

CHAPTER

9

**Managed care plans for
dual-eligible beneficiaries**

Managed care plans for dual-eligible beneficiaries

Chapter summary

Individuals who receive both Medicare and Medicaid (known as dual-eligible beneficiaries) often have complex health needs but are at risk of receiving fragmented or low-quality care because of the challenges in obtaining care from two distinct programs. 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 would improve quality and reduce federal and state spending because they would have stronger incentives to coordinate care than either program does when acting on its own. However, these plans have been difficult to develop, and only 8 percent of full-benefit dual-eligible beneficiaries are now enrolled in a plan with a high level of Medicare and Medicaid integration.

Since 2013, CMS and 10 states have tested the use of integrated Medicare–Medicaid Plans (MMPs) as part of the financial alignment demonstration. The demonstrations in nine states, with a combined enrollment of about 380,000 dual eligibles, are still under way and will likely continue at least through 2019. (The other demonstration ended as planned in 2017.) There are limited data available on the demonstration’s effects on areas such as quality, service use, and cost because the evaluations of the demonstration are taking longer to complete than expected. However, the information available is generally positive. Although the demonstration has often been difficult to implement, enrollment now appears stable (although participation is lower than many

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expected) and quality appears to be improving. During site visits we made to several states, we found that the participating plans have grown more confident about their ability to manage service use as the demonstration has matured, with many plans reporting declines in the use of expensive services such as inpatient care. There also continues to be widespread support for the demonstration among the diverse collection of stakeholders interviewed on our site visits.

The demonstration is part of a broader effort by many states to use Medicaid managed care to provide long-term services and supports (LTSS), such as nursing home care and personal care. Between 2004 and 2018, the number of states that have managed LTSS (MLTSS) programs grew rapidly, from 8 to 24, and more states will likely develop similar programs in the future. The growing use of managed care to provide LTSS—which account for most of Medicaid’s spending on dual eligibles—means that, in many states, the development of health plans that provide both Medicare and Medicaid services is probably the most feasible approach for pursuing closer integration.

Medicare now has four types of integrated plans that serve dual eligibles: the demonstration’s Medicare–Medicaid Plans, Medicare Advantage dual-eligible special needs plans (D–SNPs), fully integrated dual-eligible SNPs (FIDE SNPs), and the Program of All-Inclusive Care for the Elderly. There are significant differences among these plans in several key areas, such as their level of integration with Medicaid, ability to use passive enrollment, and payment methodology. In addition, allowing MMPs and D–SNPs to operate in the same market has been problematic in some states because competition between the plans has reduced enrollment in the more highly integrated MMPs. Policy changes to better define the respective roles of each type of plan or consolidate them in some fashion may be needed.

Three potential policies that would help encourage the development of integrated plans are (1) limiting how often dual eligibles can change their coverage, (2) limiting enrollment in D–SNPs to dual eligibles who receive full Medicaid benefits, and (3) expanding the use of passive enrollment, particularly when beneficiaries first qualify for Medicare. Collectively, these policies would improve care coordination and continuity of care, require D–SNPs to focus on the dual eligibles who stand to benefit the most from integrated care, and encourage more dual eligibles to enroll in plans with higher levels of Medicare–Medicaid integration. ■

Introduction

More than 10 million people qualify for both Medicare and Medicaid and are known as dual-eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, post-acute care, physician services, durable medical equipment, and prescription drugs. The federal–state Medicaid program covers a variety of long-term services and supports (LTSS), such as custodial nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. The program also provides assistance with Medicare premiums and, in some cases, cost sharing.

Dual-eligible beneficiaries are generally in poorer health than other Medicare beneficiaries. For example, as a group, dual eligibles are more likely to have functional impairments, behavioral health conditions, and substance abuse disorders. As a result, dual eligibles account for a disproportionately large share of Medicare spending: In 2013, the most recent year of linked Medicare and Medicaid enrollment and spending data available, 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).

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 would improve quality and reduce federal and state spending because they would have stronger incentives to coordinate care than either program does when acting on its own. However, these plans have been difficult to develop, and their enrollment remains low.

Our analysis examines the use of managed care for dual eligibles, focusing on the following topics: an update on CMS’s financial alignment demonstration, which is testing two new models of care for dual eligibles and has focused on managed care plans that provide both Medicare and Medicaid services; the growing use of Medicaid managed care for dual eligibles, which is making managed care the most feasible approach for better Medicare–Medicaid integration in many states; the various types of Medicare health plans that serve dual eligibles; and three potential policies to encourage the development of integrated plans.

Background on dual-eligible beneficiaries

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 17 percent of Medicare beneficiaries who 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). Some individuals who are eligible for Medicaid do not participate in the program, particularly those who qualify for the Medicare Savings Programs (Medicaid and CHIP Payment and Access Commission 2017). In December 2016, about 10.5 million Medicare beneficiaries (18 percent of the total) were dual eligibles.

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 long-term services

**TABLE
9-1**

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

	Medicare	Medicaid	Total
Dual-eligible beneficiaries			
All	\$18,112	\$11,126	\$29,238
Full benefit	19,256	15,222	34,478
Partial benefit	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.

and supports. In contrast, partial-benefit dual eligibles receive assistance only with Medicare premiums and, in some cases, assistance with cost sharing. In December 2016, there were 7.5 million full-benefit dual eligibles and 3.0 million partial-benefit dual eligibles.

Given the role that factors such as disability and functional impairment play in becoming a dual eligible, it is not surprising that dual eligibles are more likely than other Medicare beneficiaries to report that they are in poor health (18 percent vs. 6 percent) or need help performing three or more activities of daily living (30 percent vs. 9 percent) (Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission 2018).¹ The poorer health of this population leads in turn to higher costs (Table 9-1). Measured on a per capita basis, the average annual Medicare cost for dual eligibles in 2013 was over \$18,000, more than two times higher than for 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 for partial Medicaid benefits only. In 2013, Medicare and Medicaid together spent more than \$34,000 per capita, on average, on full-benefit dual eligibles, with Medicare accounting for about 56 percent of the combined spending and Medicaid the other 44 percent.

The high Medicare costs for dual eligibles are driven by a combination of higher utilization of all major types of services and higher per user spending for those who receive care.² For example, in 2013, full-benefit dual eligibles

were more likely than other Medicare beneficiaries to use inpatient care (26 percent vs. 16 percent), and those who were hospitalized had higher inpatient costs (\$19,580 vs. \$16,362, respectively). The Medicaid costs for full-benefit dual eligibles largely comprised spending on 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).

Update on the financial alignment demonstration

Under the financial alignment demonstration, CMS has been working with 13 states to test 2 new models of care for full-benefit dual eligibles—a *capitated* model and a *managed fee-for-service* (FFS) model. Both models seek to improve the coordination of Medicare and Medicaid for dual eligibles, improve the quality of their care, and lower costs (Centers for Medicare & Medicaid Services 2011):

- Under the capitated model, managed care plans provide the full range of Medicare and Medicaid benefits to dual eligibles. The plans receive a blended Medicare–Medicaid payment rate that is reduced to reflect expected savings from the demonstration.

**TABLE
9-2**

Overview of the financial alignment demonstrations

State	Model type	Eligible population	MOU date	Start/end dates	January 2018 enrollment
California	Capitated	Aged and disabled	March 2013	April 2014 to 2019	116,721
Colorado	Managed FFS	Aged and disabled	February 2014	September 2014 to 2017	—
Illinois	Capitated	Aged and disabled	February 2013	March 2014 to 2019	53,927
Massachusetts	Capitated	Disabled only	August 2012	October 2013 to 2018	19,337
Michigan	Capitated	Aged and disabled	April 2014	March 2015 to 2020	39,638
Minnesota	Alternative	Aged only	September 2013	September 2013 to 2018	38,994
New York (1)	Capitated	Aged and disabled	August 2013	January 2015 to 2019	4,263
New York (2)	Capitated	Aged and disabled	November 2015	April 2016 to 2020	731
Ohio	Capitated	Aged and disabled	December 2012	May 2014 to 2019	75,161
Rhode Island	Capitated	Aged and disabled	July 2015	July 2016 to 2020	14,144
South Carolina	Capitated	Aged only	October 2013	February 2015 to 2018	11,598
Texas	Capitated	Aged and disabled	May 2014	March 2015 to 2020	47,527
Virginia	Capitated	Aged and disabled	May 2013	April 2014 to 2017	—
Washington	Managed FFS	Aged and disabled	October 2012	April 2013 to 2018	19,609

Note: MOU (memorandum of understanding), FFS (fee-for-service). All states use additional eligibility criteria beyond age and disability. New York's first demonstration targets individuals who use certain kinds of long-term services and supports, while the second targets individuals with intellectual and developmental disabilities. All demonstrations will end on December 31 of the indicated calendar year. Massachusetts, Minnesota, and Washington plan to extend their demonstrations for two years, but these extensions have not been finalized and are not reflected in the table. South Carolina can extend its demonstration for two years but has not indicated whether it will do so. The enrollment figure for Washington is for December 2017.

Source: MedPAC analysis of state MOUs, CMS demonstration guidance, and Medicare Advantage enrollment data for January 2018; personal communication with L. Barnette (Centers for Medicare & Medicaid Services 2018c).

- Under the managed FFS model, states provide greater care coordination to dual eligibles who are enrolled in both FFS Medicare and FFS Medicaid. States receive a retrospective performance payment from Medicare if expenditures for demonstration enrollees are below a target amount.

Our update is based on a wide range of CMS guidance related to the demonstration, the evaluations of its effects that have been completed to date, administrative data, and findings from site visits to participating states. Between December 2015 and February 2018, we made eight site visits to six states (California, Illinois, Massachusetts, New York, Ohio, and Texas) and conducted phone interviews with stakeholders in two other demonstration states (Colorado and Washington). In all, we conducted over 80 interviews with a diverse range of stakeholders

that included state Medicaid officials, executives and care coordination staff for health plans participating in the demonstration, several different kinds of providers, and beneficiary advocacy groups. This update focuses primarily on the experience with the capitated model, which most participating states are testing, but also touches on the managed FFS model.

Table 9-2 provides an overview of the programs that are part of the demonstration. There are 14 demonstrations in 13 states (2 of those demonstrations have ended). Most participating states are testing the capitated model; only Colorado and Washington have tested the managed FFS model, while Minnesota is testing an alternative model.³ Most demonstrations are open to both disabled and aged dual eligibles, although one (Massachusetts) is limited to disabled beneficiaries, and two (Minnesota and

Findings from earlier efforts to develop integrated plans

The financial alignment demonstration's capitated model was influenced by an earlier set of demonstrations under which CMS and states developed the first integrated plans for dual eligibles. These efforts started in the 1990s and 2000s, when CMS approved demonstration projects in Wisconsin (1996), Minnesota (1997), and Massachusetts (2004). All three states succeeded in developing integrated plans, and making the plans a permanent part of Medicare was one motivation for the creation of Medicare Advantage dual-eligible special needs plans (D-SNPs) in 2003 (Schmitz et al. 2008). The demonstration plans were converted into D-SNPs in 2006, and many still operate today. CMS is now testing integrated plans on a broader scale with the financial alignment demonstration, but its evaluations are taking longer to complete than initially expected. As a result, much of the research on integrated plans and their effects on spending, service use, and quality of care still draws on the experience of these earlier demonstrations.

The Wisconsin program, known as the Wisconsin Partnership Program (WPP), was designed to serve elderly and disabled dual eligibles who need the level

of care provided in a nursing home but still live in the community, similar to the Program of All-Inclusive Care for the Elderly. In 2004, an evaluation of the program compared WPP enrollees with dual eligibles who had similar characteristics but were not enrolled.⁴ The WPP enrollees had similar or slightly lower rates of hospital use, mortality, and nursing home admission. However, the study found that WPP did not reduce Medicare spending because of the methodology that was used to set the capitation rates for the participating plans (Kane and Homyak 2004).

The Minnesota program, known as Minnesota Senior Health Options (MSHO), was limited to beneficiaries who were 65 or older, and it used a traditional managed care approach. The same 2004 report that evaluated the Wisconsin demonstration also assessed MSHO. The study found that MSHO enrollees in nursing homes had significantly fewer hospital admissions and emergency room visits than comparison groups of dual eligibles. However, MSHO enrollees did not perform significantly better in key areas such as mortality rates and change in functional status over time, and the quality of their nursing home care was similar (Kane and Homyak 2004).

(continued next page)

South Carolina) are limited to aged beneficiaries. CMS approved each demonstration by signing a memorandum of understanding (MOU) with the state that summarizes the key parameters of the demonstration. The first MOU (Massachusetts) was signed in August 2012; the last (for New York's second demonstration) was signed in November 2015. Most of the demonstrations started enrolling beneficiaries about a year after the signing of the MOU.

As of January 2018, about 440,000 dual eligibles were enrolled in the demonstrations, making this one of the largest demonstrations CMS has conducted that is specifically aimed at this population. The four largest demonstrations—California, Ohio, Illinois, and Texas—account for about two-thirds of the national total.

CMS initially planned for the demonstrations to last three years, but it has extended most of them because their evaluations have not been completed. In July 2015, CMS announced that all states could extend their demonstrations for an additional two years; in January 2017, it announced that the first three states to start their demonstrations (Massachusetts, Minnesota, and Washington) could extend them for another two years on top of that and said that other states could receive similar extensions if more time is needed to complete their evaluations (Centers for Medicare & Medicaid Services 2017c, Centers for Medicare & Medicaid Services 2015a). Colorado and Virginia decided against extending their demonstrations and concluded them at the end of 2017.⁵ The other states have finalized their extensions or indicated their intent to do so, except for South Carolina, which has not decided

Findings from earlier efforts to develop integrated plans (cont.)

A 2016 study of MSHO had much more positive findings. This study compared MSHO enrollees with dual eligibles in Minnesota who did not participate and were mostly enrolled in a combination of fee-for-service 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 long-term services and supports (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).

Like MSHO, the program in Massachusetts—Senior Care Options (SCO)—is also limited to beneficiaries who are 65 and older. One study found that SCO

enrollees, relative to a comparison group of dual eligibles, had lower rates of nursing facility use and lower mortality rates (JEN Associates 2015). However, another study found that SCO enrollment did not have a statistically significant effect on 30-day hospital readmission rates (Jung et al. 2015).

