values was statistically significant. This analysis is based on beneficiaries who had at least one month of partial-benefit dual eligibility and no months of full-benefit dual eligibility during the year, were enrolled in the same D–SNP or traditional MA plan for the entire year, and were enrolled in Medicare for the entire year. Figures do not include employer plans, other types of special needs plans, or plans in Puerto Rico. HEDIS is a registered trademark of the National Committee for Quality Assurance.

Source: MedPAC analysis of HEDIS data for 2017 (for measurement year 2016) and common Medicare environment and denominator files.

in each type of plan.[15] We also looked separately at enrollees who were under 65 and enrollees who were 65 and older because the under-65 population tends to have poorer HEDIS results.

We found that D–SNPs and traditional MA plans had similar performance on 85 percent to 90 percent of HEDIS measures (35 of 39 measures for enrollees under 65; 36 of 42 measures for enrollees 65 and older), which suggests that partial-benefit dual eligibles fare about equally well in either plan type (Table 12-7). However, the partial-benefit dual eligibles in D–SNPs tend to be in somewhat poorer health than those enrolled in traditional MA plans, with average risk scores of 1.56 and 1.41, respectively (data not shown). (Risk scores show how the expected costs for a beneficiary compare with the average for all FFS Medicare beneficiaries. A score of 1.0 means that a beneficiary's expected costs equal the average, while a score of 1.2 means that a beneficiary's expected costs are 20 percent higher than the average.) We checked to see whether this difference could affect these results by comparing HEDIS measures for subsets of beneficiaries with similar risk scores, and we found similar results.

The partial-benefit dual eligibles in D–SNPs were also more likely to have income between 75 percent and 100 percent of the federal poverty level than those enrolled in traditional MA plans (72 percent vs. 31 percent) and less likely to have income between 100 percent and 135

percent of the federal poverty level (28 percent vs. 69 percent). These two subgroups of partial-benefit dual eligibles could differ in numerous ways, so we compared HEDIS measures for each subgroup and again found that D–SNPs and traditional MA plans performed very similarly.

Many D–SNPs are offered by companies that do not have Medicaid MLTSS contracts

Although all D–SNPs must have Medicaid contracts, the minimum standards for those contracts do not require states to make capitated payments for any Medicaid services and, by themselves, do relatively little to promote greater integration of Medicare and Medicaid benefits. For dual eligibles with full Medicaid benefits, the presence or absence of an MLTSS program is a more important factor in determining how much integration is achievable. (As we noted earlier, many MLTSS plans are really comprehensive Medicaid managed care plans and thus have the potential to provide integrated care to a wide range of dual eligibles, including those who do not use LTSS.) D–SNPs in states with these programs can have much higher levels of integration if the D–SNP's parent company also offers an MLTSS plan. Having an MLTSS contract allows the parent company to either combine the two products into a single plan, as in the FIDE–SNP model, or operate them in tandem as "companion" or "aligned" plans.

We estimate that less than half of the full-benefit dual eligibles in D–SNPs (690,000 out of almost 1.6 million, or 44 percent) are in plans where the parent company operates an MLTSS plan in the same area (middle of Table 12-6, p. 436). Most of these beneficiaries (585,000) live in the 15 states with full MLTSS programs. D–SNPs may not have a companion plan for several reasons, and these differences are worth highlighting before considering policies to promote greater Medicare–Medicaid integration.

Some D–SNPs are in states without MLTSS programs

As we noted earlier, 27 states and the District of Columbia currently do not have MLTSS programs. We estimate that about 307,000 full-benefit dual eligibles are enrolled in the D–SNPs that operate in these states, which equals 14 percent of D–SNP enrollment nationwide, a relatively small share because many states without MLTSS programs have smaller populations. (For example, Georgia is the only state that ranks in the top 10 in population but does not have an MLTSS program.) The D–SNPs in these states appear to have low levels of integration; they may provide no Medicaid services at all or receive capitated payments for selected services such as payment of Medicare cost sharing. Some plan sponsors—particularly those that operate MLTSS plans elsewhere—might be willing to develop more highly integrated plans, but they will be unable to do so while the state continues to provide key services such as LTSS and behavioral health on an FFS basis.

Some D–SNPs are in states with MLTSS programs but do not have an MLTSS contract themselves

When states develop MLTSS programs, they generally use competitive procurements to select the participating plans. States use this approach because it helps them obtain more favorable payment rates, makes it easier to oversee the MLTSS program, and helps ensure that each plan has enough enrollment to be financially viable. However, the use of competitive procurement means that some companies that sponsor D–SNPs in the state may not receive an MLTSS contract, either because they do not submit bids or because they are not selected. To give one example, 10 companies currently offer D–SNPs in Pennsylvania, but only 3 have MLTSS contracts (Pennsylvania Department of Human Services 2016).[16]

We estimate that 292,000 full-benefit dual eligibles are enrolled in D–SNPs that operate in states that have

MLTSS programs, but the D–SNPs are offered by parent companies that do not have MLTSS contracts (158,000 beneficiaries in states with full MLTSS programs and 134,000 beneficiaries in states with limited programs). Like the D–SNPs in states without MLTSS programs, these plans may be willing to offer a more highly integrated product but cannot do so. These plans could receive an MLTSS contract in the future, but states usually award multiyear contracts and the next opportunity to win a contract could be several years away, particularly for D–SNPs in states with full programs. The prospects for D–SNPs in states with limited programs are less clear cut because those programs are still evolving and could ultimately expand to include more plans.

One key difference between these "Medicare-only" D–SNPs and those in states without MLTSS programs is that more highly integrated plans are usually available. We found that a substantial majority of MLTSS plans (123 of 153, or 80 percent) have a companion Medicare product (Table 12-8, p. 440). Ten states require their MLTSS plans to offer companion D–SNPs to encourage greater integration, while the MLTSS plans that are part of the financial alignment demonstration all have companion MMPs (Health Management Associates 2018). About half of the MLTSS plans without companion Medicare products are in New York. That state's MLTSS program is unusual because many of its plans are sponsored by LTSS providers that do not have a broader health insurance business (such as MA products or traditional Medicaid plans). Several of these plans developed MMPs for the state's financial alignment demonstration but have dropped out because of low enrollment.

States can use their control over D–SNPs' Medicaid contracts to shut down plans offered by companies that do not have MLTSS contracts. (Although all D–SNPs must have a Medicaid contract, states are not required to sign contracts with every company that wants to offer a D–SNP, which lets states control which plans participate in their D–SNP markets.) At least six states with MLTSS programs do not allow companies to offer a D–SNP unless they have an MLTSS contract; thus, such states do not have any "Medicare-only" D–SNPs. When these states reprocure their MLTSS plans, any incumbent plans that do not win new contracts terminate their D–SNPs, while any new plans are typically required to begin offering D–SNPs.

TABLE
12–8

TABLE 12–8   **Most Medicaid MLTSS plans have companion Medicare plans**

	Number	Percentage
Total number of MLTSS plans, as of January 2019	153	100%
MLTSS plan offers a companion Medicare plan		
Yes	123	80
No	30	20
Type of companion Medicare plan:		
D–SNP only	77	50
MMP only	32	21
D–SNP and MMP	14	9

Note: MLTSS (managed long-term services and supports), D–SNP (dual-eligible special needs plan), MMP (Medicare–Medicaid Plan). Table does not include the Program of All-Inclusive Care for the Elderly.

