MEDPAC | Medicare Payment Advisory Commission

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January 13, 2023

Senator Bill Cassidy, M.D.
Senator Tim Scott
Senator John Cornyn
dualeligibles@cassidy.senate.gov

Senator Thomas R. Carper
Senator Mark R. Warner
Senator Robert Menendez

RE: Congressional Request for Information on Dual-Eligible Beneficiaries

Dear Senators Cassidy, Carper, Scott, Warner, Cornyn, and Menendez:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to respond to the Request for Information (RFI) issued on November 22, 2022, on ways to improve care for individuals who qualify for both Medicare and Medicaid benefits, known as dual-eligible beneficiaries. The Commission has long been concerned about dual-eligible beneficiaries, who are generally in poorer health than other Medicare beneficiaries and are vulnerable to receiving fragmented or poorly coordinated care because of the challenges in obtaining care from two distinct programs.

For dual-eligible beneficiaries, Medicare covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. Medicaid covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound benefits such as dental services and transportation. The program also provides assistance with Medicare premiums and, in some cases, cost sharing. Both programs are complex, with their own distinct rules for eligibility, covered services, and administrative processes. Medicare and Medicaid each also have relatively little direct incentive to engage in activities that might predominantly accrue benefits to the other program.[1] In fact, states have incentives to adopt policies that shift costs to Medicare and providers have incentives to deliver care in a manner that charges the higher paying program (often Medicare) even if that care does not benefit patients.

Our response to this RFI summarizes the Commission's work on improving the integration of Medicare and Medicaid for dual-eligible beneficiaries over the past decade. Our work has largely focused on the development of managed care plans that provide all of the services that the two programs cover. Supporters of this approach contend that integrated plans, because of their

[1] For example, state Medicaid programs may not encourage providers to make investments in efforts to reduce inpatient hospital admissions by dual-eligible beneficiaries because Medicare pays for their inpatient care and any subsequent skilled nursing care. Similarly, Medicare has relatively little incentive to discourage dual-eligible beneficiaries from going into nursing homes, where Medicaid pays for most of their care.

responsibility for the full range of Medicare and Medicaid benefits, have stronger incentives to coordinate care across the programs and eliminate the incentive to shift costs to the other program. Supporters also contend that dual-eligible beneficiaries would 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-eligible beneficiaries and potentially reduce Medicare and Medicaid spending by reducing the use of high-cost services, such as inpatient hospital and nursing home care.

Potential ways to improve integrated plans

Medicare currently has three types of health plans that serve dual-eligible beneficiaries: Medicare Advantage (MA) dual-eligible special needs plans (D–SNPs), the Medicare–Medicaid Plans (MMPs) that operate under CMS's financial alignment demonstration, and the Program of All-Inclusive Care for the Elderly (PACE). Enrollment in D–SNPs (4.1 million beneficiaries in July 2022, not counting plans in the U.S. territories) is far higher than enrollment in MMPs or PACE (428,000 and 54,000, respectively).

We consider plans to be highly integrated if they cover all or most Medicaid-covered services in addition to the Medicare benefit package (either directly or through an affiliated Medicaid plan offered by the same parent company). MMPs and PACE have a high level of integration, but the level of integration between D–SNPs and Medicaid varies. Only 9 percent of D–SNP enrollees are in plans with a high level of integration, known as fully integrated dual-eligible SNPs (FIDE–SNPs). Another 38 percent of enrollees are in plans known as highly integrated dual-eligible SNPs (HIDE–SNPs) that are less integrated to varying degrees. The remaining 53 percent of enrollees are in "coordination-only" D–SNPs that provide little, if any, integration.

The Commission has long believed that D–SNPs should have a high level of integration so they have the proper incentives to coordinate care across Medicare and Medicaid. In 2013, when the authority for MA insurers to offer special needs plans was still temporary, the Commission recommended that the authority for D–SNPs that "assume clinical and financial responsibility for Medicare and Medicaid benefits" (that is, were highly integrated) should be made permanent and that the authority for all other D–SNPs should be allowed to expire.[2]

In 2018 and 2019, the Commission examined the Medicare managed care plans that serve dual-eligible beneficiaries in depth and discussed a number of potential policies that would improve the ability of those plans to provide integrated care:

Limit how often dual-eligible beneficiaries can change plans.[3] Medicare allows most beneficiaries to change their MA or Part D plan only once a year, during the annual enrollment period. However, this provision does not apply to dual-eligible beneficiaries. Before 2019, dual-eligible beneficiaries could switch plans on a monthly basis. Starting in 2019, they can switch plans once