On balance, the findings from the early experiments with integrated plans are moderately positive. Integrated plans have shown some ability to reduce enrollees’ use of hospital services and redirect LTSS use from nursing home care to community-based care. The available research has sometimes found that integrated plans perform no better than other arrangements in some areas (such as readmission rates in the Massachusetts program), but, at the same time, the research has not found that dual eligibles have fared worse in integrated plans. Our understanding of the effectiveness of integrated plans should improve significantly as more evaluations of the financial alignment demonstration become available. ■

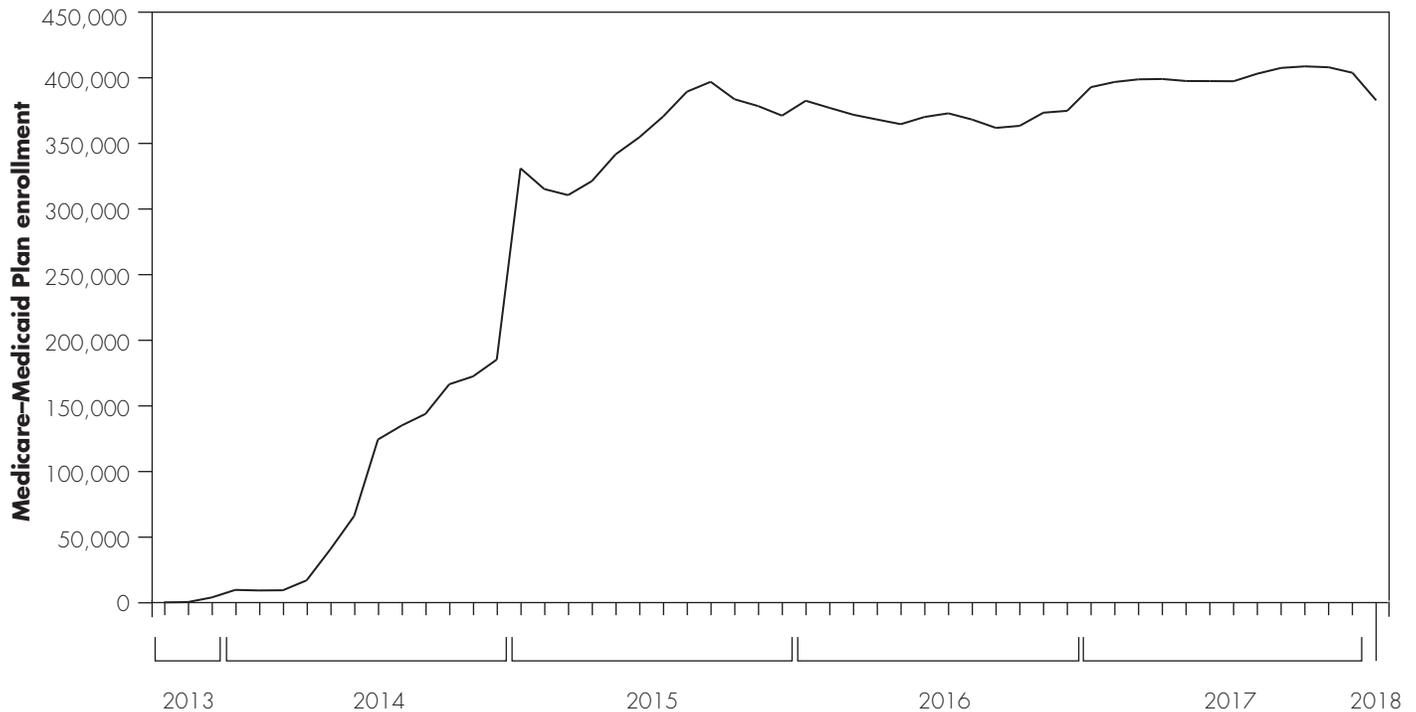
yet (Centers for Medicare & Medicaid Services 2018b). Most of the demonstrations therefore appear likely to last for five to seven years and operate until 2019 or 2020, if not longer.

CMS is conducting the financial alignment demonstration using the authority of its Center for Medicare & Medicaid Innovation (CMMI). Under this authority, the Secretary can test new payment models and subsequently expand the use of a model that he determines will either (1) reduce spending without affecting the quality of care or (2) improve the quality of care without increasing spending. As part of this process, the CMS chief actuary must certify that expanding the model will not increase overall Medicare or Medicaid spending. CMS could thus potentially expand the use of the capitated model and managed FFS model in the future.

Demonstrations using the capitated model

The key feature of the capitated model, which is used by most states, is a managed care plan that provides all

Medicare and Medicaid services. We refer to this type of plan as an *integrated plan*. The use of integrated plans has long been suggested as a way to improve care for dual eligibles, and CMS has tested their use in other demonstrations (see text box on earlier findings). 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 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 care and nursing home care.

**FIGURE
9-1****Total enrollment in Medicare–Medicaid Plans has been relatively stable since mid-2015**

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

The integrated plans in the financial alignment demonstration are known as Medicare–Medicaid Plans (MMPs). They provide all Medicare-covered and all or most Medicaid-covered services to their enrollees. The MMPs are required to provide their enrollees with a high level of care coordination and receive a blended capitation rate that combines Medicare Part A, Part B, and Part D and Medicaid payments.

Beneficiary participation

CMS has limited eligibility for the financial alignment demonstration to full-benefit dual eligibles—individuals who are eligible for both Medicare (Part A, Part B, and Part D) and full Medicaid benefits in their state. States can further limit eligibility based on the particular needs of their demonstration, and every state testing the capitated model has done so. For example, 8 of the 10 active demonstrations operate only in certain parts of the state, usually around large metropolitan areas, and 6 exclude beneficiaries enrolled in certain Medicaid home- and community-based waiver programs, particularly those

that serve individuals with intellectual or developmental disabilities. In all, about 1.3 million beneficiaries are eligible for the 10 active demonstrations.

Under the demonstration, states can passively enroll 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. (See the Commission’s June 2016 report for a fuller discussion of how passive enrollment has been used in the demonstration and how it is used elsewhere in the Medicare and Medicaid programs.) Every state testing the capitated model has used passive enrollment for at least some beneficiaries, although California, New York, and Rhode Island no longer use it.⁶ In the other states, passive enrollment is now being used largely to enroll beneficiaries who have become dually eligible since the start of the demonstration.

Total enrollment in MMPs grew gradually between 2013 and 2015 because the individual state demonstrations

**TABLE
9-3**

MMP participation rates, by state, as of June 2017

State	MMP enrollment	Eligible beneficiaries	Participation rate
California	118,386	424,000	28%
Illinois	51,063	146,000	35
Massachusetts	16,950	104,000	16
Michigan	39,681	105,000	38
New York (1)	4,708	156,000	3
New York (2)	575	20,000	3
Ohio	75,603	111,000	68
Rhode Island	14,002	30,000	47
South Carolina	8,033	39,000	21
Texas	40,738	165,000	25
Virginia	27,958	67,000	42
Total	397,697	1,367,000	29

Note: MMP (Medicare–Medicaid Plan). Virginia’s demonstration ended in December 2017.

Source: Medicare Advantage enrollment data for June 2017; personal communication with L. Barnette (Centers for Medicare & Medicaid Services 2017).

started at different times, and many were implemented in stages (Figure 9-1). Since mid-2015, overall enrollment has not changed much, usually ranging between 360,000 and 400,000 beneficiaries per month. Enrollment dropped somewhat in January 2018, due largely to the end of Virginia’s demonstration, and stood at about 383,000 beneficiaries.

The participation rates for many demonstrations have been lower than expected and vary widely across states. Table 9-3 shows the MMP enrollment, number of eligible beneficiaries, and participation rate for each demonstration as of June 2017. Across all the demonstrations, only about 29 percent of eligible beneficiaries were enrolled in an MMP. Ohio (68 percent) and Rhode Island (47 percent) had the highest participation rates, while New York had the lowest rates (3 percent in both of its demonstrations). The participation rates for MMPs have been relatively low because many beneficiaries opted out or left the MMP after a short period of time.⁷ In the states we visited, stakeholders said many beneficiaries declined to participate because they were satisfied with their existing care, did not fully understand how the demonstration would affect them, or were encouraged to opt out by providers (Medicare Payment Advisory Commission 2016).

Comparing MMP enrollees and beneficiaries who opted out

One question about the demonstration and its use of passive enrollment has been whether the beneficiaries who opted out differed from those who accepted passive enrollment in an MMP. To better examine this issue, we obtained data for the MMPs from the Medicare Advantage Prescription Drug (MARx) system, which CMS uses to process enrollment transactions for all types of Medicare health plans. The MARx data have two advantages over traditional enrollment data: (1) They indicate whether a beneficiary was passively enrolled in an MMP or enrolled voluntarily, and (2) they can be used to identify beneficiaries who were scheduled for passive enrollment but later opted out. The MARx data that we obtained have all transactions involving MMPs from October 2013 (the start of the first capitated demonstration) through April 2016 and thus do not have information for the second New York or Rhode Island demonstrations, which started later in 2016.

During this period, we found that states attempted to passively enroll about 855,000 beneficiaries in MMPs and that 41 percent of them opted out (Table 9-4, p. 252). We also examined whether opt-out rates varied by age, sex, race/ethnicity, and whether the beneficiary was a long-stay nursing home resident at some point during the year.

**TABLE
9-4****Opt-out rates for MMPs varied, October 2013–April 2016**

	Number of beneficiaries (in thousands)	Share of population	Opt-out rate
All passive enrollments	855	100%	41%
Age			
Under 65	307	36	35
65 and older	549	64	45
Sex			
Female	522	61	44
Male	333	39	38
Race/ethnicity			
White	299	35	43
Hispanic	222	26	36
African American	207	24	36
Asian	110	13	56
All other/unknown	17	2	46
Long-term nursing home use			
Zero months	757	89	41
At least 1 month	98	11	42

Note: MMP (Medicare–Medicaid Plan). Components may not sum to totals because of rounding.

Source: MedPAC analysis of MMP enrollment transaction data and Medicare enrollment data. These figures do not include records for beneficiaries who opted out by contacting the state Medicaid agency or beneficiaries with end-stage renal disease.

Beneficiaries ages 65 and older were more likely to opt out than those under age 65 (45 percent vs. 35 percent), and women were more likely to opt out than men (44 percent vs. 38 percent). The similarity between these two metrics is not surprising because dual eligibles over 65 are disproportionately female. As for race/ethnicity, beneficiaries of Asian ancestry were the most likely to opt out (56 percent), while African American and Hispanic beneficiaries were least likely (36 percent). Finally, the opt-out rates for long-stay nursing home residents and other beneficiaries were similar. The figures shown in Table 9-4 are aggregated across all MMP states; the figures for individual states will vary given the differences in their demographic characteristics (such as race/ethnicity) and the eligibility criteria for each demonstration.

These opt-out rates should be viewed as somewhat conservative because the MARx data do not include every beneficiary who opted out. The MARx data can identify beneficiaries who opted out only after CMS has begun the process of passively enrolling them, which starts at least

60 days before the actual enrollment date. (During this 60-day period, states send beneficiaries two notices about their upcoming passive enrollment, and beneficiaries can opt out any time before the scheduled enrollment date.) However, beneficiaries in some states were able to opt out by contacting the state before the start of the passive enrollment process. The beneficiaries who opted out in this manner do not appear in the MARx data because states never began the process of passively enrolling them. CMS does not know how many beneficiaries have used this other method to opt out.

In addition to high opt-out rates, another challenge for MMPs has been high disenrollment rates (enrollees leaving the plan for other coverage). For example, we found that 25 percent of the beneficiaries who were passively enrolled in MMPs disenrolled within the first three months. However, the share of beneficiaries who disenrolled within the first three months varied relatively little across the various categories shown in Table 9-4. For comparison, we also examined beneficiaries who

**TABLE
9-5**

Risk scores for beneficiaries enrolling in Medicare–Medicaid Plans

	2013	2014	2015	2016*
Number of active demonstrations	1	5	9	9
Total enrollment actions				
New MMP enrollees	5,120	241,284	395,334	59,688
Beneficiaries who opted out	N/A	74,448	255,304	24,366
Average risk score				
New MMP enrollees	1.14	1.39	1.59	1.59
Beneficiaries who opted out	N/A	1.48	1.83	1.75
New MMP enrollees, by length of enrollment				
1 to 3 months	905	69,686	102,510	12,276
4 to 6 months	343	25,604	39,277	6,534
7 months or more	<u>3,872</u>	<u>145,994</u>	<u>253,547</u>	<u>40,878</u>
Total	5,120	241,284	395,334	59,688
Average risk scores for new MMP enrollees, by length of enrollment				
1 to 3 months	1.20	1.64	1.86	1.89
4 to 6 months	1.20	1.52	1.72	1.65
7 months or more	1.12	1.24	1.45	1.48

Note: MMP (Medicare–Medicaid Plan), N/A (not applicable). Table does not include records for beneficiaries who opted out by contacting the state Medicaid agency or beneficiaries with end-stage renal disease. There were no opt-outs in 2013 because the only demonstration then under way (Massachusetts) did not begin passive enrollment until 2014. “New MMP enrollees” are those who first joined an MMP in the stated year. “Length of enrollment” is based on the number of months of enrollment through December 2016.

*2016 figures are for enrollment actions with January through April effective dates and do not include the second demonstration in New York or the demonstration in Rhode Island, which both started later in 2016.

Source: MedPAC analysis of MMP enrollment transaction data, Medicare enrollment data, and CMS–hierarchical conditions categories risk score data.

enrolled voluntarily, who represented about 15 percent of all MMP enrollees. The share of voluntary enrollees who disenrolled within the first three months was 17 percent, lower than the figure for passive enrollees but still high for a group that had actively chosen to enroll in an MMP. Like the passive enrollees, the disenrollment rates for voluntary enrollees varied little by age, sex, race/ethnicity, or nursing home use.

Evidence of favorable selection for MMPs We also used the MARx data and MMP enrollment data to examine whether beneficiaries who opted out or disenrolled were healthier or sicker than those who enrolled in MMPs. We compared beneficiaries using their risk scores from the CMS hierarchical condition category (CMS–HCC) risk adjustment model. CMS uses this model to adjust payments to Medicare Advantage (MA) plans and other

plan types, such as MMPs, to account for differences in beneficiaries’ health status. Risk scores are based on a combination of demographic information (such as age, sex, and whether the beneficiary first qualified for Medicare based on a disability) and diagnostic information from claims; scores are scaled to show how a beneficiary’s expected Medicare costs compare with the average expected cost for all FFS beneficiaries. For example, a risk score of 1.0 indicates that the expected costs for a beneficiary equal the overall average, and a risk score of 1.3 indicates that the expected costs for a beneficiary are 30 percent higher than the overall average.

We found that the dual eligibles who have participated in the demonstration appear to be healthier than those who opted out (Table 9-5). For example, in 2014, the beneficiaries who joined an MMP had an average risk

score of 1.39, while the beneficiaries who opted out had an average score of 1.48. The figures for 2015 and 2016 follow the same basic pattern, although the average risk scores for new enrollees and those opting out vary from year to year.

Among beneficiaries who enrolled in MMPs, there were also differences in risk scores when the enrollees were stratified based on the length of time they were enrolled. In 2014, about 241,000 beneficiaries joined MMPs, but almost 70,000 (29 percent) were enrolled for 3 months or less, and about 26,000 (11 percent) were enrolled for between 4 and 6 months.⁸ The beneficiaries who were enrolled for three months or less had a higher average risk score (1.64) than those who were enrolled for four to six months (1.52), who in turn had a higher average risk score than those who were enrolled for seven months or more (1.24). The patterns for 2015 and 2016 were similar. As with Table 9-4 (p. 252), the figures in Table 9-5 (p. 253) are aggregated across all MMP states, and the figures for individual states will vary.