Source: MedPAC analysis of Medicaid MLTSS plans and D–SNP/MMP landscape data.

However, many states with MLTSS programs sign D–SNP contracts with a broader range of plans. The size of the D–SNP market when the MLTSS program is first implemented appears to be a key factor in states' decision-making. The six states that require their D–SNPs to have an MLTSS contract had either no D–SNPs or very few D–SNPs when they launched their MLTSS programs. For example, New Jersey had no D–SNPs when it began developing its program, and Virginia had 2 D–SNPs with about 2,000 enrollees. States that already had a significant D–SNP market—such as Florida, Pennsylvania, and Texas—have continued to sign D–SNP contracts with a broad range of plans, including those without MLTSS contracts.

Some D–SNPs have companion MLTSS plans but their service areas differ

When states select plans for their MLTSS programs, they can award contracts for the entire state or for particular geographic regions. For example, Tennessee uses statewide contracts, while Florida and Texas are divided into 11 and 13 regions, respectively. As a result, MLTSS plans in states that use geographic regions do not necessarily serve the entire state. In contrast, MA plans typically determine their own service areas. "Local" plans serve one or more counties, while "regional" plans serve CMS-defined regions composed of one or more states. Almost all D–SNPs are local plans.

These differences in how service areas are defined can mean that a company that operates a D–SNP and an MLTSS plan in a given state can nonetheless have counties where only one of those products is available. In these counties, the company is unable to offer a more integrated product, even though it does so elsewhere in the state. We estimate that about 277,000 full-benefit dual eligibles are enrolled in a D–SNP that has a companion MLTSS plan, but it is not offered in the beneficiary's county. We do not have the data to estimate how many dual eligibles are in the reverse situation (i.e., enrolled in an MLTSS plan that has a companion D–SNP, but the D–SNP is not available in their county).

States can ensure that D–SNPs have the same service area as their companion MLTSS plans by using their control over the D–SNP contracting process in two ways:

- They can prohibit D–SNPs from operating in counties located outside the service area of the companion MLTSS plan.

- They can require MLTSS plans to offer companion D–SNPs throughout the MLTSS plan's service area.

Misaligned enrollment

Even when a company offers a D–SNP and an MLTSS plan in the same area, many dual eligibles may be enrolled

in only one of those products. Some of these discrepancies can occur because the MLTSS plan has more-restrictive eligibility requirements than the D–SNP. For example, some full-benefit dual eligibles, like those in certain home- and community-based waiver programs, might be excluded from the state's MLTSS program.

However, even when dual eligibles can (or are required to) enroll in an MLTSS program, they can receive their Medicare benefits from the FFS program or an MA plan offered in their area (which could include a variety of traditional plans and D–SNPs as well as other types of special needs plans). As a result, dual eligibles can be enrolled in MLTSS plans and D–SNPs that are offered by separate companies. These cases of misaligned enrollment are unlikely to lead to any meaningful integration given the inherent challenges of coordinating the efforts of two separate managed care companies. States have the authority to limit enrollment in D–SNPs to dual eligibles who are already enrolled in the parent company's MLTSS plan, but only four states have done so for all of their D–SNPs.

Misaligned enrollment appears to significantly limit the amount of integration in D–SNPs. We estimate that 56 percent of full-benefit dual eligibles in D–SNPs that have companion MLTSS plans (386,000 of 690,000) receive their Medicare and all or most of their Medicaid benefits from the same parent company (bottom of Table 12-6, p. 436). Put another way, only about 18 percent of D–SNP enrollees are in plans with a significant level of Medicaid integration. The beneficiaries who get their Medicare and Medicaid benefits from the same parent company are split about evenly between those enrolled in FIDE–SNPs (184,000) and those enrolled in regular D–SNPs that have companion MLTSS plans (202,000) (data not shown). We do not have enough Medicaid data to determine how many of the remaining 304,000 full-benefit dual eligibles could enroll in their D–SNP's companion MLTSS plan and thus receive more integrated care.

The growing use of "look-alike" plans to circumvent D–SNP requirements

The widespread availability of D–SNPs indicates that MA plan sponsors find it profitable to enroll dual-eligible beneficiaries. As a result, plan sponsors that do not have access to the D–SNP market have an incentive to find other ways to enroll this population. One strategy is to develop products known as "look-alike" plans, which are traditional MA plans that have some of the same features as D–SNPs. D–SNPs largely appeal to beneficiaries because of their coverage of supplemental medical benefits, such as dental, hearing, and vision services, rather than their ability to offer a product that integrates Medicare and Medicaid coverage. These extra benefits are financed using MA rebates—Medicaid funding plays no role—so plan sponsors can develop traditional MA plans with coverage similar to that offered by D–SNPs. And since traditional MA plans do not have to meet the extra requirements that apply to D–SNPs (such as having a state Medicaid contract), plan sponsors can use look-alike plans to circumvent any restrictions that states might apply to their D–SNP markets.

Look-alike plans can thus undermine efforts to develop more highly integrated D–SNPs by encouraging dual eligibles to enroll instead in plans that provide many of the same extra benefits as D–SNPs but do nothing to integrate Medicaid coverage. However, there is no agreed-on definition of look-alike plans, and little research has been done about their prevalence in the MA program. In this section, we take a closer look at how many traditional MA plans primarily serve dual-eligible beneficiaries.

One way to identify look-alike plans is to determine what share of each plan's enrollees are dual eligibles and classify plans that exceed a certain threshold as look-alikes. We calculated these percentages for 2017, the most recent data available, to demonstrate how much the share of enrollees who are dual eligibles varies across plans. We included both full-benefit and partial-benefit dual eligibles in our calculation. We also limited our analysis to traditional MA plans with prescription drug coverage (all D–SNPs have drug coverage, and we assume that look-alike plans do as well) and excluded employer-sponsored plans and all types of special needs plans.

Dual eligibles were a relatively small share of enrollment in most traditional MA plans in 2017 (Table 12-9, p. 442). They accounted for less than 10 percent of enrollment in just over half of plans and less than 30 percent of enrollment in about 95 percent of plans, which is roughly in line with their overall prevalence in the Medicare population.[17] However, dual eligibles were a much larger share of enrollment in some plans: These beneficiaries were a majority of enrollees in 44 plans; in 31 of those plans, dual eligibles made up more than 80 percent of

TABLE
12–9

Dual eligibles were a large share of enrollment in a small number of traditional MA plans in 2017

	Traditional MA plans with drug coverage		Enrollees (in thousands)	
	Number	**Percent**	**Number**	**Percent**
Share of plan enrollees who were dual eligibles				
0% to 10%	893	51.6%	6,495	53.5%
10% to 20%	605	35.0	4,683	38.6
20% to 30%	137	7.9	568	4.7
30% to 40%	36	2.1	125	1.0
40% to 50%	15	0.9	68	0.6
50% to 60%	9	0.5	53	0.4
60% to 70%	4	0.2	6	<0.1
70% to 80%	0	0	0	0
80% to 90%	4	0.2	6	<0.1
90% to 100%	27	1.6	145	1.2
Total	1,730	100.0	12,148	100.0
Greater than 50%	44	2.5	209	1.7
Greater than 80%	31	1.8	151	1.2

Note: MA (Medicare Advantage). The figures in this table are based on December 2017 enrollment in traditional Medicare Advantage plans that provided drug coverage. Employer plans, special needs plans, cost plans, Medicare Savings Account plans, and plans in Puerto Rico are excluded. Figures for share of plan enrollees who were dual eligibles include both full-benefit and partial-benefit dual eligibles. Components may not sum to totals because of rounding.

