MEDPAC

Advising the Congress on Medicare issues

Mandated report: Dual-eligible special needs plans

Eric Rollins

November 2, 2023

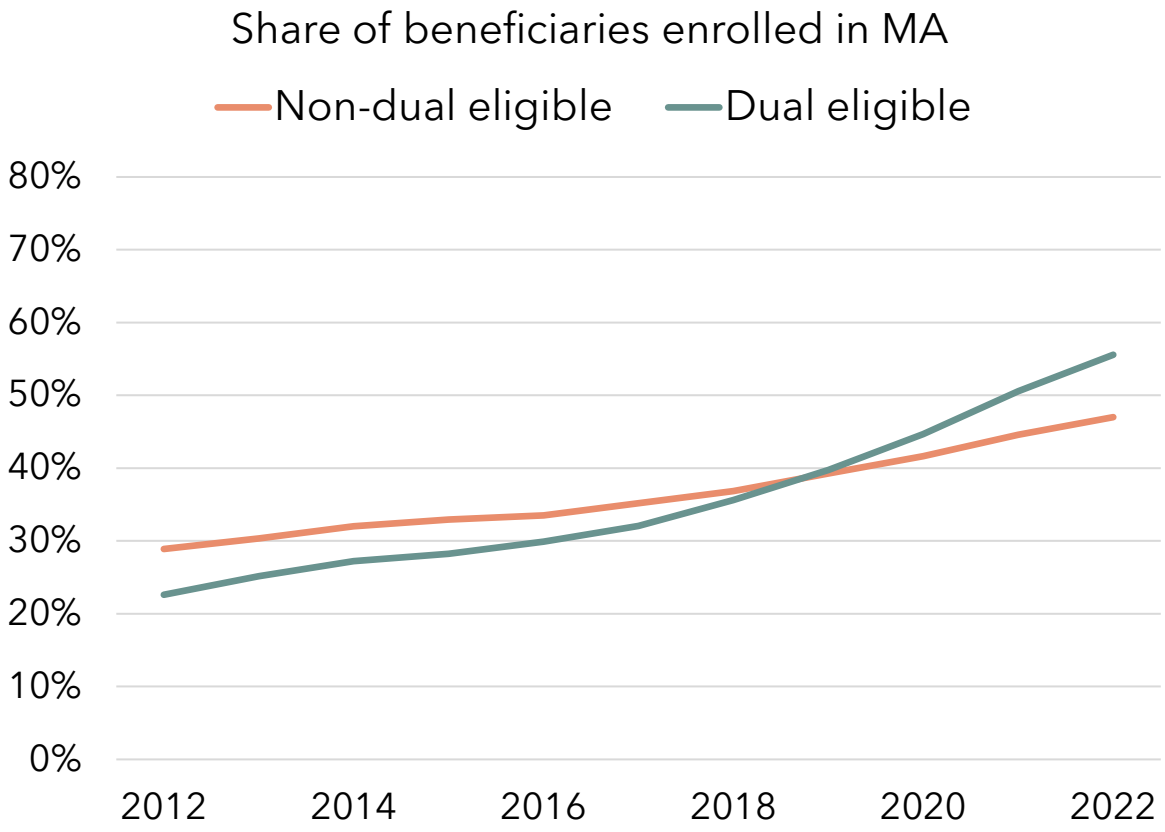
Introduction

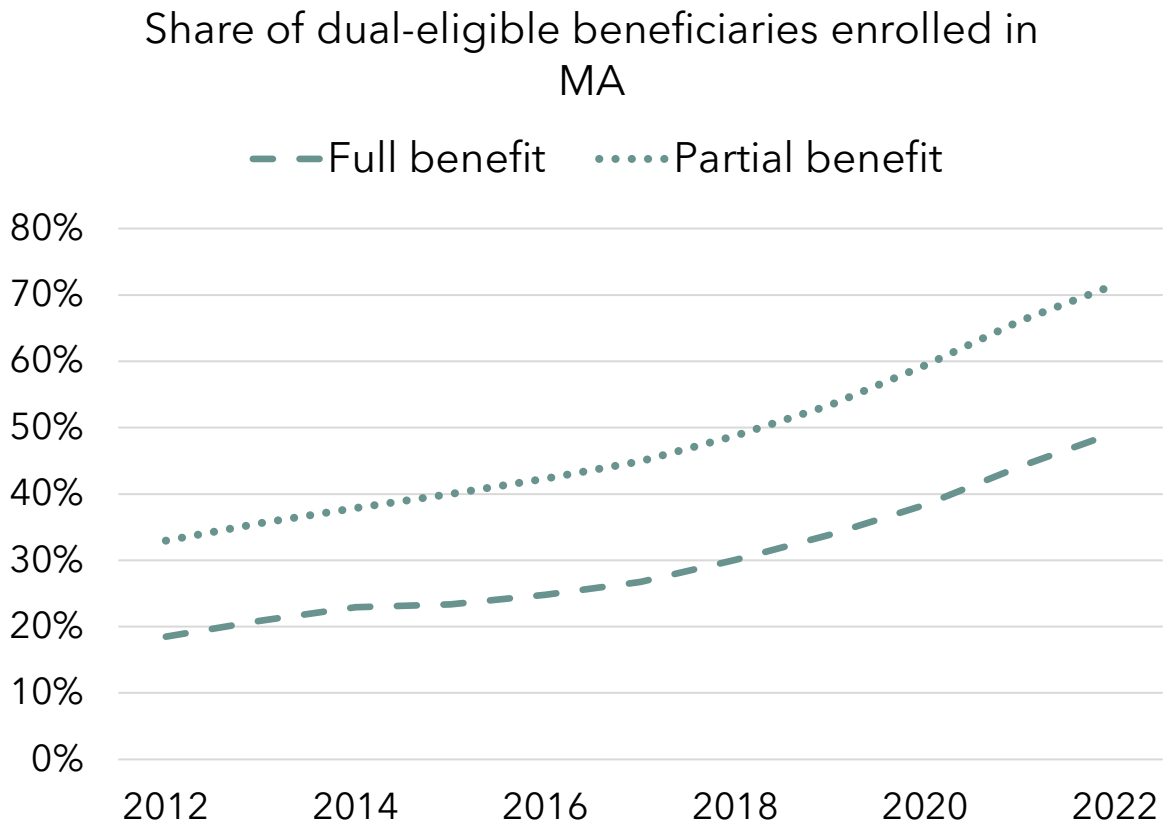
- Dual-eligible special needs plans (D-SNPs) are specialized Medicare Advantage (MA) plans that serve beneficiaries who qualify for both Medicare and Medicaid
- The Bipartisan Budget Act (BBA) of 2018 requires the Commission to periodically assess the performance of D-SNPs and other plans that serve dual-eligible beneficiaries
- This is our second report under the BBA of 2018 mandate