Taken together, these differences in risk scores indicate that favorable selection has occurred in the capitated demonstrations, meaning that the healthier beneficiaries among those eligible have been more likely to participate.⁹ In this respect, the financial alignment demonstration is similar to other managed care programs that feature voluntary enrollment. For example, the Commission has found that Medicare beneficiaries who enroll in MA plans are healthier than FFS enrollees and that beneficiaries who switch from MA plans to FFS coverage have higher risk scores than beneficiaries who remain in MA (Medicare Payment Advisory Commission 2012b). Some older studies also found evidence of favorable selection in voluntary Medicaid managed care programs (American Academy of Actuaries 1996, Scholle et al. 1997).¹⁰ Nevertheless, the presence of favorable selection means that the demonstration is not fully serving relatively sicker dual eligibles, who might benefit the most from better care coordination.

The stakeholders we interviewed on our site visits indicated that many beneficiaries opted out of the demonstration to maintain access to their current providers or because their providers encouraged them to opt out. Beneficiaries with higher risk scores would tend to have higher service use and see a larger number of providers. As a result, they might have been more likely to find that one or more of their providers was not in their MMP's provider

network and more likely to have at least one provider encourage them to opt out. Similarly, beneficiaries with lower risk scores may have had less interaction with the health care system in the past and therefore may be more likely to be satisfied with the plan's provider network.

One concern about favorable selection is that plans may have a financial incentive to avoid serving sicker enrollees. However, many MMPs we interviewed said they would like to have more enrollees, and several expressed support for policies that would make it harder for dual eligibles to disenroll from MMPs. CMS and states also mitigate financial incentives to avoid serving sicker enrollees by risk adjusting the Medicare and Medicaid payments to MMPs, which should reduce this incentive because sicker enrollees also generate more revenues for plans. In addition, CMS increased MMP payment rates for Part A and Part B services after finding that the CMS-HCC model had historically tended to underestimate costs for full-benefit dual eligibles (Centers for Medicare & Medicaid Services 2015b).

Health plan participation

A total of 68 MMPs (counted at the contract level) have participated in the demonstration. Most are sponsored by organizations with prior experience in Medicare Advantage, Medicaid managed care, or both (Weiser and Gold 2015). However, 18 plans have left the demonstration since it started, and only 50 are still participating. CMS has not allowed any new MMPs to join the demonstration so far, although new plans will be able to join in the future when states reprocure their Medicaid managed care plans. Plans have left the demonstration for a variety of reasons:

- Most of the departing plans (11 of 18) were part of New York's first demonstration and left because of low enrollment. The demonstration started with an unusually large number of MMPs (21), but beneficiary participation has been very low (see Table 9-3, p. 251), leaving many plans with very little enrollment. The 11 plans that left the demonstration all had fewer than 300 enrollees.
- Three MMPs left because of Virginia's decision to end its demonstration at the end of 2017.
- Two plans that left in 2015—one in Massachusetts and one in Illinois—cited inadequate payment rates as a primary reason for their decision. However, CMS increased payment rates for MMPs in 2016, and we are not aware of any plan departures since then that have been attributed to inadequate payment rates.

**TABLE
9-6**

Enrollment in individual MMPs varies widely

Enrollment range	MMPs		Enrollees		Average enrollees per MMP
	Number	Share	Number	Share	
Less than 1,000	9	18%	2,432	1%	270
1,001 to 5,000	11	22	34,064	9	3,097
5,001 to 10,000	13	26	89,346	23	6,873
More than 10,000	17	34	257,205	67	15,130
Total	50	100	383,047	100	7,661

Note: MMP (Medicare–Medicaid Plan). MMPs are counted at the contract level.

Source: Medicare Advantage enrollment data for January 2018.

- One plan left the Illinois demonstration at the end of 2017 after the plan’s parent company decided to end all of its Medicaid-related business in the state.

The number of plans in each demonstration varies. California and the first New York demonstration currently have 10 plans each, while the second New York demonstration and Rhode Island have only 1 plan each. The other demonstrations have between two and seven plans. Many MMPs serve only part of the demonstration area. For example, Texas is conducting its demonstration in six counties. The state has five MMPs, but only one to three plans operate in each county.

Each MMP has signed a three-way contract with CMS and the state that specifies its requirements under the demonstration. States initially selected the plans for the demonstration and could limit the number of plans that participate. Plans also had to satisfy CMS requirements and pass a readiness review that examines areas such as network adequacy, financial solvency, care management capabilities, and plan staffing for functions like customer service (Medicaid and CHIP Payment and Access Commission 2015).

The number of dual eligibles enrolled in each MMP varies widely (Table 9-6). Nine MMPs that were operating in January 2018 had fewer than 1,000 enrollees. All of these plans were in New York, and 5 had fewer than 250 enrollees. A total of 30 MMPs had more than 5,000 enrollees, and 17 MMPs had more than 10,000 enrollees.

The largest MMP, sponsored by Inland Empire Health Plan in California, had more than 25,000 enrollees (data not shown).

One question about the demonstration has been whether health plans need a certain level of enrollment to successfully operate an MMP. Before the demonstration, many health plans believed that they would need to make significant upfront investments to provide the level of care coordination required for MMPs. CMS authorized the use of passive enrollment in the demonstration partly to ensure that plans would have enough enrollment to justify those initial investments, and many plans we interviewed indicated that passive enrollment was a key factor in their decision to participate in the demonstration.

During our site visits and in other interviews with MMPs, we asked plan officials whether an MMP needed a minimum level of enrollment to operate effectively. Some plans did not provide a figure, but most of the plans that did indicated that MMPs were easier to operate with at least 5,000 to 7,500 enrollees because they could benefit from economies of scale in providing care coordination, such as hiring staff with clinical expertise in behavioral health, and spreading relatively fixed costs for activities such as the development of member materials. Some plans also said that higher enrollment would make it easier for them to get providers to join their networks. Except for New York, most plans appear to have enough enrollees to adequately test the capitated model.

Evaluations of the demonstration

CMS has contracted with RTI International to evaluate each demonstration's effect on areas such as access to care, service use, quality of care, and cost. These evaluations will include qualitative analyses, such as findings from beneficiary focus groups and interviews with key stakeholders, as well as quantitative analyses using claims, encounter, assessment, and enrollment data. RTI plans to release an annual evaluation report for each demonstration and a final evaluation report that synthesizes findings across all participating states (Walsh et al. 2013).

However, these evaluations are taking much longer to complete than expected. So far, only one annual evaluation for a capitated demonstration has been released, covering the first year of the Massachusetts demonstration (Gattine et al. 2017).¹¹ The delays have been due to difficulties in gathering the data needed to conduct the quantitative analyses. RTI plans to measure the effects of the demonstrations on both Medicare and Medicaid service use by comparing the dual eligibles who are eligible for the demonstrations (whether or not they participate) with similar groups of dual eligibles living in other states. This approach requires a great deal of administrative data, such as Medicaid FFS claims and encounter data from multiple states, MMP encounter data for both Medicare and Medicaid services, Medicare FFS claims, MA encounter data, and Medicare Part D data (Walsh et al. 2013). Some of those data, particularly MMP encounter data and Medicaid data from comparison states, are taking longer to obtain than anticipated.

CMS will release more evaluations as these data issues are resolved, but the annual reports for the first one or two years of each demonstration may not provide much insight into the effects of the capitated model. In the states we visited, there was broad agreement among stakeholders that the demonstrations had been challenging to implement. Many MMPs we interviewed said they had needed roughly 18 to 24 months to fully establish themselves and that their impact on enrollees' service use during that time was limited. The first-year evaluation of the Massachusetts demonstration took a similar view; that report found "limited evidence of the demonstration's effect during the first demonstration year, partly due to initial implementation challenges but also due to the need for allowing adequate time for care interventions at the beneficiary level to affect service utilization" (Gattine et al. 2017).

Many stakeholders we interviewed on our more recent site visits said they were frustrated with the delays in completing the evaluations. At the time of these visits, the demonstrations in California, Massachusetts, New York, Ohio, and Texas had been in operation for about three years. Many stakeholders in those states believed that the demonstrations showed promise and wanted to know what CMS was going to do in the "post-demonstration" era.

Given the delays with the quantitative analyses, RTI has issued several reports with qualitative analyses of the demonstration, such as findings from focus groups of MMP enrollees and a review of how MMPs are providing care coordination (Ptaszek et al. 2017, Weiner et al. 2017). CMS has also issued other data, such as results from surveys of MMP enrollees about their patient experience. The rest of our update on the capitated model incorporates findings from these other data sources and from our site visits.

Care coordination

Under the demonstration, CMS and states hope that greater care coordination for dual eligibles will improve the quality of their care and reduce Medicare and Medicaid spending. MMPs are required to provide care coordination using a model that has three main elements:

- Each enrollee must receive an initial health assessment. Each demonstration has its own deadlines for completing the assessments; most are within 90 days of enrollment. The assessments must be comprehensive, covering physical health, behavioral health, ability to perform activities of daily living, and cognitive status (Medicaid and CHIP Payment and Access Commission 2015). The assessments must also be updated periodically, usually at least once a year.
- Each enrollee must have an individual care plan that is based in part on the results of the assessment. These care plans must be developed by an interdisciplinary team of providers. The membership of the team varies by demonstration but usually includes the enrollee's care coordinator, primary care physician, LTSS providers, and relevant specialists (such as behavioral health providers). Enrollees can also participate if they wish.
- Each enrollee is assigned to a care coordinator who often takes the lead in developing the enrollee's care plan and provides ongoing help in finding and obtaining necessary care.

Learning more about how MMPs provide care coordination was a primary goal of our site visits, and RTI has also issued two reports on the topic as part of its evaluation of the demonstration (Ptaszek et al. 2017, Weiner et al. 2017). The views that we heard during our interviews with stakeholders are consistent with the findings in RTI's reports.

Many MMPs have had trouble completing the initial health assessments on time for two reasons. First, plans have not been able to locate many enrollees because their contact information is out of date. RTI found that most plans had trouble finding between 20 percent and 35 percent of their enrollees, and the plans we interviewed supplied similar figures. Second, some plans we interviewed found it challenging to conduct assessments when large numbers of beneficiaries were passively enrolled at the same time. In 2015, the share of assessments that were completed within 90 days was between 55 percent and 75 percent for most demonstrations (Weiner et al. 2017). Completion rates are higher when beneficiaries who could not be located or did not want to participate in an assessment are excluded, and have been rising over time, from an average of 69 percent in 2014 to 78 percent in 2015 and 89 percent in 2016 (Centers for Medicare & Medicaid Services 2017g).

Our interviews and RTI both found that plans had difficulty with the next stage of the care coordination process—using interdisciplinary teams of providers to formulate care plans. One particular challenge has been low participation by primary care physicians, who are usually not paid for taking part (Weiner et al. 2017).

The MMPs have hired a significant number of care coordinators for the demonstration. In 2015, the plans in the 9 demonstrations then in operation employed almost 4,600 care coordinators. Most coordinators have backgrounds in social work or nursing; those who oversee enrollees with complex needs are more likely to have a clinical background. About 80 percent of coordinators worked on tasks such as providing care management and conducting assessments; the rest worked in other capacities such as supervision (Weiner et al. 2017). On average, the MMPs have 1 care coordinator for roughly every 100 enrollees (if the coordinators working in other capacities are included, the ratio is closer to 1:80).

Care coordinators can work directly for the plan or one of the plan's subcontractors, such as a medical group or social service agency. Most of the plans we interviewed used a mix of these approaches, and many plans had

modified their care coordination arrangements as they gained experience and tested new approaches. Many of the plans we interviewed had increased their use of subcontractors to provide care coordination, particularly as they developed relationships with local social service agencies (such as area agencies on aging or behavioral health providers) and gained a better understanding of the capabilities of those entities. Texas appears to be an exception in this regard; the plans we interviewed there relied entirely on internal employees to provide care coordination.

The MMPs we interviewed said the level of care coordination that enrollees receive depends on their care needs. High-risk enrollees, such as those who use LTSS, receive the most extensive care coordination, such as regular calls from their care coordinators and in-person meetings or assistance in some states. In contrast, lower risk enrollees appear to have much less regular contact with their care coordinators, and their interactions are more likely to be limited to periodic phone calls.

RTI conducted focus groups of MMP enrollees in five states and found that most knew they had a care coordinator or had interacted with that person. Most of the participants who had used care coordination found it helpful, but some beneficiaries had not known they could receive care coordination before they participated in the focus group (Ptaszek et al. 2017). Other reports have found that care coordination has had a significant, positive impact on some enrollees, leading to improvements in their health and functioning (Carver 2016, Gattine et al. 2017, SCAN Foundation 2017).

During our later site visits, some plan representatives we interviewed indicated that the care coordination requirements for the demonstration were too prescriptive. Many of these comments focused on low-risk enrollees, with plans saying that their assessments did not need to be as comprehensive or be completed as quickly as those for higher risk enrollees. Another plan said that interdisciplinary provider meetings were difficult to schedule and were worthwhile only for beneficiaries with very complex needs.

Care coordination requirements have been a major issue in New York in particular, where overly prescriptive requirements appear to be the main reason that its first demonstration has had such low participation. The stakeholders we interviewed said that beneficiary advocacy groups had played a large role in developing the

requirements, which were modeled after those used in the Program of All-Inclusive Care for the Elderly (PACE), and that there had been relatively little input from physicians. Under the requirements, members of the interdisciplinary team of providers (which included the beneficiary's care coordinator and primary care provider) had to meet at the same time, in person, to develop the beneficiary's care plan. Beneficiaries were also expected to participate in the planning meetings, and primary care providers had to complete training on the care planning process.

This approach to care coordination is feasible in PACE because of the central role that adult day-care centers play in that program. The providers on the interdisciplinary team all work at the center (and are employees of the PACE plan) and enrollees typically visit the center several times each week to receive care. In-person meetings of the care planning team, including beneficiaries if they desire, are thus relatively easy to arrange.

This approach did not work well in the demonstration, where enrollees receive care from multiple providers in different locations, and providers were often expected to work with multiple plans. Stakeholders indicated that providers, especially primary care physicians, thought the requirements were overly burdensome and encouraged their patients to opt out. One plan we interviewed said providers also opposed the demonstration because MMPs could authorize only services that were explicitly listed in an enrollee's care plan (the interdisciplinary team had to meet again to approve any additional services, even minor ones), and because providers had to attest that all of their facilities complied with the Americans with Disabilities Act, something they had never been required to do before.