Source: MedPAC analysis of enrollment data from CMS.

enrollees. The 44 plans in which dual eligibles were a majority of enrollees were located in 16 states, comprising about 209,000 enrollees. Most enrollees were in California (19 plans and 106,000 enrollees) and Florida (4 plans and 76,000 enrollees).

We then used MA bid data for 2019 to assess whether the number of traditional MA plans that primarily serve dual eligibles has changed since 2017. The bid data include each plan's estimate of its enrollment for the plan year, broken down into dual eligibles and all other beneficiaries. As with the 2017 data, we limited our analysis to traditional MA plans with drug coverage. Although these figures are only estimates, they are useful in identifying plans that expect a large share of their enrollees to be dual eligibles. If anything, the figures in the bid data may be conservative: We compared the estimates in the bid data for 2017 with plans' actual enrollment and found that

traditional MA plans almost always underestimated the share of their enrollment that was dually eligible.

The bid data indicate that the number of plans that primarily serve dual eligibles has grown significantly (Table 12-10). For 2019, 95 traditional MA plans projected that more than 50 percent of their enrollees would be dual eligibles. These plans are in 35 states and have a total projected enrollment of about 220,000 beneficiaries. The number of plans and states have both more than doubled since 2017. The increase in enrollment is also larger than it appears because some plans that met the 50 percent threshold in 2017 did not meet it in 2019, either because the plan left the MA program or because the plan sponsor projected that less than half of its enrollees in 2019 would be dual eligibles. There has also been substantial growth in the number of plans in which more than 80 percent of enrollees are dually eligible.

**TABLE
12–10**

The number of traditional Medicare Advantage plans that primarily serve dual eligibles grew substantially from 2017 to 2019

	2017 (Actual)	2019 (Projected)
More than 50 percent of plan enrollees are dual eligibles:		
Number of plans	44	95
Number of states with at least one plan	16	35
Enrollment	209,000	220,000
More than 80 percent of plan enrollees are dual eligibles:		
Number of plans	31	54
Number of states with at least one plan	10	13
Enrollment	151,000	193,000

Note: The figures in this table are based on traditional Medicare Advantage plans that provide drug coverage. Employer plans, special needs plans, cost plans, Medicare Savings Account plans, and plans in Puerto Rico are excluded. Figures for share of plan enrollees who are dual eligibles include both full-benefit and partial-benefit dual eligibles.

Source: MedPAC analysis of enrollment data and Medicare Advantage bid data from CMS.

More than half of the plans that projected a majority of their enrollees would be dual eligibles in 2019 (56 of 95 plans) are new, and many of the plans that have entered the market since 2017 are being offered by Humana and UnitedHealth, the two leading MA plan sponsors. Both companies are now offering what appear to be look-alike plans in multiple states: Humana has 36 plans in 27 states under the "Humana Value Plus" name, while UnitedHealth has 18 plans in 8 states under the "UnitedHealthcare MedicareComplete Assure" name. A few of the Humana plans did not project that more than 50 percent of their 2019 enrollees would be dual eligibles and are not included in the figures in Table 12-10.

We examined the parent organizations and service areas for these 95 plans and found further evidence that most of them are look-alike plans. Most are being offered in situations that enable plan sponsors to circumvent restrictions on offering a D–SNP:

- *States without D–SNPs (12 plans).* Eight states do not have any D–SNPs, usually because the state has decided as a matter of policy that it will not sign Medicaid contracts with them. Look-alike plans operate in six of those states. The only exceptions are Alaska, which does not have any MA plans, and Wyoming.

- *California's financial alignment demonstration (24 plans).* Look-alike plans operate in the seven counties that are part of California's Cal MediConnect demonstration. The state has frozen D–SNP enrollment in these counties to encourage dual eligibles to enroll in the demonstration's Medicare–Medicaid Plans, but this policy has also spurred many plan sponsors to offer look-alike plans. We discussed the role that look-alike plans have played in Cal MediConnect in greater detail in our June 2018 report (Medicare Payment Advisory Commission 2018a).

- *States where the parent organization does not participate in the D–SNP market (36 plans).* These plans operate in states that sign contracts with D–SNPs but the look-alike plans' parent organizations do not offer a D–SNP there. This group includes Idaho, Minnesota, and New Jersey, which have been leaders in developing FIDE–SNPs and limit their D–SNP markets to plans with comprehensive Medicaid managed care contracts.

- *States where the parent organization also offers a D–SNP (23 plans).* These look-alike plans would normally be competitors with their parent company's D–SNP since both products serve the dual-eligible population, but in many cases the overlap between them is limited or might be explained by other factors.

For example, this category includes 13 Humana plans, but there is almost no overlap between their service areas and the service areas of the Humana D–SNPs in their states: Look-alike plans are offered in 437 counties and D–SNPs are offered in 286 counties, but there are only 3 counties where both types of plans are offered. Another three plans in this category are in states that recently conducted a new procurement for their comprehensive Medicaid managed care plans and do not allow plan sponsors to offer D–SNPs unless they have a Medicaid plan. In these cases, look-alike plans may have been created as a contingency in case the plan sponsor lost its Medicaid and D–SNP contracts.

Policy options to promote greater integration in D–SNPs

Federal policymakers' efforts to promote greater integration in D–SNPs, as with many issues involving Medicaid, must weigh the tradeoffs between setting uniform federal standards and giving states flexibility to design their own programs. In this section, we examine four potential policies that would improve the integration between D–SNPs and Medicaid:

- prohibiting beneficiaries who receive partial Medicaid benefits from enrolling in D–SNPs or requiring plan sponsors to cover them in separate plans;

- requiring D–SNPs to have comprehensive Medicaid contracts;

- limiting enrollment in D–SNPs to dual eligibles who are enrolled in an MLTSS plan from the same parent company, an approach known as *aligned enrollment*; and

- preventing plan sponsors from offering look-alike plans.

States can already implement some of these policies by adding extra provisions to their D–SNP contracts, but few have done so, likely for a variety of reasons. For example, states may be reluctant to make significant changes to their D–SNPs because of potential opposition from beneficiaries (because some would have to change their D–SNP or their Medicaid plan) and plan sponsors (because some could lose access to the D–SNP market).

States also have limited incentives to develop more highly integrated D–SNPs because they do not benefit financially from any Medicare savings that those plans might generate. Given the lack of integration in many D–SNPs, federal policymakers may want to be more prescriptive and turn these policies into standard requirements that apply to all D–SNPs, particularly those in states with MLTSS programs.