Background on dual-eligible beneficiaries

- About 19 percent of Medicare beneficiaries (12 million people) are dually eligible
  - Medicare is primary payer for services covered by both programs
  - Medicaid covers long-term services and supports (LTSS), other services
  - "Full-benefit" vs. "partial-benefit" dual eligibles
- Dual eligibles are more likely to be in poor health and have higher spending than other beneficiaries
- Policymakers have long been concerned that dual eligibles may receive care that is fragmented or poorly coordinated

The share of dual-eligible beneficiaries enrolled in MA plans has grown substantially





Note: MA (Medicare Advantage). Figures are based on July enrollment and do not include enrollment in Medicare health plans that are not part of the MA program.
Source: MedPAC analysis of Medicare enrollment and eligibility data.

Distribution of MA enrollment by dual-eligibility status and type of plan

	Conventional plan	Employer plan	D-SNP	Other MA plan
All MA enrollees	66%	18%	14%	2%
Non-dual-eligible beneficiaries	75	23	<1	1
Dual-eligible beneficiaries	34	1	62	3
Full-benefit dual eligibles	25	1	71	3
Partial-benefit dual eligibles	51	1	47	2

Note: MA (Medicare Advantage), D-SNP (dual-eligible special needs plan). Figures are based on July 2022 enrollment and do not include enrollment in Medicare health plans that are not part of the MA program.
Source: MedPAC analysis of Medicare enrollment and eligibility data.

Medicare also has other plans that primarily serve dual eligibles

- These plans target beneficiaries who need LTSS, for which Medicaid is the largest payer
  - Institutional special needs plans (I-SNPs) largely focus on beneficiaries living in nursing homes (~110,000 enrollees)
  - The Program of All-Inclusive Care for the Elderly (PACE) focuses on frail beneficiaries who still live in the community (~60,000 enrollees)
- Almost all of the enrollees in both types of plans are dual-eligible beneficiaries

There are three types of D-SNPs

- Coordination-only D-SNP (least integrated)
  - Must notify state about inpatient/SNF admissions for at least one group of high-risk enrollees
- Highly integrated D-SNP (HIDE SNP)
  - Same legal entity or an affiliated plan has a capitated Medicaid contract to provide LTSS and/or behavioral health services
- Fully integrated D-SNP (FIDE SNP, most integrated)
  - Same legal entity has a capitated Medicaid contract to provide LTSS, primary care, and acute care

Note: D-SNP (dual-eligible special needs plan), SNF (skilled nursing facility), LTSS (long-term services and supports).

Under the BBA of 2018, D-SNPs must meet one of three standards for integrating Medicaid services

- Coordination-only D-SNP (57% of D-SNP enrollees)
- HIDE SNP or FIDE SNP without exclusively aligned enrollment (36% of enrollees)
- HIDE SNP or FIDE SNP with exclusively aligned enrollment (7% of enrollees)

Note: BBA (Bipartisan Budget Act), D-SNP (dual-eligible special needs plan), HIDE SNP (highly integrated dual-eligible special needs plan), FIDE SNP (fully integrated dual-eligible special needs plan).