CMS and New York moved relatively quickly to address these concerns, eliminating or scaling back many requirements during the first year of the demonstration. However, many stakeholders indicated that providers still have a negative view of the demonstration, which has made it difficult to increase enrollment.

Service use and access to care

One key question about the capitated model has been whether MMPs can lower costs and improve the quality of care for dual eligibles by reducing their use of expensive services like inpatient care and nursing home care and by promoting greater use of primary care and home- and community-based services (HCBS). When we made our first site visits to California, Illinois, and Massachusetts between December 2015 and February 2016, those

demonstrations had been under way for 18 to 24 months. The plans we interviewed at the time had not yet seen noticeable changes in their enrollees' service use and said it was unrealistic to expect savings that quickly given the initial implementation challenges that plans had faced.

On our later visits—when the demonstrations in California, Massachusetts, New York, Ohio, and Texas had been under way for about three years—plans were much more definitive. Almost every plan we interviewed said the use of inpatient care and emergency room visits by their enrollees had declined. (The MMPs in New York were an exception; they said they had not seen significant changes in service use.) Several plans said that nursing home use was also declining, although those reductions appeared to be smaller. A few plans said they had seen lower service use in other areas, such as post-acute care and certain types of HCBS. However, we did not get a clear sense of whether the use of other services like primary care had changed.

One particularly important area for many dual eligibles is behavioral health. Many stakeholders we interviewed said there was a shortage of behavioral health providers in their area, but they saw this deficiency as a shortcoming of the broader health care system rather than something that was specific to the demonstration. Some stakeholders on our later visits felt the demonstration had expanded access to care for individuals with moderate behavioral health care needs—people who could benefit from treatment but did not have an illness that was severe enough to receive treatment from the traditional behavioral health care system.

The plans we interviewed said consistently that inadequate housing had been a significant challenge in caring for some enrollees. For example, one plan said even a few days in short-term housing could help homeless enrollees who had just been discharged from a hospital by making it easier for them to get appropriate follow-up care. MMPs cannot spend funds on room and board for people who live in the community (a long-standing policy in Medicaid), but some plans we interviewed were trying to develop closer relationships with local housing agencies so they could more easily help their enrollees find housing.

Some states have included additional transportation benefits, such as nonmedical transportation, in their demonstrations to help attract enrollment, but several stakeholders said the service was often unreliable. However, Medicaid programs often have problems

**TABLE
9-7**

MMP performance on the CAHPS® survey has improved, 2015-2017

	2015	2016	2017
Number of MMPs reporting CAHPS data	27	40	45
Share of beneficiaries giving the highest rating for:			
Health plan	51%	59%	63%
Health care quality	55	59	60
Getting needed care	58	58	59
Getting appointments and care quickly	48	50	54
Doctors who communicate well	76	76	77
Customer service	67	71	76
Care coordination	69	69	70
Getting needed prescription drugs	73	77	77

Note: MMP (Medicare–Medicaid Plan), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). Except for the number of MMPs reporting data, the numbers in this table are the share of beneficiaries giving the highest rating (a 9 or 10 on a 10-point scale or answering “always” when asked about the ability to get appointments when needed). Rates are case-mix adjusted for response bias.

Source: CAHPS survey results for MMPs released by CMS in April 2016, July 2017, and December 2017.

providing transportation benefits, and it was not clear whether the problems that the MMPs had encountered in this area were any worse.

Quality of care

Improving the quality of care for dual eligibles is one of the primary goals of the demonstration. MMPs are required to submit quality data to help CMS and states oversee the demonstration and evaluate its impact. Some requirements are modeled after the MA and Part D programs, while others were developed specifically for MMPs. The MMP-specific measures are a mix of process and structure measures, such as completing health assessments on time and establishing a consumer advisory board, and utilization measures, such as emergency room visits related to behavioral health and diversion of beneficiaries from nursing homes (Centers for Medicare & Medicaid Services 2017e).

Patient experience One source of quality information is the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®), a beneficiary survey that measures patient experience. Like MA plans, MMPs are required to administer the CAHPS survey each year. The survey is usually conducted in the spring and asks enrollees to assess their experience during the previous six months.

For example, CAHPS results for 2017 measure patient experience in late 2016 and early 2017.

CMS has released overall CAHPS results for MMPs for 2015 through 2017 (Table 9-7). The number of plans that reported data grew as the individual state demonstrations were implemented, increasing between 2015 and 2017 from 27 plans to 45 plans.¹² During that period, MMP performance on all measures either improved or remained stable, with the share of enrollees giving their plan the highest possible rating rising from 51 percent to 63 percent. Enrollees also reported improvements in overall health care quality, getting appointments and care quickly, customer service, and getting needed prescription drugs.

These results naturally raise the question of how MMPs perform compared with MA plans and FFS. We do not have the data to make this comparison based on the method used to report CAHPS results in Table 9-7, which shows the share of beneficiaries providing the highest rating for each metric. However, we can compare CAHPS results using another method that calculates the average score on each metric for all survey respondents and rescales that average so it ranges between 0 percent and 100 percent. Using this approach, the results for MMPs, MA plans, and FFS are quite similar, with about

**TABLE
9-8**

Performance of MMPs and MA plans on HEDIS® measures, based on full-benefit dual eligibles only, measurement year 2016

	Enrollees under age 65	Enrollees ages 65 and older
Number of HEDIS measures evaluated	40	43
Number of measures where:		
MMP and MA performance was similar	18	18
MA plans performed better than MMPs	14	15
MMPs performed better than MA plans	8	10

Note: MMP (Medicare–Medicaid 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 more than 5 percent greater than the average measure value for the other type of plan.

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

85 percent of enrollees in each sector giving their health plan the highest possible rating.

Clinical quality measures Another source of quality information that MMPs and MA plans both submit is the Healthcare Effectiveness Data and Information Set® (HEDIS®), a set of clinical quality measures. We used HEDIS person-level data to compare MMP enrollees with full-benefit dual eligibles who were enrolled in MA plans.¹³ We 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.

Our evaluation of HEDIS data for 2016 produced mixed results (Table 9-8). We found that MMPs and MA plans had similar results for roughly 40 percent to 45 percent of the measures that both plans collect (18 of 40 measures for enrollees under 65; 18 of 43 measures for enrollees 65 and older). MA plans performed better on a third of the measures, while MMPs performed better on about 20 percent to 25 percent of the measures.

MA plans performed substantially better than MMPs on three measures: control of blood sugar among diabetics, osteoporosis management for women who have experienced a fracture, and medication reconciliation after a hospital discharge. MMPs’ poor performance on the last measure is particularly concerning since they should pay close attention to transitions in care settings as part of their care coordination efforts. MMPs performed better than MA plans (for both age groups) on five measures: control of blood pressure among diabetics, two measures related

to mental health (providing follow-up care within 7 days and 30 days of an inpatient mental health admission), and two measures related to substance abuse (initiation of and engagement in substance abuse treatment).

We also compared HEDIS results for MMPs in 2015 and 2016 and found that MMP performance had improved, on balance. We made this comparison by finding out how many MMPs (measured at the contract level) improved on a given measure during this period. There were 33 measures we could examine on this basis; a plurality of MMPs improved on 12 measures, did worse on 8, and showed no change on the other 13.

There are several caveats to our analysis. First, we used full-benefit dual eligibles in MA plans as a comparison group for MMP enrollees, but there could be systematic differences between the two groups that affect their HEDIS results. For example, MA enrollees actively enrolled in their plans, while most MMP enrollees were passively enrolled and were difficult to contact in some cases. Second, older, more established plans tend to perform better than new plans on quality measures, and MMPs are still relatively new compared with MA plans. Finally, the 2 types of plans have different financial incentives when it comes to quality measures: 11 HEDIS measures are used in the MA star rating system while only 2 HEDIS measures are used in the quality incentive for MMPs, which is known as the “quality withhold.” Many of the measures on which MA plans performed better are used in the star rating system but not the quality withhold,

while the reverse is true for some measures on which MMPs performed better.

Development of a star rating system for MMPs In 2015, CMS began developing a star rating system for MMPs. CMS does not expect to have a fully developed system ready during the demonstration; the agency is working instead to prepare for the possibility that the Secretary would expand the use of the capitated model in the future using CMMI authority. The MMP ratings will differ from the star ratings for MA plans because MMPs will be assessed on their performance in providing both Medicare and Medicaid services. For example, the ratings for MMPs will incorporate measures related to LTSS and Medicaid-covered behavioral health services (Centers for Medicare & Medicaid Services 2015e). The rating system will be tested before being used and will account for differences in beneficiaries' socioeconomic status where appropriate. CMS will decide in the future whether the star ratings will be used to adjust MMP payments, but it has indicated that MMPs would not be subject to payment adjustments under both the quality withhold and the star ratings at the same time (Centers for Medicare & Medicaid Services 2016c).

Lessons from CAHPS and HEDIS results Taken together, the CAHPS and HEDIS results indicate that the quality of care provided by MMPs is improving, but the plans do not perform as well as MA plans in some areas. As CMS develops a star rating system for MMPs, it may want to put particular emphasis on measures where MMPs currently have poor performance. The findings from our examination of HEDIS results—with MA plans tending to perform better than MMPs on measures that are used in the MA star rating system but not the MMP quality withhold, and vice versa—suggest that plans pay closer attention to the measures used to determine their quality rating, particularly if that rating affects their payments.

Payment adequacy

Under the capitated model, MMPs receive three separate capitation payments: one for Part A and Part B services, one for Part D drugs, and one for Medicaid services. The payment methodology for MMPs differs from those used in MA and Part D because MMPs do not submit bids. Instead, for Part A and Part B services, MMPs are paid using county-specific rates that are based on historical FFS and MA spending for beneficiaries who meet the demonstration's eligibility criteria. In most states, the eligible population was largely enrolled in FFS Medicare before the demonstration, so the rates are based primarily

on historical FFS experience. For Part D drugs, MMPs are paid based on the national average bid for all Part D plans. Like Part D plans, MMPs receive a capitated direct subsidy payment as well as prospective payments for estimated reinsurance costs for beneficiaries with high drug costs and for beneficiary cost sharing covered by the Part D low-income subsidy, which all dual eligibles receive. The two Medicare capitation payments are adjusted for differences in beneficiaries' health status using the same risk adjustment models that are used in MA and Part D.

For Medicaid benefits, each state determines its own payment rates, subject to CMS approval. The rates include both federal and state Medicaid spending and typically vary based on beneficiaries' use of LTSS. Medicaid rates are typically highest for beneficiaries in nursing homes and lowest for those not receiving any LTSS, with rates for beneficiaries receiving HCBS somewhere in between. Some states have also "carved out" certain benefits from the demonstration and continue to provide them through FFS arrangements.

CMS and states also reduce the Part A and Part B and Medicaid capitation rates (there is no reduction to the Part D capitation rate) by a certain percentage to reflect savings they assume the MMPs will be able to produce under the demonstration. The savings percentages vary by demonstration but are generally around 1 percent in the first year, 1 percent to 2 percent in the second year, and 2 percent to 5 percent in later years.

In 2016, CMS increased MMP payment rates for Part A and Part B services after finding that the existing MA risk adjustment model underestimated costs for full-benefit dual eligibles (Centers for Medicare & Medicaid Services 2015b, Centers for Medicare & Medicaid Services 2015f).¹⁴ This change raised the payment rates for most MMPs by about 5 percent to 10 percent and was viewed favorably by the plan representatives we interviewed. During our early visits—which took place in late 2015 and early 2016, after the increase in payment rates had been announced but not yet implemented—stakeholder views on the adequacy of the MMP rates varied greatly. Many interviewees in Massachusetts said the existing rates were too low and the initial savings assumptions had proven to be unrealistic. Interviewees in California and Illinois did not express any significant concerns about the rates, although they also thought the initial savings assumptions were not realistic. On our later visits, none

of the stakeholders we interviewed (including those we met with on a follow-up visit to Massachusetts) raised any significant concerns about Medicare's rates, which suggests that the current rates are adequate.

Quality incentives for MMPs MMP payments are also tied to the plans' performance on certain quality measures through a quality withhold. Under the withhold, the Part A and Part B and Medicaid components of the MMP payment rates are reduced by a specified percentage (usually 1 percent in the first year of the demonstration, 2 percent in the second year, and 3 percent in later years) that MMPs can receive later depending on their performance.

MMPs are assessed on their performance on a combination of "core" measures that are used in all capitated demonstrations and state-specific measures. There are five core measures for the first year of the demonstration and seven core measures for later years; the number of state-specific measures varies, with most states having between two and five measures. For the first year, most measures are related to plan administration (such as submitting encounter data and completing assessments) or patient experience (such as customer service) (Centers for Medicare & Medicaid Services 2014). For later years, plans are assessed largely on clinical quality or outcome measures such as readmission rates, medication adherence for diabetes medications, and nursing home use (Centers for Medicare & Medicaid Services 2016b).

CMS and states determine whether plans "pass" each measure by comparing their performance with a benchmark. The benchmarks for the core measures are absolute, meaning they do not change based on how other MMPs perform. In contrast, for the state-specific measures, some benchmarks are absolute while others are relative, meaning the benchmark depends on how other MMPs perform. For example, the benchmark for several state-specific measures is the performance of the state's highest scoring MMP minus 10 percentage points (Centers for Medicare & Medicaid Services 2015c, Centers for Medicare & Medicaid Services 2015d). Starting in the second year of the demonstration, plans can also pass all core measures and some state-specific measures by improving their performance by a sufficient amount (Centers for Medicare & Medicaid Services 2016b).¹⁵ At the end of each year, CMS and states determine what share of the measures each MMP has passed, with each measure weighted equally. Plans that pass fewer than 20 percent of the measures do not receive any of the quality

withhold, while those that pass between 20 percent and 80 percent of the measures receive part of the withhold (either 25 percent, 50 percent, or 75 percent), and plans that pass more than 80 percent receive the entire withhold (Centers for Medicare & Medicaid Services 2014).

The only data on MMP performance for the quality withhold that are currently available are for 2014, when five demonstrations (California, Illinois, Ohio, Massachusetts, and Virginia) were under way. The lack of data is likely due to the same problems with data availability that have hindered work on the demonstration's evaluations. For 2014, MMPs received about 70 percent of the quality withhold, on average. Every MMP received at least some of the withheld funds, and a third of plans received the full amount (Centers for Medicare & Medicaid Services 2017a, Centers for Medicare & Medicaid Services 2017b, Centers for Medicare & Medicaid Services 2017d, Centers for Medicare & Medicaid Services 2017h, Centers for Medicare & Medicaid Services 2017k). Since the quality withhold equaled 1 percent in 2014, that level of performance means the quality withhold reduced the Part A and Part B and Medicaid payments to MMPs by about 0.3 percent, on average. If MMPs perform at a similar level once the quality withhold reaches its ultimate level of 3 percent, the withhold will reduce plan payments by roughly 1 percent, on average.