Partial-benefit dual eligibles and D–SNPs

The rationale for D–SNPs is that dual eligibles may have difficulty obtaining high-quality care because of the unique challenges of coordinating Medicare and Medicaid coverage and would thus benefit by enrolling in a specialized MA plan that is tailored to their needs instead of a traditional MA plan. However, the Medicaid coverage for partial-benefit dual eligibles is so limited that a specialized MA plan provides little, if any, benefit in terms of integrating Medicare and Medicaid coverage, and all of the states with the most highly integrated D–SNPs have chosen to limit enrollment to full-benefit dual eligibles. Our analysis of HEDIS data also suggests that D–SNPs perform about the same as traditional MA plans in caring for partial-benefit dual eligibles.

However, for some partial-benefit dual eligibles, there may nonetheless be an advantage to enrolling in D–SNPs because those plans are more likely than traditional MA plans to offer coverage of dental, hearing, vision, and transportation services. These additional benefits are particularly attractive to the subset of partial-benefit dual eligibles who have their Medicare cost sharing covered by Medicaid.

Given these considerations, policymakers could change the rules governing the enrollment of partial-benefit dual eligibles in one of two ways:

- ***Limit enrollment in D–SNPs to dual eligibles with full Medicaid benefits.*** Under this approach, partial-benefit dual eligibles could enroll in other types of MA plans, but they would not be allowed to enroll in D–SNPs. Seven states restrict D–SNP enrollment this way. The partial-benefit dual eligibles who are now enrolled in D–SNPs (who represent about a third of the partial-benefit dual eligibles in MA plans) would need to select either another MA plan or FFS coverage. Policymakers could lessen the disruption for these beneficiaries by allowing plan sponsors to transfer them into one of their traditional MA plans.

Nevertheless, some partial-benefit dual eligibles who are now enrolled in D–SNPs may find the extra benefits offered by other MA plans less attractive.

- *Require plan sponsors to have separate D–SNPs for partial-benefit and full-benefit dual eligibles.* Under this approach, partial-benefit dual eligibles could enroll in D–SNPs where states allow it. However, plan sponsors would no longer be able to enroll partial-benefit and full-benefit dual eligibles in the same D–SNP. Instead, sponsors would be required to have separate D–SNPs, one for partial-benefit dual eligibles and one for full-benefit dual eligibles. Some plan sponsors already use this approach.[18] Many plan sponsors would probably be willing to operate separate D–SNPs because these plans are generally profitable (Medicare Payment Advisory Commission 2018b). This approach would be less disruptive than excluding partial-benefit dual eligibles because most would just be transferred to a new D–SNP offered by their current plan sponsor, thus retaining the specialized extra benefits that many D–SNPs provide.

The prospects of greater Medicare–Medicaid integration for partial-benefit dual eligibles are inherently low because of their limited Medicaid coverage, but both options outlined above would make higher levels of integration more feasible because all D–SNP enrollees (or those enrolled in certain D–SNPs, under the second option) would be full-benefit dual eligibles, the subset of dual eligibles that uses far more Medicaid services and thus stands to benefit the most from integrated care.

Require D–SNPs to have comprehensive Medicaid contracts

The appeal of integrated plans is based on evidence from states such as Minnesota, which suggests better coordinated care can result from making these plans responsible for the delivery of both Medicare and Medicaid services. However, many D–SNPs do not have Medicaid contracts under which states make capitated payments for the delivery of Medicaid-covered services, and so the level of integration for most D–SNPs is low.

Policymakers could address this limitation by requiring D–SNPs (or their parent companies) to have comprehensive contracts for the delivery of Medicaid-covered services. For example, these contracts could be required to meet the higher standard that now applies to FIDE–SNPs, which must have a contract that "includes coverage of specified primary, acute, and long-term care

benefits and services, consistent with state policy, under risk-based financing" (Centers for Medicare & Medicaid Services 2018c).

States vary greatly in their ability to contract more extensively with D–SNPs. The states with MLTSS programs would be in the best position to meet this requirement. LTSS makes up the bulk of Medicaid's spending on dual eligibles, so the ability to make capitated payments for these services is a key element in giving D–SNPs more responsibility for providing Medicaid services. In addition, most states with MLTSS programs have also developed the ability to use capitation for other Medicaid services, such as acute care and (in some cases) behavioral health, so their MLTSS plans usually have comprehensive Medicaid contracts. Even so, these states would need to decide what to do with their "Medicare-only" D–SNPs—the D–SNPs that do not have MLTSS contracts. Some states may be willing to offer MLTSS contracts to some or all of these plans, which would allow them to continue operating, but other states may decide to keep their current roster of MLTSS plans, which would force the Medicare-only D–SNPs to leave the market.
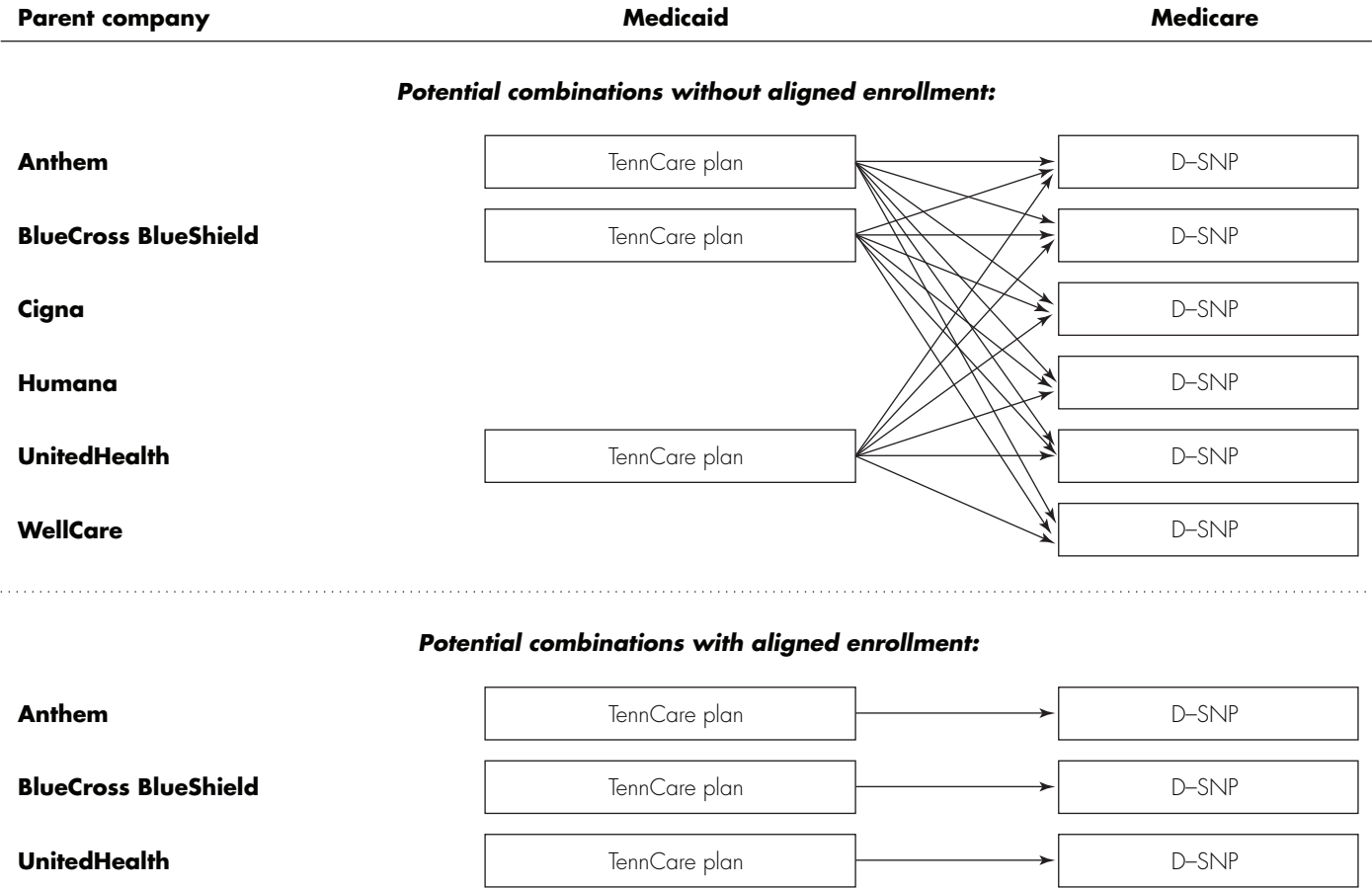
One important question is whether the requirement of a comprehensive Medicaid contract should apply to D–SNPs in states that do not have MLTSS programs. If the requirement did apply, it might prompt some states to develop programs, particularly those that have previously explored the idea. States usually need several years to develop an MLTSS program, so policymakers would also need to give states time before the requirement took effect.