The BBA of 2018 directs the Commission to periodically assess D-SNP performance

- Use HEDIS® clinical quality data to assess performance (with CAHPS® patient experience surveys and encounter data as other potential data sources)
- Compare five types of plans that serve dual eligibles
  - Three types of D-SNPs, divided based on the integration standards in the BBA of 2018
  - Medicare-Medicaid Plans (MMPs)
  - Other MA plans
- Provide a report every two years from 2022 to 2032 and then every five years starting in 2033

Note: BBA (Bipartisan Budget Act), D-SNP (dual-eligible special needs plan), HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems). HEDIS® is a registered trademark of the National Committee for Quality Assurance. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Analytic approach for HEDIS clinical quality data

- Similar to the approach we used in our first mandated report
- Used 2021 person-level HEDIS data
- Calculated scores for 38 measures
  - Focused on measures that use administrative data only
  - Excluded "hybrid" measures that use medical record sampling because they do not generate reliable plan-level estimates
- Identified instances where one plan type clearly performed better or worse than the others (based on a difference of 3+ percentage points, a threshold CMS has used in some analyses)

Note: HEDIS (Healthcare Effectiveness Data and Information Set).

HEDIS results were mixed and did not clearly favor any plan type

	Out of the 38 measures in our analysis	
	Number with better performance	**Number with worse performance**
Coordination-only D-SNP	0	0
HIDE SNP / FIDE SNP without aligned enrollment	2	1
HIDE SNP / FIDE SNP with aligned enrollment	2	0
Medicare-Medicaid Plan	3	4
Other MA plan	0	2

- MMPs had the greatest variation in performance of the five plan types
- These mixed results are consistent with our first mandated report

Note: HEDIS (Healthcare Effectiveness Data and Information Set), D-SNP (dual-eligible special needs plan), HIDE SNP (highly integrated dual-eligible special needs plan), FIDE SNP (fully integrated dual-eligible special needs plan), MA (Medicare Advantage), MMP (Medicare-Medicaid Plan).
Source: MedPAC analysis of HEDIS person-level data for measurement year 2021.

Analytic approach for CAHPS patient experience surveys

- This analysis is new; our first mandated report did not examine CAHPS data
- Used results from 2022 MA version of survey
- Focused on scores for:
  - Six composite measures that combine scores on groups of closely related individual measures (e.g., getting care quickly, customer service)
  - Five measures for which enrollees give an overall rating for a key feature of their health care experience (e.g., personal doctor, health plan)
- Adjusted results to account for case-mix differences

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems), MA (Medicare Advantage).

Coordination-only D-SNPs performed slightly better on many CAHPS measures

- Coordination-only plans had higher scores on both composite measures and enrollee ratings
- MMPs had slightly lower scores on several composite measures and enrollee ratings
- However, differences in scores were relatively small in absolute terms and may not be very meaningful for beneficiaries
  - Scores for "getting care quickly" composite measure ranged from 73 to 76
  - Scores for rating of personal doctor ranged from 89 to 91
- Other analyses have found that CAHPS scores for many measures cluster within a narrow range

Note: D-SNP (dual-eligible special needs plan), CAHPS (Consumer Assessment of Healthcare Providers and Systems), MMP (Medicare-Medicaid Plan).

Difficult to draw broader conclusions about plan performance from our analyses

- Other factors besides plan performance could contribute to differences in HEDIS and CAHPS scores
- Highly integrated FIDE SNPs and MMPs are not widely available; differences in scores across plan types could be influenced by regional differences in factors such as state Medicaid eligibility requirements and physician practice patterns

Note: HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems), FIDE SNP (fully integrated dual-eligible special needs plan), MMP (Medicare-Medicaid Plan).

Difficult to draw broader conclusions about plan performance from our analyses (continued)

- MA plans and MMPs also have structural differences that may contribute to somewhat poorer MMP performance
  - MMPs may have more difficulty engaging passive enrollees
  - MA and MMP quality incentives largely use different measures
- For our next mandated report, we plan to add a comparison of ambulatory care–sensitive hospitalization rates (calculated using a combination of plan encounter data and hospital discharge data)

Note: MA (Medicare Advantage), MMP (Medicare-Medicaid Plan).

MMPs are part of a broader effort to develop new models of care for dual-eligible beneficiaries

- MMPs have been testing whether capitated, integrated health plans can reduce costs and improve quality
  - Allowed to use passive enrollment
  - Expected savings shared between states and federal government
- One of the largest demonstrations targeted to dual eligibles
  - Ten states have conducted a total of 11 MMP demonstrations
  - Demonstrations have been under way since 2013-2016
  - At their peak, MMPs had between 400K and 450K enrollees

Note: MMP (Medicare-Medicaid Plan).

Findings from evaluations of MMP demonstrations released to date

- Higher Medicare spending, with statistically significant increases in 7 of the 11 demonstrations
- Some evidence of higher Medicaid spending, although there are no estimates for six demonstrations due to data limitations
- Mixed effects on service use
- Findings are challenging to interpret given the relatively low participation rates in many demonstrations
- CMS plans to end the MMP demonstrations in 2025 and will work with states to convert MMPs into D-SNPs

Note: MMP (Medicare-Medicaid Plan), D-SNP (dual-eligible special needs plan).

Discussion

- This mandated report will appear as a separate informational chapter in our March 2024 report to the Congress
- Comments on draft mandated report

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