The quality withhold differs in several respects from the quality bonus program in Medicare Advantage, in which plans that have ratings of 4 stars or better and submit bids that are lower than the MA benchmarks receive additional funding that they use to provide extra benefits to their enrollees:

- The quality incentive for MA plans is structured as a bonus, while the quality incentive for MMPs is structured as a penalty.
- MA plans are assessed on more measures (43) than MMPs (about a dozen measures in most states). However, the smaller number of measures for MMPs is partly due to the lack of good quality measures for LTSS and care coordination, which are still being developed.
- MA plans receive a star rating on each individual measure, and those ratings are combined into an overall star rating. MA plans cannot improve their rating on any individual measure by showing improvement, while MMPs can "pass" most measures

by showing sufficient improvement. However, MA plans can receive a higher overall star rating if they show improvement across multiple measures.

- The MA quality bonus is an all-or-nothing proposition; plans either receive the entire bonus or receive nothing. In contrast, MMPs can receive part of the quality withhold.

Given these differences and the work that CMS has begun to develop a star rating system for MMPs, it is unclear what kind of quality incentive MMPs might face if the Secretary expands the use of the capitated model.

Demonstrations using the managed fee-for-service model

Unlike the capitated model, which relies on managed care plans to improve care and reduce costs, the managed FFS model aims to achieve those goals by providing greater care coordination in an FFS environment. Two states—Colorado and Washington—have been testing the managed FFS model. Colorado ended its demonstration at the end of 2017; Washington’s demonstration is scheduled to end in 2018 but may be extended until 2020.

Under the managed FFS model, the state passively enrolls dual eligibles who have both FFS Medicare and FFS Medicaid in a Medicaid-funded entity that is responsible for providing care coordination. Beneficiaries can receive care coordination services from the entity, but their participation is entirely optional, and they remain enrolled in FFS Medicare and FFS Medicaid regardless. Colorado enrolled all FFS dual eligibles in its demonstration, while Washington has focused on a subset of dual eligibles who are expected to have high costs.

Colorado’s demonstration was part of a broader effort to improve care coordination in FFS Medicaid known as the Accountable Care Collaborative (ACC). The ACC provides care coordination through entities that function somewhat like accountable care organizations. The state had excluded dual eligibles from the ACC when it was first developed and added them through the demonstration. Although the demonstration is now over, the state has decided that dual eligibles will remain in the ACC, and there should be little day-to-day change in their care.

The Washington demonstration relies on entities known as health homes to provide care coordination, with organizations such as area agencies on aging, mental health clinics, and community health centers providing

most of the actual assistance to beneficiaries (Medicare Payment Advisory Commission 2016). RTI has released an evaluation that covers the first 18 months of the demonstration (July 2013 to December 2014). Much like the initial report for the Massachusetts demonstration, the evaluation found “little evidence of the demonstration’s effect” during its initial period of operation. In Washington’s case, the initial impact of the demonstration may have been limited because dual eligibles were enrolled gradually, some health homes found they needed to develop more capacity for providing care coordination, and health homes found it challenging to engage enrollees (Justice et al. 2017).

At the end of each year, states can receive a “performance payment” if the demonstration produces savings for the federal government. CMS calculates the savings by comparing Part A and Part B spending for beneficiaries in the demonstration with an estimate of how much Medicare would have spent without the demonstration. Savings must be at least 2 percent for the state to receive a performance payment (to guard against random variation in program spending), and CMS deducts any additional Medicaid costs when calculating the overall federal savings. The state’s performance payment equals 30 percent to 50 percent of the federal savings, depending on the state’s performance on certain quality measures.

In July 2017, CMS released a report estimating that Washington’s demonstration reduced Medicare spending by \$67 million during its first two and a half years of operation (July 2013 to December 2015), a savings of about 9 percent (Wilkin et al. 2017b). That figure was based on an estimate of what Medicare would have spent on the dual eligibles who were assigned to a health home (about 20,000 beneficiaries) without the demonstration. As noted in our June 2016 report, we are skeptical that the savings from the demonstration could be that large because the number of beneficiaries who actually received care coordination services during this period was relatively low—about 3,000 people, many of whom received care coordination for only part of the time. As for Colorado, an August 2017 report estimated that its demonstration had actually increased Medicare spending by \$10 million in its first 15 months of operation (September 2014 to December 2015), a cost of about 4 percent (Wilkin et al. 2017a). Both reports note that their findings are preliminary and do not account for any changes in Medicaid spending.¹⁶ RTI also plans to estimate the savings from the demonstrations using more rigorous, regression-based methods as part of its evaluations.

Overall assessment of the financial alignment demonstration

Despite the conceptual appeal of integrated plans, their use in Medicare has always been limited. About 30 percent of full-benefit dual eligibles are now enrolled in some type of Medicare managed care plan, but the extent to which those plans integrate with Medicaid varies widely. Even with the demonstration, only 8 percent of full-benefit dual eligibles are enrolled in plans that have a high degree of integration.¹⁷ Before the demonstration, the figure was about 2 percent.

The limited use of integrated plans has traditionally been attributed to several factors. First, states do not benefit financially from any Medicare savings that integrated plans might realize and, thus, have less incentive to develop such plans. Second, integrated plans have found it difficult to generate substantial enrollment because dual eligibles cannot be required to enroll in a plan to receive their Medicare benefits. Third, CMS and states do not have the authority to resolve the many differences between Medicare and Medicaid that make it harder to operate an integrated plan, such as separate grievances and appeals processes and different adequacy requirements for provider networks.¹⁸ Finally, states and health plans have had little experience using managed care to deliver LTSS, which has made it difficult to develop integrated plans.

The experience with the demonstration suggests that policy changes addressing these barriers could lead to greater interest by states and health plans in developing integrated plans:

- The demonstration allows states to benefit financially from the savings that MMPs are expected to achieve in Medicare by applying the same savings assumptions to both the Medicare Part A and Part B and Medicaid components of the MMP payment rates. Even if MMPs ultimately achieve their savings entirely by lowering Medicare costs, states still benefit financially.
- CMS made it easier for MMPs to generate enrollment by allowing states to use passive enrollment. Many MMPs we interviewed said passive enrollment was a key factor in their decision to participate in the demonstration.
- CMS has used demonstration authority to address some of the administrative challenges involved in operating integrated plans. For example, MMPs use a single identification card and a single set of member

materials (such as provider directories) instead of separate Medicare and Medicaid versions, and all MMPs have integrated at least some parts of the grievance and appeals processes.

These features helped generate widespread state interest in the demonstration, with 21 states submitting proposals to test the capitated model (Medicaid and CHIP Payment and Access Commission 2018). And while the demonstrations were often challenging to implement, the experience so far suggests that integrated plans can be developed in many states. With a few exceptions, each state's demonstration has now been under way for at least three years. The continued delays in the evaluations are a significant concern given the widespread interest in understanding the demonstration's impact on access to care, service use, costs, and quality. Nevertheless, much of the information that is currently available, while limited, is relatively positive: Enrollment is stable, quality of care appears to be improving, payment rates appear adequate, plans have grown more confident about their ability to manage service use, and stakeholders remain supportive of the demonstration.

More states are using Medicaid managed care for dual eligibles

States' interest in testing the capitated model in the financial alignment demonstration has been part of a broader shift toward the use of Medicaid managed care for the aged and disabled. Managed care has long been the dominant delivery system in Medicaid for populations such as children, pregnant women, and nondisabled adults. For example, 25 of the 32 states (including the District of Columbia) that expanded Medicaid coverage for low-income adults under the Patient Protection and Affordable Care Act of 2010 enrolled at least 80 percent of those new beneficiaries in managed care (Paradise 2017).¹⁹

However, for many years, states were much less likely to use managed care for their aged and disabled enrollees, many of whom are dual eligibles. LTSS represents a significant share of Medicaid spending on aged and disabled enrollees—about 80 percent for dual eligibles and 35 percent for those who have Medicaid only. LTSS presents distinct challenges to health plans because its services and providers can differ greatly from traditional medical services, and the number of health plans that had “both the experience and the ability to accept risk for

LTSS” was limited (Saucier et al. 2012). 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).²⁰ In addition, a state cannot require dual eligibles to enroll in Medicaid managed care unless it first obtains a waiver from CMS, a process that can take up to two years.²¹ (States do not need a waiver to require most other beneficiaries to enroll in managed care.) When states require dual eligibles to enroll in Medicaid managed care, the requirement applies only to the delivery of their Medicaid services, not their Medicare services.

Since 2004, the number of states with these programs—often referred to as managed LTSS (MLTSS) programs—has grown rapidly, from 8 states in 2004 to 16 states in 2012 and 24 states today (Lewis et al. 2018, Saucier et al. 2012). Medicaid spending on MLTSS programs has also grown significantly; between 2009 and 2015, spending rose from \$7 billion (5 percent of all Medicaid LTSS spending) to \$29 billion (18 percent of all Medicaid LTSS spending) (Eiken et al. 2017, Eiken et al. 2016). The use of MLTSS will likely grow in the future as additional states develop MLTSS programs and states that already have programs expand them.

We are not aware of a data source that indicates how many dual eligibles are currently enrolled in MLTSS plans. A recent report found that about 1.8 million individuals were enrolled in MLTSS programs (using a combination of 2016 and 2017 data), but that figure includes Medicaid-only beneficiaries, so the number of dual-eligible enrollees would be lower (Lewis et al. 2018). In rough terms, we estimate that perhaps 15 percent of full-benefit dual eligibles were in MLTSS plans in 2017. However, the 24 states that now have MLTSS programs collectively account for about 80 percent of all full-benefit dual eligibles. If these states expand the scope of their MLTSS programs in the future, the share of dual eligibles enrolled in MLTSS plans could rise significantly.

States have been developing MLTSS programs for three main reasons. First, they hope that managed care will lower Medicaid spending and make future spending growth more predictable. Second, they hope that MLTSS plans will improve the quality of care by providing effective care coordination for LTSS users, who often have complex health needs. Finally, states see MLTSS programs as a way to encourage the use of HCBS instead of nursing home care (Libersky et al. 2016). For example, some states have liberalized the eligibility criteria for HCBS as part of their MLTSS programs, and payment rates for MLTSS

plans often include financial incentives to serve enrollees in community settings where possible (Dominiak and Libersky 2016).

Many MLTSS programs have features that are commonplace in Medicaid managed care but can differ substantially from the Medicare Advantage program:

- Most states require at least some beneficiaries to enroll in managed care to receive their Medicaid-covered services, while enrollment in MA plans is voluntary. As a result, dual eligibles in those states may be required to enroll in an MLTSS plan for their Medicaid-covered services, but the same requirement does not apply to Medicare; for example, they can select FFS Medicare coverage or an MA plan, which may or may not be offered by the same parent company that sponsors their Medicaid plan. Some states require the sponsors of their MLTSS plans to offer a companion MA dual-eligible special needs plan so beneficiaries can receive their Medicare and Medicaid benefits from the same parent company if they wish.
- States use competitive procurements to select a limited number of plans to participate in the program. This approach increases the likelihood that all participating plans will have enough enrollment to be financially viable, helps the state obtain lower payment rates, and makes oversight of the plans easier. Medicaid generally requires states to have at least two plans available before they can require beneficiaries to enroll in managed care, and, in practice, states often contract with at least three plans to ensure that mandatory enrollment in managed care can continue even if one plan drops out. In contrast, Medicare does not limit the number of MA plans available in an area, although CMS requires all plans to satisfy a variety of requirements such as provider network adequacy standards.
- States typically have multiyear contracts with their MLTSS plans, which gives the state flexibility in deciding when to conduct its next procurement and gives plans a greater incentive to participate, offer competitive rates, and invest in care coordination. Many contracts have a base period and can be extended for an additional period by the state at its discretion. For example, the latest contract for Arizona’s MLTSS plans has a three-year base period and three optional renewals (a two-year renewal

followed by two one-year renewals) for a potential total length of seven years (Arizona Health Care Cost Containment System 2016). By comparison, the MA program uses annual contracts.

- Many states exclude some groups of enrollees from their MLTSS programs. For example, states have been slower to enroll individuals with developmental disabilities in MLTSS plans. In 2015, MLTSS accounted for 24 percent of LTSS spending for enrollees who were elderly or had physical disabilities, but only 7 percent for enrollees with developmental disabilities (Eiken et al. 2017). Partial-benefit dual eligibles are also routinely excluded from MLTSS programs. States may also initially limit their programs to certain parts of the state and expand them once they have gained experience.
- Some states may exclude or “carve out” certain services from their MLTSS programs and provide them separately. For example, MLTSS plans in a number of states exclude at least some behavioral health services. However, as Medicaid managed care programs mature, states tend to reduce the use of carve-outs and make the coverage provided by plans more comprehensive. In contrast, MA plans are required to provide all Part A and B services, except for hospice, and most plans (including all special needs plans) also provide Part D drug coverage.

Given the growth in MLTSS programs, efforts to better integrate Medicare and Medicaid in many states now take place in an environment where managed care is already being used to provide some services to dual eligibles. As a result, the development of health plans that provide both Medicare and Medicaid services is probably the most feasible approach for pursuing closer integration.

Medicare plans that serve dual eligibles differ in key respects

Although the use of managed care appears to be the most feasible route for better integrating Medicare and Medicaid in many states, this broad concept can be implemented in numerous ways. Medicare has several types of health plans that are aimed at serving dual eligibles but nonetheless differ in key respects. Comparing these plans highlights some of the issues that policymakers may want to consider if they decide to encourage the development

of highly integrated plans. However, the experience with the financial alignment demonstration also suggests that operating multiple types of plans targeted at dual eligibles at the same time can be problematic. Policy changes to better define their respective roles or consolidate them in some fashion may be needed.

In addition to MMPs, Medicare has three other types of health plans that serve dual eligibles and seek to integrate with Medicaid in some way:

- **Dual-eligible special needs plans (D-SNPs)** are MA plans that limit their enrollment to dual eligibles. (In contrast, most MA plans are open to all beneficiaries in the plan’s service area.) These plans were first offered in 2006. The 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 earlier this year in the Bipartisan Budget Act of 2018. Since 2013, Section 1859(f)(3)(D) of the Medicare statute has required all D-SNPs to have contracts with states that “provide [Medicaid] benefits, or arrange for [such] benefits to be provided.”
- **Fully integrated dual-eligible (FIDE) SNPs** are a subset of D-SNPs that are more highly integrated with Medicaid than regular D-SNPs. These plans must meet a number of additional requirements to obtain the FIDE SNP designation, such as having a Medicaid contract to provide LTSS, and can receive higher payments if their enrollees have sufficiently high frailty levels. The FIDE SNP designation became available in 2012. Like regular D-SNPs, these plans have now been permanently authorized.
- **Program of All-Inclusive Care for the Elderly (PACE)** plans serve beneficiaries who are 55 or older and need the level of care provided in a nursing home. This program is not specifically targeted at dual eligibles like D-SNPs are, but, in practice, virtually all PACE enrollees are full-benefit dual eligibles. The program aims to keep people living in the community instead of nursing homes, and it uses a distinctive model of care based on adult day-care centers that are staffed by an interdisciplinary team that provides therapy and medical services. PACE plans provide all Medicare- and Medicaid-covered services. PACE is the oldest type of integrated plan; it started as a demonstration in the early 1980s and was permanently authorized in 1997.