However, most of these states would probably not be persuaded to develop an MLTSS program. Research suggests that states mainly develop these programs to control Medicaid spending, improve quality, and encourage the use of community-based care instead of nursing home care (Libersky et al. 2016). Improving Medicare–Medicaid integration for dual eligibles may be another motivation, but it is often secondary. As a result, requiring D–SNPs to have MLTSS contracts may not fundamentally change states' views on the merits of developing an MLTSS program, and plan sponsors would need to terminate their D–SNPs in many states without MLTSS programs. Given these tradeoffs, policymakers could limit the application of this requirement to D–SNPs in states with MLTSS programs.

One potential concern about this requirement is that states may not adequately consider a parent company's Medicare

FIGURE
12–2

Illustration of how aligned enrollment ensures that D–SNP enrollees receive their Medicare and Medicaid benefits from the same company

Parent company	Medicaid	Medicare

Potential combinations without aligned enrollment:

Parent company	Medicaid	Medicare
Anthem	TennCare plan	D–SNP
BlueCross BlueShield	TennCare plan	D–SNP
Cigna		D–SNP
Humana		D–SNP
UnitedHealth	TennCare plan	D–SNP
WellCare		D–SNP

Potential combinations with aligned enrollment:

Parent company	Medicaid	Medicare
Anthem	TennCare plan	D–SNP
BlueCross BlueShield	TennCare plan	D–SNP
UnitedHealth	TennCare plan	D–SNP

Note: D–SNP (dual-eligible special needs plan). This figure is based on Tennessee's Medicaid program, known as TennCare, but reflects some simplifying assumptions. First, some D–SNPs do not operate in all parts of the state, so dual eligibles in some counties do not have access to every D–SNP shown here. Second, the figure excludes other important options that beneficiaries have for their Medicare coverage (fee-for-service Medicare or another Medicare Advantage plan). Third, the figure does not include a fully integrated dual-eligible special needs plan sponsored by UnitedHealth.

experience when selecting their MLTSS plans. States award MLTSS contracts based on the parent company's Medicaid expertise and its ability to provide Medicaid-covered services at a reasonable cost, but the company would also be expected to provide Medicare services through a D–SNP, and Medicare is the primary payer for most services other than LTSS. In these situations, policymakers could consider whether MLTSS plan sponsors should be required to demonstrate that they have sufficient Medicare experience. For example, CMS generally allowed states to determine which companies could offer MMPs under the financial alignment

demonstration. California chose to use the companies that operate its Medicaid managed care plans, but CMS required the state to allow additional plans to participate in Los Angeles because one company had a record of poor performance in its MA products.

Require D–SNPs to have aligned enrollment

Even if states create a one-to-one relationship between their D–SNPs and Medicaid managed care plans (for example, by requiring all MLTSS plans to offer companion D–SNPs and vice versa), misaligned enrollment poses another barrier to greater integration.

Enrollment is misaligned when beneficiaries are enrolled in Medicaid plans and D–SNPs offered by different companies. Since each plan is responsible for only part of a beneficiary's care, neither can integrate care on its own.

Federal policymakers could address this issue by requiring D–SNPs to follow a practice known as aligned enrollment, under which beneficiaries cannot enroll in a D–SNP unless they also enroll in its companion Medicaid plan. This practice makes D–SNPs more highly integrated because it ensures that enrollees receive their Medicare benefits and all or most of their Medicaid benefits from the same parent company. Four states—Idaho, Massachusetts, Minnesota, and New Jersey—currently use aligned enrollment. Almost all D–SNPs in these states are FIDE–SNPs.[19]

Figure 12-2 illustrates how aligned enrollment would improve integration in a state that does not currently require it. The example in this figure is based on Tennessee's Medicaid program, known as TennCare, which uses managed care to deliver most services, including LTSS, and requires almost all recipients to enroll in plans. TennCare has three plans, sponsored by Anthem, BlueCross BlueShield, and UnitedHealth. The state also has six D–SNPs—three offered by the TennCare plan sponsors and three from other companies. Dual eligibles must enroll in a TennCare plan for their Medicaid coverage and can enroll in any D–SNP for their Medicare coverage. (They can also enroll in FFS Medicare or another MA plan, but we excluded those options to simplify the figure.) The TennCare plans and the D–SNPs can thus be combined in many ways, as shown by the arrows. For example, beneficiaries who are enrolled in Anthem's TennCare plan for their Medicaid benefits can enroll in any of the six D–SNPs for their Medicare benefits.

The use of aligned enrollment would simplify this arrangement considerably. The number of D–SNPs would be reduced from six to three, and dual eligibles would not be able to "mix and match" by enrolling in TennCare plans and D–SNPs from different companies. For example, beneficiaries could enroll in the Anthem D–SNP only if they were also enrolled in the Anthem TennCare plan. As a result, all D–SNP enrollees would receive their Medicare and Medicaid benefits from the same company, which would help set the stage for the D–SNPs to become FIDE–SNPs.

Aligned enrollment, in effect, simultaneously addresses all of the barriers to greater integration discussed in this chapter. Partial-benefit dual eligibles cannot enroll in comprehensive Medicaid plans, so aligned enrollment limits enrollment in D–SNPs to full-benefit dual eligibles. The use of aligned enrollment also has the same effect as requiring D–SNPs to have comprehensive Medicaid contracts since plan sponsors could offer D–SNPs only as a companion product to a comprehensive Medicaid plan such as most MLTSS plans. In addition, aligned enrollment bars D–SNPs from operating in counties that are not part of the companion Medicaid plan's service area. Since aligned enrollment would tightly link D–SNPs to Medicaid plans, it may be more practical to limit its use to states with comprehensive Medicaid managed care programs.