[2] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[3] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

each calendar quarter during the first nine months of the year; any requests to change plans in the last three months of the year are handled as part of the annual enrollment period and take effect the following January 1. Using 2016 data, we found that dual-eligible beneficiaries changed MA plans more often than other beneficiaries. The exemption for dual-eligible beneficiaries was originally viewed as a beneficiary protection, to ensure that a group of beneficiaries who often had complex health needs would be able to change their health plan if they had difficulty seeing certain providers or obtaining services. However, the exemption also makes it harder for plans to provide care coordination, which is most effective when there is an ongoing relationship between the beneficiary and the plan. MA plans are now much more experienced at serving dual-eligible beneficiaries than they were more than a decade ago, and as a result the exemption that makes it easier for dual-eligible beneficiaries to switch plans may no longer be appropriate.

Prohibit or segment the enrollment of partial-benefit dual-eligible beneficiaries in D–SNPs.[4] [5] Dual-eligible beneficiaries divide into two broad groups—"full benefit" and "partial benefit"—based on the Medicaid benefits they receive. Full-benefit dual-eligible beneficiaries 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 long-term services and supports. In contrast, partial-benefit dual-eligible beneficiaries receive assistance only with Medicare premiums and, in some cases, cost sharing. Roughly 70 percent of dual-eligible beneficiaries are full benefit and 30 percent are partial benefit.

The rationale for D–SNPs is that dual-eligible beneficiaries 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 meet their needs instead of a traditional MA plan. However, the Medicaid coverage for partial-benefit dual-eligible beneficiaries is so limited that a specialized MA plan provides little, if any, benefit in terms of integrating Medicare and Medicaid coverage. When we analyzed quality measures from the Healthcare Effectiveness Data and Information Set® (HEDIS®) for 2016, we found that D–SNPs performed about the same as traditional MA plans in caring for partial-benefit dual-eligible beneficiaries.[6]

Given these considerations, policymakers could change the rules governing the enrollment of partial-benefit dual-eligible beneficiaries in one of two ways: (1) limit enrollment in D–SNPs to full-benefit dual-eligible beneficiaries or (2) require MA insurers that offer D–SNPs to have separate plans for partial-benefit and full-benefit dual-eligible beneficiaries. Both options would make higher levels of integration more feasible because all D–SNP enrollees (under the first option) or all enrollees in certain D–SNPs (under the second option) would be full-benefit dual-eligible beneficiaries, who use far more Medicaid services and thus stand to benefit the most from integrated care. In these plans, it would be easier to develop a single care coordination process that oversees all Medicare and Medicaid service needs and integrate various aspects of the member experience such as enrollment and benefit materials, provider directories, and grievance and appeals processes.

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[4] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[5] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[6] HEDIS® is a registered trademark of the National Committee for Quality Assurance and refers to a set of quality measures that have been developed to evaluate health plans.

Expand the use of passive enrollment.[7] One major obstacle to using managed care to better integrate care for dual-eligible beneficiaries is that CMS and states cannot require dual-eligible beneficiaries to receive their Medicare and Medicaid benefits from the same parent company—through a highly integrated plan like an MMP or parallel enrollment in a D–SNP and companion Medicaid plan—because of Medicare's freedom-of-choice provision.

The financial alignment demonstration addressed this concern by allowing states to passively enroll dual-eligible beneficiaries in MMPs. With passive enrollment, beneficiaries are automatically enrolled in MMPs unless they indicate that they do not want to join an MMP, which is known as opting out. Every state that has tested the MMP model has used passive enrollment for at least some beneficiaries. CMS also allows D–SNPs to use a limited form of passive enrollment known as default enrollment. With default enrollment, a parent company that operates a comprehensive Medicaid managed care plan automatically enrolls the individuals in that plan in a companion D–SNP when they first become eligible for Medicare. Default enrollment can only be used for a subset of dual-eligible beneficiaries—those who qualify for Medicaid first and then for Medicare.

Expanding the use of passive enrollment could be one way of enrolling more dual-eligible beneficiaries in plans with higher levels of Medicare–Medicaid integration. Passive enrollment has been a controversial feature of the financial alignment demonstration because of the high opt-out and disenrollment rates. Nevertheless, compared to earlier demonstrations that tested the use of integrated plans and relied entirely on voluntary enrollment, passive enrollment resulted in higher enrollment than most states would have been able to achieve with a purely voluntary model.

Require all D–SNPs to have comprehensive Medicaid contracts.[8] The appeal of integrated plans is based on the concept of 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 many 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 standards that apply to FIDE–SNPs, the most highly integrated type of D–SNP.