**TABLE
9-9**

Key differences between Medicare plans that serve dual eligibles

	D-SNP			
	Regular	FIDE SNP	MMP	PACE
Authorization	Permanent	Permanent	Demonstration	Permanent
States where plan is available	41	9	9	31
Number of plans	348	45	50	124
Enrollment	1,695,074	159,158	383,047	41,079
Contracting structure	Separate Medicare and Medicaid contracts	Separate Medicare and Medicaid contracts	Single 3-way contract with CMS & state	Single 3-way contract with CMS & state
Level of integration	Varies widely but generally low	High	High	High
Share of enrollees who are partial-benefit dual eligibles	28%	<1%	<1%	<1%
Passive enrollment	Allowed for default enrollment only	Allowed for default enrollment only	Allowed	Not allowed
Plan can provide noncovered benefits	Yes, using MA rebates	Yes, using MA rebates	Yes, varies by state and plan	Yes
Medicare payment methodology	Plans bid against MA benchmarks	Plans bid against MA benchmarks	Rates are set administratively	Rates are set administratively
Plan eligible for frailty adjustment	No	Yes, if frailty levels are similar to PACE enrollees	No*	Yes
States can share Medicare savings	No	No	Yes	No
Type of quality incentive	MA quality bonus program	MA quality bonus program	Quality withhold	None

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), MA (Medicare Advantage). Figures do not include Puerto Rico. Many states have more than one type of plan. The number of D-SNPs and FIDE SNPs are based on unique combinations of contract and plan number; the number of MMPs and PACE plans are based on unique contracts. Enrollment figures are for January 2018. The figures for the share of enrollees that are partial-benefit dual eligibles are based on enrollment data for December 2016. *Starting in 2019, the MMPs in New York’s first demonstration will be eligible for a frailty adjustment if the frailty levels of their enrollees are similar to those in PACE.

Dual eligibles can also enroll in other types of plans, such as regular MA plans and special needs plans for individuals who live in long-term care institutions or have certain chronic conditions.

The key features for each type of plan, as well as MMPs, are summarized in Table 9-9. For this comparison, the

term *regular D-SNP* refers to a D-SNP that is not a FIDE SNP. Regular D-SNPs are the most widely used type of plan, with 348 plans in 40 states and the District of Columbia covering almost 1.7 million beneficiaries in January 2018. The use of FIDE SNPs is much more limited; these are available in only 9 states and cover about 159,000 beneficiaries, with 3 states (Massachusetts,

Minnesota, and New Jersey) accounting for about 75 percent of the overall enrollment. Only 11 percent of all D–SNPs (45 of 393 plans) are FIDE SNPs. Finally, PACE plans are available in 31 states, but they are typically small, and overall enrollment has always been fairly low (now about 41,000).

The differences among the plans start with their contracting structure. All D–SNPs have a standard MA contract with CMS to provide Medicare services and a separate contract with the state that details their Medicaid responsibilities. In contrast, MMPs and PACE plans sign three-way contracts with CMS and the state that combine all of their Medicare and Medicaid responsibilities into a single document. For MMPs, each demonstration also has a contract management team (CMT) composed of state Medicaid officials and multiple CMS representatives that oversees the day-to-day management of the three-way contract. RTI found that both sides think the CMT has been “a very successful vehicle for joint oversight of MMP performance” (Chepaitis et al. 2015).

On some site visits, we asked state Medicaid officials and MMP representatives if they preferred the three-way contract over the more traditional approach of separate Medicare and Medicaid contracts. All interviewees that had an opinion preferred the three-way contract. Both states and plans said that the initial development of the three-way contract had been time consuming and challenging but that it had been easier to administer and oversee once in place. However, Medicaid officials in one state said the process for amending the three-way contract could be simplified. One plan we interviewed also said the three-way contract was helpful in getting its parent company’s Medicare and Medicaid divisions to work together more closely.

The level of integration between regular D–SNPs and Medicaid varies widely but is generally low. Since 2013, all D–SNPs have been required to have Medicaid contracts that meet certain minimum requirements. For example, the contract must specify which categories of dual eligibles can enroll, the plan’s service area, the Medicaid benefits the plan will cover, and the plan’s responsibility to provide or arrange for Medicaid benefits. However, states are not required to contract with D–SNPs to provide any Medicaid services, let alone 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 can do so by

adding additional provisions to their D–SNP contracts (see text box on D–SNPs).²²

CMS found in 2016 that about 75,000 full-benefit dual eligibles in regular D–SNPs received all of their Medicare and Medicaid services from the same parent company and that another 75,000 received all of their Medicare services and a majority of their Medicaid services from the same company (Centers for Medicare & Medicaid Services 2017f, Centers for Medicare & Medicaid Services 2017i). Those figures indicate that only about 15 percent of the full-benefit dual eligibles in regular D–SNPs are in plans that may have a significant level of Medicaid integration.

The other three types of plans have higher levels of integration. FIDE SNPs are required to cover Medicaid LTSS services, although they are not required to cover behavioral health. They must also have a single enrollment process, an integrated model of care that covers both Medicare and Medicaid services, and coordinated Medicare and Medicaid assessment processes (Gibbs and Kruse 2016). These requirements are similar to some of the requirements for MMPs, but the level of integration in MMPs is higher because they provide all or almost all Medicaid-covered services, and more of their administrative processes have been combined. PACE is completely integrated because its plans are required to provide all Medicare and Medicaid services.

Although all four plan types serve dual eligibles, the share of enrollees who are partial-benefit dual eligibles—whose Medicaid coverage is limited to Medicare premiums and, in some cases, cost sharing—is much higher in regular D–SNPs (28 percent) than in the other plan types (less than 1 percent in each). D–SNPs can cover partial-benefit dual eligibles as long as the state agrees to it in its Medicaid contract, while MMPs cannot cover them under the terms of the demonstration.²³ Partial-benefit dual eligibles can join PACE if they meet the program’s eligibility requirements, but, in practice, very few enroll. PACE plans must provide all Medicaid-covered services to their enrollees, regardless of their actual Medicaid eligibility, and any enrollees who are not eligible for full Medicaid benefits have to pay a substantial premium equal to the plan’s monthly Medicaid capitation payment.

The plans also differ in the amount of flexibility they have to spend their Medicare and Medicaid revenues on services that are not covered by either program. Supporters of integrated plans argue that giving plans a significant degree of flexibility would result in better

Using D-SNPs to promote Medicare–Medicaid integration for dual eligibles

A number of states are using Medicare Advantage (MA) dual-eligible special needs plans (D-SNPs) as the vehicle for more closely integrating Medicare and Medicaid for dual-eligible beneficiaries. States have promoted integration by adding extra requirements to their Medicaid managed care contracts and the contracts that D-SNPs are required to sign with state Medicaid agencies. These requirements are designed to increase the number of dual eligibles who are enrolled in a D-SNP and a Medicaid managed care plan offered by the same parent company. The Integrated Care Resource Center, a technical assistance entity sponsored by CMS, reviewed the contracts in many of these states and provided some examples of these extra requirements:

- A growing number of states (at least 10 in 2018) require Medicaid plans that cover aged and disabled beneficiaries (many of whom are dually eligible) and provide long-term services and supports to offer a companion D-SNP. States may also require the D-SNP to serve the same geographic area as the Medicaid plan. These provisions ensure that all dual eligibles enrolled in Medicaid managed care can receive their Medicare benefits from the same parent company if they wish.
- A smaller number of states (at least six in 2018) do not sign D-SNP contracts with companies unless they sponsor Medicaid managed care plans in their state. This requirement eliminates any D-SNPs that do not have a companion Medicaid plan and,

when combined with the first set of requirements discussed above, creates a one-to-one relationship between a state’s Medicaid plans and its D-SNPs.

- A few states have taken additional steps to encourage dual eligibles to enroll in a D-SNP and a Medicaid plan offered by the same parent company. Massachusetts, Minnesota, and New Jersey prohibit their D-SNPs from enrolling beneficiaries who are not also enrolled in the parent company’s companion Medicaid plan, while Arizona periodically reassigns some dual eligibles to a new Medicaid plan that “matches” their D-SNP (i.e., both are offered by the same parent company).
- Some states also require their D-SNPs to provide a variety of additional information about their operations, such as encounter data, bid data, and any MA-related correspondence between CMS and the plan. This added information makes it easier for states to understand the Medicare side of their integration efforts (Verdier et al. 2016).

Although these requirements can improve the integration of Medicare and Medicaid for dual eligibles, their reach is nonetheless limited because Medicare’s freedom-of-choice provision prohibits states from requiring dual eligibles to enroll in Medicaid plans and D-SNPs from the same organization. ■

quality care because noncovered services could reduce overall costs and improve outcomes in some instances. D-SNPs have had the least flexibility and can provide noncovered services only as a supplemental benefit using rebates—the additional funding that MA plans receive if they submit a bid that is lower than the benchmark. CMS has traditionally required these supplemental benefits to be primarily health related, but D-SNPs that meet certain integration requirements can use rebates to cover additional services for individuals who have functional impairments. In addition, the Bipartisan Budget

Act of 2018 gives MA plans greater flexibility to offer supplemental benefits that are not primarily health related starting in 2020. MMPs have more flexibility than D-SNPs to spend their Medicare and Medicaid revenues on noncovered services. A state can require its MMPs to provide certain noncovered services or give each plan discretion to develop its own package of noncovered services. PACE plans have the most flexibility in this area, with broad legislative authority to spend their Medicare and Medicaid revenues on noncovered services.

The ability to passively enroll beneficiaries in each type of plan also varies. D–SNPs can passively enroll some beneficiaries using an MA provision known as “default enrollment” or “seamless conversion” that allows an insurer to automatically enroll individuals who have been in a comprehensive Medicaid managed care plan in a companion D–SNP when those individuals first become eligible for Medicare. States’ use of passive enrollment in MMPs has been a key feature of the financial alignment demonstration. PACE plans cannot use passive enrollment.

The final areas of difference among the plans are related to Medicare payment issues. Rates for D–SNPs are determined using the standard MA payment system, under which plans bid against a predetermined benchmark that CMS calculates using local FFS costs. In contrast, MMPs and PACE plans do not submit bids and are instead paid using rates that are set administratively. (The payment rates for any Medicaid services that each type of plan provides are set separately.) Payment rates for all four plan types are adjusted for differences in beneficiaries’ health status using the MA risk adjustment model. However, PACE plans receive an additional payment, known as a frailty adjustment, because the model underestimates costs for beneficiaries with functional impairments. FIDE SNPs can also receive a frailty adjustment if the frailty level of their enrollees is comparable to PACE enrollees.²⁴ MMPs are the only type of plan where states share some of the savings that the plans are expected to achieve in Medicare. D–SNP and MMP rates both include quality incentives (through the MA quality bonus program and the quality withhold, respectively), while PACE rates do not have a quality incentive.

Allowing D–SNPs and MMPs to operate in the same areas has been problematic in some states

The financial alignment demonstration has effectively given states that are testing the capitated model two ways to use managed care to better integrate Medicare and Medicaid on a large scale: D–SNPs and MMPs. Although PACE is another option, it has never been used on a widespread basis and usually covers no more than 1 percent to 2 percent of a state’s full-benefit dual eligibles.

Each participating state has allowed both plan types to operate in certain markets, but the extent to which a state relies on one type of plan versus the other varies. Some states, like Illinois and Michigan, had relatively low D–SNP enrollment before the demonstration and have

more dual eligibles enrolled in MMPs.²⁵ Other states, like California and Texas, had higher D–SNP enrollment before the demonstration and now have a significant number of dual eligibles enrolled in both types of plans. The low participation in New York’s first demonstration (which is largely due to care coordination requirements that were initially too prescriptive) has meant that D–SNPs remain the state’s predominant plan type. Finally, Massachusetts has both plan types, but they serve different populations and do not overlap (its MMPs serve dual eligibles under age 65, while its D–SNPs serve those ages 65 and older).

The availability of both plan types and differences between the MMP and D–SNP models raise the prospect that insurers and other entities such as insurance brokers may have financial incentives to favor the use of D–SNPs in some instances, which could hinder efforts to encourage dual eligibles to enroll in the more highly integrated MMPs. In some instances, allowing MMPs and D–SNPs to operate in the same areas has been problematic. To some extent, the friction between MMPs and D–SNPs was unavoidable for the demonstration since the states that were most likely to be interested in the capitated model were also likely to be states that had already developed D–SNPs. Nevertheless, the interplay between the two plan types is worth exploring since the Secretary could use CMMI’s authority to expand the use of MMPs in the future.

MMP payment rates for Part A and Part B services can be higher or lower than D–SNP rates

Payment rates for D–SNPs are determined using the same methodology that applies to all non-employer MA plans. (The only exception is the frailty adjustment that some FIDE SNPs receive.) 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 costs. Benchmarks for counties in the highest spending quartile equal 95 percent of FFS costs, 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 costs, respectively. In addition, plans that have a rating of 4 stars or higher in the CMS star system for MA plans also have a bonus amount, usually 5 percent of FFS costs, 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 lower 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 are adjusted for differences in beneficiaries' health status using the CMS-HCC risk adjustment model.

In contrast, MMPs do not submit bids; instead, CMS determines their payment rates using historical FFS and MA spending for beneficiaries who meet the demonstration's eligibility criteria. In most states, these beneficiaries were largely enrolled in FFS Medicare before the demonstration. The rates are then reduced to reflect MMPs' expected savings and to set aside funding for the demonstration's quality withhold.

During the demonstration, MMPs have benefited from a number of adjustments that increased their overall payments compared with what they would have received as D-SNPs. These adjustments have been largely temporary and have affected both the base payment rates for MMPs and how those rates are adjusted for differences in beneficiaries' health status:

- CMS has increased the MMP rates in most demonstrations (9 of 11) to account for the bad debt payments that, without the demonstration, FFS Medicare would make to providers such as hospitals for services provided to dual eligibles. MA benchmarks also include an allowance for bad debt payments, but it is smaller. This adjustment has increased the FFS component of the MMP rates in most states by about 1.75 percent.
- For 2013 and 2014, CMS "repriced" the claims that were used to measure FFS costs to reflect more current wage data for physicians and hospital employees. This adjustment increased the FFS component of MMP rates by about 3.8 percent in 2013 and 1.8 percent in 2014. Starting in 2015, CMS began making this adjustment when calculating MA benchmarks, so it now applies equally to MMPs and D-SNPs.