The use of aligned enrollment would also make it possible to achieve higher levels of integration in other important areas, such as the development of a single care coordination process that manages all of a beneficiary's Medicare and Medicaid service needs, an integrated set of member materials, and a unified process for handling grievances and appeals.

The use of aligned enrollment would require a significant number of D–SNP enrollees to change plans. For example, in states with full MLTSS programs, we estimate that 688,000 full-benefit dual eligibles would need to select a new plan. For some beneficiaries, however, this selection might entail changing their MLTSS plan instead of their D–SNP. The decision could be left to beneficiaries (under current rules, those who did not select a plan would be placed in FFS Medicare), or policymakers could consider using passive enrollment to assign beneficiaries to a matching D–SNP and Medicaid plan. The states in the financial alignment demonstration have passively enrolled beneficiaries in MMPs and have used a variety of "intelligent assignment" strategies to determine which plan is the best fit for an enrollee based on factors such as the plan's provider network and formulary. However, our impression from the site visits we made to 7 of the 10 states testing MMPs is that any approach inevitably has shortcomings due to data limitations and the diverse care needs of the dual-eligible population.

Prevent plan sponsors from developing look-alike plans

The policies outlined above would significantly reshape D–SNPs by linking them more closely to Medicaid managed care programs. The ability of plan sponsors to offer D–SNPs would be tied to their participation in

the Medicaid MLTSS market, which usually has fewer plans, and enrollment in D–SNPs could be limited to beneficiaries enrolled in companion Medicaid plans. These policies would likely reduce overall D–SNP availability and enrollment, at least in the short term, although the number of beneficiaries enrolled in plans with a meaningful level of Medicaid integration would increase.

Some plan sponsors might try to circumvent these restrictions by developing look-alike plans. As a result, policymakers interested in achieving better Medicare–Medicaid integration would need to account for potentially offsetting effects in the market for traditional MA plans. Although look-alikes give dual eligibles a broader selection of MA plans, especially plans with richer coverage of supplemental medical benefits, ultimately they encourage dual eligibles to enroll in plans with no Medicaid integration instead of the more highly integrated D–SNPs.

Broadly speaking, policymakers could use two approaches to prevent plan sponsors from developing look-alike plans. The first would apply to plans after they have entered the MA market, while the second would be used when sponsors apply to offer new MA plans. These approaches are complementary and would likely be more effective if used together.

Under the first approach, CMS could monitor the share of enrollees in MA plans who are dually eligible and designate plans that exceed a certain threshold—for example, between 50 percent and 75 percent—as look-alike plans. Setting the threshold below 50 percent would be difficult to justify because it could affect plans where dual eligibles are less than half of enrollment. At the same time, setting the threshold above 75 percent would be too restrictive: The distribution in Table 12-9 (p. 442) indicates that plans in which dual eligibles are more than 75 percent of enrollment are far outside the typical experience for traditional MA plans. CMS could regularly make these calculations using MA plan enrollment transactions and the files that states submit that identify their dual-eligible beneficiaries. This monitoring would focus on traditional MA plans with drug coverage, but should exclude plans with very low enrollment since the share of dual-eligible enrollees in these plans is more likely to fluctuate. This monitoring would also not apply to special needs plans for beneficiaries with chronic conditions or beneficiaries living in long-term care institutions.

One concern in setting a threshold is whether plans that are targeted at dual eligibles (look-alikes) can be distinguished from plans that simply operate in areas where dual eligibles are a large share of the Medicare population. For example, a plan where dual eligibles are 55 percent of enrollment might be treated as a look-alike plan if it serves an area where dual eligibles are 15 percent of all beneficiaries, but not if it serves an area where dual eligibles are 50 percent of all beneficiaries.

Policymakers could set the threshold in a way that accounts for this variation in plans' service areas. Figure 12-3 compares the share of a plan's enrollees who were dual eligibles with the corresponding figure for the plan's service area. Like Table 12-9 (p. 442), Figure 12-3 uses 2017 data for traditional MA plans with drug coverage. Each point in the figure represents an individual plan. The horizontal axis shows the share of beneficiaries in the plan's service area who were dual eligibles, which ranged from 6 percent to 48 percent. The vertical axis shows the share of plan enrollees who were dual eligibles. The solid diagonal line shows where the two shares are equal; plans above this line had a disproportionately high share of enrollees who were dual eligibles and plans below this line had a disproportionately low share.

The figure shows that, even if the threshold for look-alike plans were set at a relatively low 50 percent, the share of enrollees who are dual eligibles in almost every plan that exceeded the threshold was much higher than the corresponding figure for the plan's service area—by 30 percentage points or more, in most cases. Only two plans modestly exceeded the threshold (i.e., between 50 percent and 60 percent of their enrollees were dual eligibles) and operated in areas with a very large dual-eligible population (more than 35 percent of all beneficiaries). One way to prevent these plans from being classified as look-alikes would be to use a higher threshold in areas where dual eligibles are a large share of the Medicare population. The dotted line in Figure 12-3 illustrates this approach by showing a threshold set at the greater of (1) 50 percent or (2) the share of beneficiaries in the plan's service area who are dual eligibles plus 15 percentage points.

Once CMS has identified a look-alike plan, the agency could be given authority to treat it as a de facto D–SNP and require it to meet the same standards that apply to traditional D–SNPs, such as having a Medicaid contract and an NCQA-approved model of care. Requiring look-alike plans to have Medicaid contracts would be particularly important because states could then close look-alike plans that undermined integrated care programs.