States vary greatly in their ability to contract more extensively with D–SNPs. The states that use managed care to provide LTSS—known as managed LTSS (MLTSS) programs—would be in the best position to meet this requirement. LTSS makes up the majority of Medicaid's spending on dual-eligible beneficiaries, so the ability to make capitated payments for these services is a key element in giving D–SNPs more responsibility for providing Medicaid services. 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

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[7] Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

[8] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

their current roster of Medicaid plans, which would force the Medicare-only D–SNPs to leave the market.

Under this option, policymakers would need to consider whether the requirement of a comprehensive Medicaid contract would 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 develop MLTSS programs for a variety of reasons and that improving Medicare–Medicaid integration is often not the primary motivation. As a result, requiring D–SNPs in these states to have comprehensive Medicaid contracts could result in those plans leaving the market. Given these tradeoffs, policymakers could limit the application of this requirement to D–SNPs in states with MLTSS programs.

Require D–SNPs to have aligned enrollment.[9] Even when dual-eligible beneficiaries live in states that have MLTSS programs, they can receive their Medicare benefits from the fee-for-service 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-eligible beneficiaries can be enrolled in Medicaid 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.

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. A small number of states currently use aligned enrollment for all of their D–SNPs, and starting in 2025 CMS will require FIDE–SNPs to use aligned enrollment.

Policymakers could also consider making aligned enrollment a requirement for other, less highly integrated D–SNPs, such as HIDE–SNPs. We believe that HIDE–SNPs are intended to be more highly integrated than coordination-only plans because they must have a capitated Medicaid contract to provide LTSS and/or behavioral health. However, this integration will not occur for beneficiaries who enroll in one company's HIDE–SNP for their Medicare benefits and another company's Medicaid plan for their LTSS and/or behavioral health benefits.

Assessing the performance of health plans that serve dual-eligible beneficiaries is difficult

The Bipartisan Budget Act (BBA) of 2018 permanently authorized D–SNPs and, starting in 2021, requires them to meet new standards for integrating Medicare and Medicaid services. The BBA mandated that the Commission periodically compare the performance of different types of D–SNPs and other plans that serve dual-eligible beneficiaries. In our first report under the mandate, we found that the HEDIS performance data that plans report provide limited insight on the relative

[9] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

performance of D–SNPs.[10] As mandated by the BBA, we compared five types of plans that serve dual-eligible beneficiaries: three types of D–SNPs (divided based on the BBA's three integration standards), MMPs, and all other MA plans. We analyzed person-level HEDIS data for measurement year 2020, the most recent available.

The results from our analysis are mixed—each plan type performed relatively well on some measures and relatively poorly on others—and do not clearly favor one plan type over the others. Drawing broader conclusions from this analysis is challenging due to the underlying differences in the five comparison groups, which differ in the geographic distribution of their enrollment (for example, most enrollment in MMPs and FIDE–SNPs is clustered in a small number of states) and the type of beneficiary they serve (for example, partial-benefit dual-eligible beneficiaries account for only 2 percent of the enrollment in FIDE–SNPs but 55 percent of the dual-eligible beneficiaries enrolled in other MA plans).

We also noted that MMPs and MA plans have different quality incentives. MA plans can receive a bonus based on their star rating, while MMPs are subject to a withhold that lowers payments for plans that do not meet performance thresholds. We found that MA plans performed better than MMPs on three quality measures that are used in the MA star ratings but not the MMP quality withhold, while MMPs performed better on a quality measure that is used in the MMP quality withhold but not the MA star ratings. This variation suggests that the financial incentives that plans have to focus on certain measures over others may influence plan performance.

Although this analysis was somewhat inconclusive, the Commission remains supportive of integrated plans as a way to address the misaligned incentives between Medicare and Medicaid, improve care coordination, and improve outcomes for dual-eligible beneficiaries. Following the schedule specified in the BBA, the Commission will submit its next report on the performance of plans that serve dual-eligible beneficiaries in 2024. For that work, we plan to broaden our analysis by using additional data sources, such as patient experience measures from the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey.[11] The use of additional data sources should provide a richer picture of the relative performance of these plans.

We appreciate the opportunity to provide feedback on these very important issues related to the integration of Medicare and Medicaid for dual-eligible beneficiaries. Please consider us a resource for any issue related to the Medicare program. If you have any questions regarding our comments or wish to discuss the Commission's work on dual-eligible beneficiaries in greater detail, please contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[10] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

[11] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.