- CMS risk adjusts payments to MA plans based on enrollees' demographic information and diagnosis codes from their claims. These adjustments are based on experience in the FFS program, but MA plans have an incentive to submit more diagnosis codes than FFS providers because doing so increases their payments. CMS partially accounts for the effect of this additional coding by applying a "coding intensity adjustment" that reduces payments to MA plans. MMPs have the same incentive to submit more diagnosis codes, but CMS has phased in the application of the coding intensity adjustment to their payments, usually over a three-year period. (New MA plans are subject to the full coding intensity adjustment from the outset.) The rationale for the phase-in is that most MMP enrollees were coming from the FFS program and did not have any additional coding. This transition period has meant that MMPs have received higher payments during the first two years of the demonstration than they would have if they had instead entered the market at the same time as D-SNPs. The increase has varied by state but, for most MMPs, has been between 5 percent and 6 percent in the first year of the demonstration and 2 percent to 4 percent in the second year.
- In 2017, CMS began using a new risk adjustment model that raised payments to both MA plans and MMPs for full-benefit dual eligibles. However, CMS also increased MMP rates for 2016 by amounts that approximated the extra payments that the plans would receive under the new model, effectively allowing MMPs to benefit from the new model a year earlier than D-SNPs. The increase for most MMPs in 2016 was between 5 percent and 10 percent.

For this analysis, we compared MMP payment rates for Part A and Part B services with D-SNP benchmarks, which are both determined administratively by CMS. The MMP rates incorporate all of the adjustments described above. We did not account for the effects of each plan's quality incentive (i.e., we did not reduce MMP rates to account for the quality withhold or increase D-SNP benchmarks to account for the MA quality bonus) or the frailty adjustment that FIDE SNPs can receive. Table 9-10 (p. 272) shows how the relationship between MMP rates and MA benchmarks has changed over time. Since the start of the demonstration, MMP rates have declined relative to MA benchmarks as the temporary increases that CMS made to MMP rates have expired and the reductions

**TABLE
9-10****MMP payment rates have declined relative to MA benchmarks**

	2013	2014	2015	2016	2017
Number of demonstrations	1	5	9	11	11
Total enrollment	3,988	180,730	363,491	368,281	396,509
MMP rates as a share of MA benchmarks	103%	104%	103%	106%	97%
Share of MMP enrollment in counties where rates are:					
≤ 90% of MA benchmark	0%	4%	2%	0%	8%
91% to 95% of MA benchmark	1	15	7	6	18
96% to 100% of MA benchmark	21	10	21	16	38
101% to 105% of MA benchmark	52	22	31	16	32
106% to 110% of MA benchmark	26	26	34	26	4
> 110% of MA benchmark	0	25	5	36	0

Note: MMP (Medicare–Medicaid Plan), MA (Medicare Advantage). Figures are based on enrollment in December of the calendar year. Figures do not include effects of the MMP quality withhold, the MA quality bonus program, or the frailty adjustment that fully integrated dual-eligible special needs plans can receive. Components may not sum to totals due to rounding.

Source: MedPAC analysis of MMP payment rate data and MA benchmarks.

for expected savings under the demonstration have grown larger. For 2017, MMP rates were about 97 percent of MA benchmarks.

Although MMP rates are lower than MA benchmarks in the aggregate, the relationship between the two varies from county to county and over time. Since MMP rates in most states are closely tied to FFS costs, MMP rates are typically lower than MA benchmarks in counties with relatively low FFS spending, such as those where benchmarks equal 107.5 percent or 115 percent of FFS costs. For example, MMP rates were substantially lower than MA benchmarks in Virginia, where the average MMP rate in 2017 was about 100 percent of FFS costs, while the average MA benchmark was about 110 percent of FFS costs. In contrast, MMP rates can be higher than MA benchmarks in counties with relatively high FFS spending, where benchmarks equal 95 percent of FFS costs. This tendency was especially true in the early years of the demonstration, when MMP rates in these areas often exceeded 100 percent of FFS costs because the phasing in of the coding intensity adjustment and the additional payments for bad debt more than offset the reductions for expected savings. In later years, MMP rates may still

equal 95 percent to 98 percent of FFS costs when the full reduction for expected savings is made. The MMPs in these areas thus might receive lower payments if they operated as D–SNPs.

The relationship between MMP rates and MA benchmarks can also vary within a state. Illinois provides a good example. The state’s demonstration is taking place in two areas: a 6-county region that includes Chicago and a 15-county region in central Illinois. When we visited Illinois in 2016, the second full year of its demonstration, the plan representatives we interviewed said MMPs were paid better than D–SNPs in the Chicago region, where the average MA benchmark is about 95 percent of FFS costs, and worse than D–SNPs in the central Illinois region, where the average benchmark is about 109 percent of FFS costs. The demonstration has had significant problems in the central Illinois region; one of the region’s two MMPs withdrew at the end of 2015, and the remaining plan had to suspend operations in some counties for a few months in 2017 because of problems with its provider network.

Table 9-10 shows the distribution of MMP enrollment based on the relationship between MMP rates and MA benchmarks. There have been some relatively large

changes in the distribution as new demonstrations have started, overall enrollment has grown, and the various adjustments that CMS has made to MMP rates have taken effect or expired. For example, the share of enrollees living in counties where MMP rates are greater than 110 percent of MA benchmarks jumped sharply in 2016 because of the one-time increase in MMP rates to account for the effects of the new risk adjustment model. Despite the year-to-year volatility, the share of enrollment in counties where MMP rates were lower than MA benchmarks grew noticeably between 2014 and 2017, from 29 percent to 64 percent.

A full comparison of how health plans are paid when operating as MMPs or D-SNPs would need to account for several other factors. For MMP rates, we would need to account for plan performance on the quality withhold. The available data on MMP performance for the quality withhold (which is for 2014 only) suggest that, when fully implemented, the withhold will reduce MMP payments by about 1 percent, on average, although the reduction for individual plans will vary between 0 percent and 3 percent. For D-SNP rates, we would need to account for the competing effects of the quality bonus, which increases overall payments, and the bidding process, which decreases overall payments. However, our most recent analysis of the MA program suggests that the two largely offset each other: In 2018, the average benchmark for all D-SNPs without the quality bonus was about 103 percent of FFS costs, while the average payment to D-SNPs, after accounting for quality bonuses and plan bids, was 102 percent of FFS costs. Taken together, these data points suggest that our comparison of MMP rates and D-SNP benchmarks is a reasonable approximation of how overall payments for the two types of plans differ.

This comparison of MMP rates and MA benchmarks does not account for more intensive coding of beneficiary diagnoses. Both plan types have an incentive to submit more diagnoses than many FFS providers because doing so increases the plans' total Medicare payments. In MA, we have estimated that excess coding adds about 2 percent to overall MA spending (Medicare Payment Advisory Commission 2018). We have not examined the extent of excess coding by MMPs.

Competition between MMPs, regular D-SNPs, and “look-alike” plans in California

Our first example of the difficulties in having both MMPs and D-SNPs in the same area comes from California. Before the demonstration, there was a large number of

D-SNPs in the seven participating counties, and the state took several steps to encourage dual eligibles to enroll in MMPs instead:

- Companies that offer both plan types had to transfer any D-SNP enrollees who qualified for the demonstration into their MMP. These companies can continue to offer a D-SNP but can use it only for beneficiaries who do not qualify for the demonstration.²⁶
- Companies that offer a D-SNP but not an MMP can continue offering a D-SNP, and the beneficiaries in the plan were exempt from passive enrollment. However, these D-SNPs have not been allowed to enroll any new beneficiaries who qualify for the demonstration. The only new beneficiaries who can enroll are dual eligibles who do not qualify for the demonstration.
- The state is not allowing any companies to offer new D-SNPs in the counties that are part of the demonstration (California Department of Health Care Services 2014).

During one of our visits to California, several stakeholders said that many plan sponsors and enrollment brokers have opposed these restrictions. (The brokers receive commissions when they help people enroll in MA plans such as D-SNPs, but the demonstration prohibits MMPs from using brokers.) Many sponsors have circumvented the state's restrictions by offering what our interviewees referred to as “mirror” or “look-alike” plans. These plans are designed to serve dual eligibles and look like D-SNPs, but they are marketed as conventional MA plans and thus are not affected by the state's limits on D-SNPs.

The look-alike plans resemble D-SNPs because their benefit structures have many of the same distinctive features, such as a beneficiary premium for Part D coverage, the highest allowable limit on beneficiary out-of-pocket costs for Part A and Part B services, and the highest allowable deductible for Part D coverage. These features are not appealing to the broader Medicare population. The other conventional MA plans in these counties usually have no premium, a lower out-of-pocket limit, and no Part D deductible—but these features matter relatively little for dual eligibles because Part D's low-income subsidy (LIS), which all dual eligibles receive, covers their premium (LIS coverage of premiums is subject to a dollar limit, but the premiums for the look-alike plans are usually very

**TABLE
9-11**

California’s demonstration has led to a proliferation of “look-alike” MA plans that enroll dual-eligible beneficiaries

	2013	2014	2015	2016	2017
MMPs					
Number of plans	0	8	10	10	10
Enrollees	0	59,757	117,413	113,673	116,190
Share that are dual eligibles		99%	99%	98%	N/A
D-SNPs					
Number of plans	32	25	21	20	18
Enrollees	155,725	186,779	104,566	80,724	72,696
Share that are dual eligibles	97%	98%	98%	97%	N/A
“Look-alike” MA plans					
Number of plans	4	7	11	18	19
Enrollees	5,032	11,640	61,752	82,186	95,047
Share that are dual eligibles	91%	96%	97%	95%	N/A
Other MA plans					
Number of plans	119	109	121	123	120
Enrollees	905,196	960,069	1,013,621	1,041,715	1,103,697
Share that are dual eligibles	7%	8%	9%	10%	N/A

Note: MA (Medicare Advantage), MMP (Medicare–Medicaid Plan), N/A (not available), D-SNP (dual-eligible special needs plan). These figures are for the seven counties in the Cal MediConnect financial alignment demonstration (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) and do not include plans or enrollees in the rest of the state. We counted MMPs using contract numbers and all types of MA plans using the combination of contract number and plan number. Enrollment figures are for December of each year. None of the plans shown in this table serve every demonstration county. The figures for other MA plans do not include employer-sponsored plans or Program of All-Inclusive Care for the Elderly plans.

Source: MedPAC analysis of Medicare enrollment data and MA, SNP, and MMP landscape files.

close to this limit), Medicaid covers their Part A and Part B cost sharing, and the LIS covers the Part D deductible. The look-alike plans instead likely have better coverage of supplemental benefits such as dental, vision, and hearing services that Medicare and Medicaid either do not cover or cover to only a limited degree.

The use of look-alike plans has grown steadily during California’s demonstration (Table 9-11). The state’s MMPs began operation in 2014 and 2015 and covered about 116,000 beneficiaries at the end of 2017. Given the state’s restrictions on D-SNPs, enrollment in those plans has dropped sharply (from about 187,000 in 2014 to about 73,000 in 2017), and several sponsors have stopped offering them. However, the decline in D-SNP enrollment has been largely offset by growing enrollment in look-alike plans. Since 2013, the number of look-alike plans

has risen from 4 to 19, and their enrollment has risen from about 5,000 to about 95,000, which exceeds the number enrolled in D-SNPs.²⁷

The ability of plans and brokers to market look-alike plans to dual eligibles is demonstrated by the fact that almost all of their enrollees—95 percent in 2016—are dual eligibles. That figure differs little from the corresponding shares for MMPs and D-SNPs, which are limited to dual eligibles. By comparison, dual eligibles accounted for 10 percent of enrollment in the other MA plans in the counties that are part of the demonstration, and the highest share in any individual plan was less than 30 percent (data not shown).

Competition between MMPs and FIDE SNPs in New York

Operating both D-SNPs and MMPs in the same area has also been a challenge in New York’s first demonstration.

Before the demonstration, the state had developed a program that uses FIDE SNPs to integrate Medicare and Medicaid for dual eligibles who need more than 120 days of home- and community-based LTSS. The demonstration serves the same population, and many stakeholders we interviewed said this overlap had generated confusion among beneficiaries and providers about each program's respective role. The MMPs we interviewed are sponsored by companies that also offer FIDE SNPs, and the officials we met with thought that beneficiary outcomes were similar in the two products. One plan said the MMP was easier to operate in some respects (such as having an integrated enrollment process and a fully integrated system for grievances and appeals) and harder in others (more extensive reporting requirements and shorter deadlines for responding to requests for formulary exceptions for Part D drugs).

In addition, companies that offer both a FIDE SNP and an MMP have had a financial incentive to favor the FIDE SNP. FIDE SNPs receive a frailty adjustment if the frailty level of their enrollees is comparable with that of PACE enrollees. This adjustment typically increases Medicare payments by roughly 5 percent to 10 percent. There has not been any such adjustment for MMPs, so the companies that qualify for the frailty adjustment have received higher payments for their FIDE SNP than they did for their MMP. At the start of the demonstration, the FIDE SNPs also had higher Medicaid payment rates than the MMPs, but the state has since equalized them. As a result, companies that offer both plan types have had little incentive to market the MMP to eligible beneficiaries enrolled in their other products, such as traditional MA plans, regular D-SNPs, or Medicaid MLTSS plans. CMS and the state have modified the demonstration so that MMPs will be eligible for the same frailty adjustment as FIDE SNPs starting in 2019. However, it is unclear how much of an impact this change will have since that is the last year of the demonstration.

The state is currently considering how it will promote Medicare–Medicaid integration after the demonstration ends and has shown interest in consolidating the two programs in some fashion.

Competition between MMPs and regular D-SNPs in Texas

Texas has used Medicaid managed care for many years and now requires most dual eligibles to enroll in MLTSS plans to receive their benefits. For the demonstration, the

state has used the parent companies of those plans as the sponsors for its MMPs. These companies were already required to offer companion D-SNPs in certain highly populated counties, including the ones that are part of the demonstration. As a result, the parent companies of the MMPs also operate D-SNPs in the same markets.

Some observers have suggested that dual eligibles who are not enrolled in a highly integrated plan like an MMP can nonetheless get some of the benefits of better-integrated care by having separate Medicare and Medicaid plans that are sponsored by the same company. Since insurers in Texas offer both options—enrollment in an MMP alone versus parallel enrollment in a D-SNP and a companion MLTSS plan—we asked them which option was better for beneficiaries. The representatives of each plan we interviewed said the MMP was better because it uses one care coordination system to oversee all Medicare and Medicaid benefits instead of separate systems for Medicare and Medicaid that may not always work together closely. Two plans also said the MMP was a better product because of the demonstration's administrative simplifications, such as a single set of member materials and a partially integrated system for grievances and appeals.

However, the Medicare payment rates for the two products differ. The MMP rates were likely higher than D-SNP rates at the start of the demonstration, but that does not always appear to be true now that the demonstration's savings reductions and quality withhold have been fully phased in. One plan we interviewed appeared to get higher payments for its D-SNP, probably because it qualified for the MA quality bonus, and its representatives said that its D-SNP had more additional benefits than its MMP. Another plan, which did not qualify for the quality bonus, indicated that the extra benefits were slightly better in its MMP.