FIGURE

12–3

A threshold for identifying look-alike plans could account for the share of beneficiaries in each plan's service area who are dual eligibles
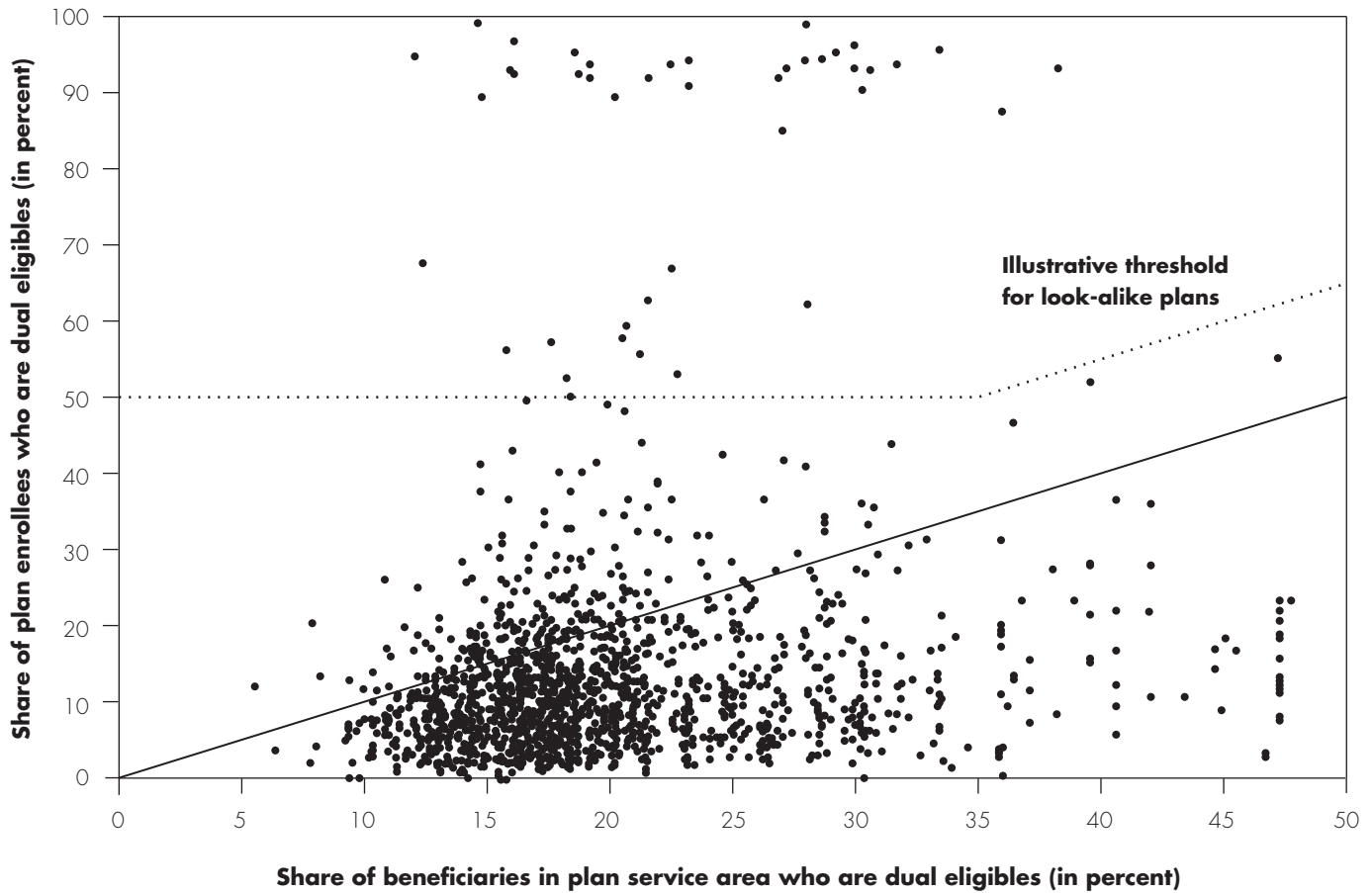
Note: The solid diagonal line shows where the share of plan enrollees who are dual eligibles equals the share of beneficiaries in the plan's service area who are dual eligibles. Plans above this line had a disproportionately high share of enrollees who were dual eligibles, and plans below this line had a disproportionately low share. This figure is based on December 2017 enrollment in traditional Medicare Advantage plans that provided drug coverage. Employer plans, special needs plans, cost plans, Medicare Savings Account plans, and plans in Puerto Rico are excluded. "Dual eligibles" include both full-benefit and partial-benefit dual eligibles.

Source: MedPAC analysis of enrollment data from CMS and Medicare Advantage landscape files.

As part of this process, CMS could be given authority to freeze enrollment in look-alike plans while the state decided whether it would sign a Medicaid contract with the plan. If the state informed CMS that it was willing to sign a contract, the freeze could be lifted while the plan worked to obtain the contract and meet the other D–SNP requirements (a process that could take a year or more). However, if the state indicated that it would not sign a contract, the freeze would remain in effect and the look-alike plan would close at the end of the plan year.

CMS would also need to decide whether to take action against look-alike plans in states that do not have D–SNPs. The agency could decide that look-alike plans

are beneficial in these states, since they may provide extra benefits that are more attractive to dual eligibles than those offered by traditional MA plans, and allow them to continue. However, the limits on look-alike plans should apply in states that do not have D–SNPs but use other types of plans to provide integrated care.[20]

Under the second approach, CMS could be given authority to reject applications to offer traditional MA plans that are targeted at dual eligibles. This approach would be less disruptive than closing look-alike plans after they entered the MA market, but its effectiveness would depend on how well CMS could identify look-alike plans when they first applied to participate in the MA program.

One way to identify look-alike plans would be to use the enrollment projections that plans submit as part of their MA bid. This method is straightforward, but these projections tend to underestimate dual eligibles as a share of plan enrollment, and plan sponsors that want to offer look-alike plans would have an incentive to further underestimate their enrollment of dual eligibles to avoid triggering a possible rejection.

CMS could also try to identify look-alike plans by examining their benefit designs for features that are common in look-alikes but rare in other traditional MA plans. Compared with the enrollment projections, this method could be more difficult for plan sponsors to manipulate because it would rely on features that are more intrinsic to look-alike plans.

We tested this concept with 2019 bid data by looking for features in plans that projected more than half of their enrollees would be dual eligibles. We found that 89 of 95 plans met 4 criteria:

- The plan provides Part D drug coverage.

- The plan does not have a supplemental premium for Part A and Part B benefits.

- The plan has a Part D premium, but it does not exceed the amount covered by the Part D low-income subsidy.[21]

- The plan uses more than half of its MA rebates (excluding any amounts used to lower the Part D premium) to provide supplemental medical benefits.

In addition to the 6 "false negatives" (plans that projected more than half of their enrollees would be dual eligibles but did not meet the four criteria listed above), this method also produced 12 "false positives" (plans that projected less than half of their enrollees would be dual eligibles but met the 4 criteria). However, some discrepancies may reflect inaccurate enrollment projections. For example, four false negative plans are being offered by a sponsor that is new to the MA program, three false positive plans are Humana Value Plus plans (part of the company's apparent line of look-alike plans), and three other false positive plans were majority dual eligible in 2017.

If CMS denied an application for a product that it identified as a look-alike plan, the plan sponsor could be given an opportunity to modify the plan's benefit design so that it did not target dual eligibles as directly. At the same time, the agency might need to modify the criteria it uses

to identify look-alikes over time if plan sponsors could develop other benefit designs that target dual eligibles. CMS could also consult with the states where the look-alike plans would be offered to get their views on whether the plans should be allowed to enter the MA market.

Developing a new framework for managed care plans that serve dual-eligible beneficiaries

In our June 2018 report, we noted that Medicare's four types of health plans that serve dual eligibles—D–SNPs, FIDE–SNPs, MMPs, and PACE—differ in several key respects, and that operating more than one type of plan in the same market can be problematic. We concluded that policymakers may want to consider consolidating these plans or better defining their roles.

The policies outlined in this chapter could be part of a new framework that uses the presence of Medicaid managed care programs, especially MLTSS programs, and the beneficiary's level of Medicaid eligibility to determine which plan type would be used. Under this framework, the existing D–SNP model with its low level of integration would be sufficient for partial-benefit dual eligibles (unless policymakers decided to prohibit them from enrolling D–SNPs altogether, as some states have done).

The plan type best suited for full-benefit dual eligibles would depend on the state's use of Medicaid managed care. States that either do not use managed care or have only limited programs could continue using the existing D–SNP model. However, states with comprehensive managed care programs—where plans provide all or most Medicaid services, including LTSS, and individuals must enroll in managed care—would use highly integrated plans similar to FIDE–SNPs or MMPs. Given the similarities between these plans, policymakers may want to combine them into a single product that could incorporate elements from both models. The policies outlined in this chapter would be important elements in moving D–SNPs to this more highly integrated model and would be consistent with the Commission's past support for greater integration.

Conclusion

The development of managed care plans that provide both Medicare and Medicaid services has the potential to improve quality and reduce spending for dual-eligible

beneficiaries, but these plans have been difficult to develop. D–SNPs have the largest enrollment of the Medicare health plans that serve dual eligibles, but their appeal may be due more to the extra benefits that they provide than to their integration with Medicaid, which is often limited. The low level of integration in these plans is due to factors such as the limited Medicaid coverage for partial-benefit dual eligibles and variation in states' use of Medicaid managed care for full-benefit dual eligibles. However, higher levels of integration are now feasible in the growing number of states with comprehensive

Medicaid managed care programs that include LTSS. Policymakers may want to consider requiring D–SNPs in these states to meet higher standards for integration, such as having comprehensive Medicaid managed care contracts and using aligned enrollment, and to prevent plan sponsors from circumventing efforts to promote more highly integrated D–SNPs by offering look-alike plans. The changes outlined in this chapter could reduce overall D–SNP enrollment, at least in the short term, but they would increase enrollment in plans with meaningful integration. ■

Endnotes

1   This figure should not be confused with the figure in the chapter summary noting that 17 percent of D–SNP enrollees are in plans with a significant degree of integration. Both figures measure the enrollment of dual eligibles in integrated plans, but they use different denominators (the 8 percent figure uses all full-benefit dual eligibles, while the 17 percent figure uses full-benefit and partial-benefit dual eligibles who are enrolled in D–SNPs) and numerators (the 8 percent figure counts enrollment in Medicare–Medicaid Plans, fully integrated D–SNPs, and the Program of All-Inclusive Care for the Elderly, while the 17 percent figure counts enrollment in D–SNPs with a significant degree of integration).

2   Put another way, partial-benefit dual eligibles represented about 29 percent of all dual eligibles, but they accounted for only about 2 percent of Medicaid's spending on dual eligibles in 2013 (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2018).

3   Like all MA plans, each D–SNP serves a specific geographic area composed of one or more counties. Very few D–SNPs serve an entire state, and some dual eligibles in those 42 states do not have access to a D–SNP.

4   The Commission recommended in its March 2008 report that D–SNPs be required to contract with states to coordinate Medicaid benefits (Medicare Payment Advisory Commission 2008).

5   The legislation also requires the Commission to periodically compare the quality of care that dual eligibles receive in these three groups of D–SNPs, in the Medicare–Medicaid Plans in the financial alignment demonstration, and in other MA plans. The first study is due in 2022 and must be updated every two years through 2032. After that, the schedule for completing the studies changes; the subsequent study is due in 2033 and must be updated every five years. The Commission must consult with the Medicaid and CHIP Payment and Access Commission as part of this work.

6   Starting in 2021, regular D–SNPs that have a Medicaid contract to provide LTSS, behavioral health, or both will be classified as highly integrated dual-eligible special needs plans (HIDE SNPs). CMS created this category to implement new requirements for D–SNPs that were enacted in the Bipartisan Budget Act of 2018. The number of plans that will qualify as HIDE SNPs is not yet known.

7   The risk scores used to adjust payment rates are revised during the plan year to account for updated information on beneficiaries' diagnoses and other factors such as Medicaid eligibility. In contrast, the rebate amounts are adjusted based on risk scores that plans submit during the MA bid process and are not adjusted later.

8   States may not pay the full amount of the cost sharing. Medicaid allows states to limit their payments for cost sharing to the difference between the state's payment rate for the service and the Medicare payment amount, instead of the difference between the Medicare allowable amount (which is usually higher than the state's Medicaid rate) and the Medicare payment amount. Most states use this "lower-of" approach for at least some services. However, beneficiaries are not liable for the remaining cost sharing when this occurs.

9   All D–SNPs and most other MA plans have prescription drug benefits. These plans follow a separate bidding process to determine the cost of providing Part D drug coverage and can use their MA rebates to cover some or all of the Part D premium that beneficiaries would otherwise have to pay.

10 Starting in 2019, CMS has expanded its definition of supplemental benefits to include services that maintain a beneficiary's health instead of preventing, curing, or diminishing an illness or injury (Centers for Medicare & Medicaid Services 2018a). Starting in 2020, Section 50322 of the Bipartisan Budget Act of 2018 gives MA plans additional flexibility to provide supplemental benefits that are aimed at "improving or maintaining the health or overall function" of chronically ill enrollees.

11 Individuals who have income below 75 percent of the federal poverty level can usually qualify for full Medicaid benefits.

12 Unlike Medicare, states can require Medicaid recipients to enroll in managed care.

13 The seven states that limit D–SNP enrollment to full-benefit dual eligibles are Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, and Virginia.

14 Of the individuals who were partial-benefit dual eligibles at a given point in time, we found that about 6 percent were eligible for full Medicaid benefits one year later. About 10 percent were eligible for full benefits three years later.

15 Roughly two-thirds of the partial-benefit dual eligibles enrolled in MA plans in 2016 met these criteria. We excluded beneficiaries with any months of full Medicaid eligibility because they spent more time as full-benefit dual eligibles, on average, than they did as partial-benefit dual eligibles, and are arguably better viewed as part of the full-benefit population.

16 Pennsylvania selected three companies for its MLTSS program; the other winning company was new to the state and did not have an existing D–SNP.

17 About 18 percent of all Medicare beneficiaries in 2017 were dually eligible.

18 In 2017, there were 26 D–SNPs in which more than 90 percent of the plan's enrollees were partial-benefit dual eligibles. These plans had a combined enrollment of about 107,000 and accounted for between 20 percent and 25 percent of all partial-benefit dual eligibles enrolled in D–SNPs. The sponsors of these plans had another D–SNP for full-benefit dual eligibles in the same geographic area. The practice of plan sponsors offering multiple D–SNPs in the same area appears to have originated in Florida but is now also being used in some other states.

19 The exceptions are in Minnesota, which has separate MLTSS programs for individuals under age 65 and those 65 and older. The D–SNPs affiliated with the program for those 65 and older, known as Minnesota Senior Health Options, are all FIDE–SNPs. The D–SNPs affiliated with the program for those under age 65, known as Special Needs Basic Care, also use aligned enrollment but do not qualify as FIDE–SNPs because their coverage of LTSS is too limited.

20 Two states that do not have D–SNPs are using other avenues to develop integrated care programs. Illinois has decided to use MMPs as its platform for integrating care and closed its D–SNPs at the end of 2017. New Hampshire has never had D–SNPs but is developing an integrated care program based on PACE.

21 We counted plans as meeting this requirement if their Part D premium exceeded the amount covered by the low-income subsidy by a trivial amount (less than 10 cents).

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