Texas is now reprocurring its MLTSS plans for new contracts that will start in 2020. The state's initial request for proposals (RFP) stated that, in the six demonstration counties, all MLTSS plan sponsors would be required to offer MMPs but would not be allowed to offer D-SNPs, which would have eliminated the competition and overlap between the two products (Texas Health and Human Services Commission 2017). However, some health plans opposed this requirement, and the state removed it from the RFP (Texas Health and Human Services Commission 2018). The representatives for the plans we interviewed

expressed a similar view, saying that offering both D–SNPs and MMPs would give dual eligibles more choices for their coverage. One plan noted that being able to offer a D–SNP was a particular benefit for partial-benefit dual eligibles, who cannot enroll in an MMP.

Potential policies to encourage the development of integrated plans

The Commission has previously examined managed care plans for dual eligibles in other contexts and has consistently supported the development of more highly integrated plans (see text box on managed care plans for dual eligibles, p. 280). The findings in this analysis suggest the need for a broader reassessment of the Medicare plans that serve dual eligibles. Enrollment in highly integrated plans remains low, and the plans that serve dual eligibles differ in numerous ways and may increasingly compete with each other, especially if CMMI expands the use of MMPs. Federal policymakers may want to develop a common framework for these plans by giving them more clearly defined roles or consolidating them in some fashion.

In this section, we examine three policy changes that would help support the development of integrated plans: (1) limit how often dual eligibles can change plans, (2) limit enrollment in D–SNPs to full-benefit dual eligibles, and (3) expand the use of passive enrollment. Collectively, these policies would improve care coordination and continuity of care, require D–SNPs to focus on the dual eligibles who stand to benefit from integrated care, and encourage more dual eligibles to enroll in plans with higher levels of Medicare–Medicaid integration.

Limit how often dual eligibles can change plans

Before 2006, all Medicare beneficiaries could change their health plan—by moving from FFS to a plan, moving from a plan to FFS, or moving from one plan to another plan—on a monthly basis. Since then, several “lock-in” provisions have limited how often most beneficiaries can change plans. These provisions were added to give plans stronger incentives to coordinate care for higher cost beneficiaries, prevent beneficiaries from changing plans in the middle of the year to receive additional benefits, and stabilize plan enrollment (Laschober 2005). Most beneficiaries can now change their MA or Part D plan only

once a year, during the annual enrollment period, or in certain special circumstances. For example, beneficiaries can change plans outside of the annual enrollment period if they move outside of their plan’s service area, enter a nursing home, or lose employer-sponsored coverage. However, the same lock-in provisions do not apply to dual eligibles, who until recently have been able to change their health plan on a monthly basis.

We used Medicare administrative data to see how often dual eligibles change plans compared with other beneficiaries. For this analysis, we examined beneficiaries who had Part A and Part B coverage for the entire year since beneficiaries must have both to enroll in an MA plan, an MMP, or PACE. We also excluded beneficiaries who were dual eligibles for only part of the year to simplify the comparison of dual eligibles with other beneficiaries, and because gaining and losing Medicaid eligibility are both special circumstances where beneficiaries can change plans outside of the annual enrollment period. We focused on voluntary changes and thus excluded instances where beneficiaries had to change plans because they had been in a plan that was no longer offered in their county or because they moved. We did not include instances where FFS beneficiaries changed their stand-alone Part D plan. Finally, we treated passive enrollments in MMPs as voluntary changes since beneficiaries can opt out.

In 2016, dual eligibles were more likely than other beneficiaries to change plans, but the two groups tended to make their changes at different times (Table 9-12). Dual eligibles were less likely to change plans in January, when changes that beneficiaries make during the annual enrollment period take effect.²⁸ About 3.4 percent of dual eligibles made some type of change—from FFS to a plan, from a plan to FFS, or from one plan to another plan—in that month, compared with 5.0 percent for other beneficiaries.²⁹ However, the share of dual eligibles who changed plans between February and December was much higher (7.0 percent compared with 1.3 percent of all other beneficiaries). Dual eligibles represented about 18 percent of the Medicare beneficiaries who we used in our analysis but accounted for 56 percent of the plan changes that occurred between February and December. The demonstration’s use of passive enrollment has raised the number of plan changes for dual eligibles, but figures for earlier years show the same basic pattern.

The share of dual eligibles who change plans (including opting into or out of FFS) has grown in recent years (Table 9-13, p. 278). The growth is partly due to the demonstration;

**TABLE
9-12**

Voluntary plan changes for dual-eligible and all other beneficiaries, 2016

	Dual-eligible beneficiaries		All other beneficiaries	
	Number	Percent	Number	Percent
Total beneficiaries (in thousands)	8,399	100.0%	37,335	100.0%
Voluntary changes that took effect in January 2016:				
Changed from FFS to a plan	87	1.0	606	1.6
Changed from a plan to FFS	33	0.4	232	0.6
Changed plans	<u>169</u>	<u>2.0</u>	<u>1,017</u>	<u>2.7</u>
Total	289	3.4	1,855	5.0
Voluntary changes that took effect in February to December 2016:				
Changed from FFS to a plan	253	3.0	179	0.5
Changed from a plan to FFS	111	1.3	117	0.3
Changed plans	<u>225</u>	<u>2.7</u>	<u>175</u>	<u>0.5</u>
Total	589	7.0	471	1.3

Note: FFS (fee-for-service). We defined a *plan* as a Medicare Advantage plan, cost plan, the Program of All-Inclusive Care for the Elderly, or Medicare–Medicaid Plan. The figures in this table are based on beneficiaries who had Part A and Part B coverage continuously from December 2015 to December 2016 and do not include beneficiaries who were dually eligible for only part of this 13-month period. We did not count instances where beneficiaries changed plans because their plan was no longer available in their area or they moved outside of their plan’s service area as voluntary changes. We did not include instances where FFS beneficiaries changed their stand-alone Part D plan. Components may not sum to totals because of rounding.

Source: MedPAC analysis of common Medicare environment, denominator, and plan crosswalk files.

in the counties that are part of the demonstration, the share of dual eligibles who changed plans at least once grew from 6.8 percent to 14.7 percent. However, there was also growth in the non-demonstration counties, with the share of dual eligibles who made at least one change increasing from 6.5 percent to 8.9 percent. In contrast, other beneficiaries became less likely to change plans.

Dual eligibles are also more likely than other beneficiaries to change plans multiple times during the year. In 2016, 1.7 percent of dual eligibles made two or more changes, compared with 0.3 percent for other beneficiaries (figures not shown in table). The share of dual eligibles making multiple changes has doubled since 2011. As with the share of dual eligibles who changed plans at least once, growth in the share making multiple changes was larger in demonstration counties, but there was also a noticeable increase in the non-demonstration counties.

Finally, we examined how retention rates for health plans differ by type of beneficiary (Table 9-14, p. 279). We

calculated retention rates as the number of beneficiaries who were continuously enrolled in the same plan for the entire year divided by the number who were enrolled in plans at the start of the year. For this analysis, we split the Medicare population into four groups to provide finer detail: full-benefit dual eligibles, partial-benefit dual eligibles, beneficiaries who do not receive Medicaid but qualify for the Part D LIS (who can also change plans on a monthly basis), and all other beneficiaries.

Of the four groups, the beneficiaries who did not qualify for Medicaid or the LIS (“All other beneficiaries” in Table 9-14) had the highest retention rates—almost 98 percent in both 2011 and 2016—which is not surprising since they cannot change their plan during the year except in special circumstances. The retention rates for LIS recipients were lower, at about 94 percent in 2016, but higher than the rates for dual eligibles, which suggests that this group makes less use of its ability to change plans on a monthly basis. The two types of dual eligibles had the lowest

**TABLE
9-13**

The share of dual eligibles who changed plans grew between 2011 and 2016

	Demonstration counties		Non-demonstration counties	
	2011	2016	2011	2016
Dual-eligible beneficiaries used in analysis (in millions)	1.8	2.4	4.9	6.0
Distribution of beneficiaries, based on number of voluntary plan changes:				
No change	93.2%	85.3%	93.5%	91.1%
At least 1 change	6.8	14.7	6.5	8.9
1 change	5.6	11.4	5.5	7.4
2 changes	1.1	2.8	0.8	1.3
3 or more changes	0.2	0.5	0.1	0.2
All other beneficiaries used in analysis (in millions)	7.6	8.9	24.2	28.4
Distribution of beneficiaries, based on number of voluntary plan changes:				
No change	93.5%	93.7%	93.3%	93.9%
At least 1 change	6.5	6.3	6.7	6.1
1 change	6.2	6.0	6.5	5.8
2 changes	0.3	0.3	0.2	0.3
3 or more changes	*	*	*	*

Note: "Demonstration counties" are counties that have at some point tested the capitated model under the financial alignment demonstration. We defined a *plan* as a Medicare Advantage plan, cost plan, the Program of All-Inclusive Care for the Elderly, or Medicare–Medicaid Plan. The figures in this table are based on beneficiaries who had continuous Part A and Part B coverage from the previous December through the end of the calendar year and do not include beneficiaries who were dually eligible for only part of this 13-month period. "Voluntary plan changes" can refer to switching from fee-for-service to a plan, switching from a plan to fee-for-service, or switching from one plan to another plan. We did not count instances where beneficiaries changed plans because their plan was no longer available in their area or they moved outside of their plan's service area as voluntary changes. We also did not include instances where fee-for-service beneficiaries changed their stand-alone Part D plan. Components may not sum to totals because of rounding.

*Less than 0.05 percent.

Source: MedPAC analysis of common Medicare environment, denominator, and plan crosswalk files.

retention rates in 2016, at about 87 percent for full-benefit dual eligibles and almost 90 percent for partial-benefit dual eligibles. The retention rates for full-benefit dual eligibles also declined between 2011 and 2016, with larger declines in demonstration counties.

When the lock-in provisions were first implemented, the exemption for dual eligibles was 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, health plans are now much more experienced at serving dual eligibles

than they were over a decade ago, and the implementation of the CMS–HCC risk adjustment system has reduced concerns that MA plans would avoid serving higher risk beneficiaries (McWilliams et al. 2012). On the other hand, research has found that MA enrollees who use high-cost services such as short- or long-term nursing home care are more likely to switch to FFS coverage than other MA enrollees (Rahman et al. 2015). Several MMPs we have interviewed said that allowing dual eligibles to switch plans on a monthly basis makes it harder to provide care coordination, which is most effective when there is an ongoing relationship between the beneficiary and the plan.

**TABLE
9-14**

Dual eligibles are less likely to remain in their plan than other Medicare beneficiaries

	Retention rate					
	Demonstration counties		Non-demonstration counties		All counties	
	2011	2016	2011	2016	2011	2016
Full-benefit dual eligibles	87.4%	84.2%	90.6%	88.8%	89.4%	86.6%
Partial-benefit dual eligibles	91.9	88.5	89.2	89.7	89.6	89.5
Part D low-income subsidy enrollees	94.9	93.7	95.3	94.2	95.2	94.1
All other beneficiaries	98.0	97.6	97.5	97.8	97.6	97.7

Note: "Demonstration counties" are counties that have at some point tested the capitated model under the financial alignment demonstration. We calculated retention rates as the number of people who were continuously enrolled in the same plan for the entire year, divided by the number of people who were enrolled in plans in January. We defined a plan as a Medicare Advantage plan, cost plan, the Program of All-Inclusive Care for the Elderly, or Medicare-Medicaid Plan. The figures in this table are based on beneficiaries who had continuous Part A and Part B coverage during the year and do not include beneficiaries who experienced any change in their Medicaid or low-income subsidy eligibility during the year. These figures do not include enrollment in stand-alone Part D plans.

Source: MedPAC analysis of common Medicare environment, denominator, and plan crosswalk files.

As a result, some lock-in provisions for dual eligibles may now be appropriate.

CMS recently issued new regulations limiting the ability of dual eligibles to change their coverage (Centers for Medicare & Medicaid Services 2018a). Under the new rules, dual eligibles can change plans only once 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. As before, dual eligibles can also change plans under the standard MA and Part D rules that apply to all Medicare beneficiaries, such as changing plans after moving. In addition, any beneficiaries who have been assigned to a plan by CMS or a state (which most often happens when dual eligibles are automatically assigned to stand-alone Part D plans) have 90 days to switch to another plan. However, these changes will probably have little effect because the number of dual eligibles who make multiple changes to their coverage in a given year is relatively small.³⁰ We plan to monitor the effects of the new rules on the behavior of dual eligibles.

In 2008, the Commission recommended that the Congress eliminate the ability of dual eligibles to enroll in MA plans outside of the annual enrollment period unless those beneficiaries were enrolling in a special needs plan. The Commission also recommended that dual eligibles in MA plans should be allowed to return to FFS coverage at any time (Medicare Payment Advisory Commission 2008).

Limit enrollment in D-SNPs to full-benefit dual eligibles

One notable difference between D-SNPs and MMPs is their treatment of partial-benefit dual eligibles, whose Medicaid coverage is limited to assistance with the Part B premium and, in some cases, Part A and Part B cost sharing.³¹ Partial-benefit dual eligibles can enroll in a D-SNP if the state authorizes it in its Medicaid contract with the plan, and most states that have D-SNPs allow it. In contrast, partial-benefit dual eligibles cannot enroll in an MMP under the terms of the financial alignment demonstration.

Across the entire MA program in 2016, most partial-benefit dual eligibles were enrolled in conventional plans (64 percent) instead of D-SNPs (33 percent). (The reverse was true for MA enrollees who are full-benefit dual eligibles, with 63 percent in D-SNPs and 31 percent in conventional plans.)³² Although only a third of the partial-benefit dual eligibles in MA are enrolled in D-SNPs, they nonetheless account for a significant portion of overall D-SNP enrollment. Between 2012 and 2016, the number of partial-benefit dual eligibles enrolled in D-SNPs rose from 213,000 to 422,000, and, during the same period, they also grew as a share of D-SNP enrollment, rising from 20 percent to 26 percent.

The share of D-SNP enrollees that are partial-benefit dual eligibles varies widely across states. In 2016, there were nine states where partial-benefit dual eligibles represented

The Commission's previous work on managed care plans for dual eligibles

The Commission has previously examined each type of health plan that integrates Medicare and Medicaid in some manner. This earlier work has consistently supported the development of more highly integrated plans.

Dual-eligible special needs plans (D-SNPs)—In 2013, the Commission examined the role of special needs plans (SNPs), which are Medicare Advantage (MA) plans that can limit their enrollment to one of three groups of beneficiaries: dual eligibles, beneficiaries who need the level of care provided in a long-term care institution, or beneficiaries with certain chronic conditions. At the time, SNPs were authorized only through the end of 2014, but they have since been permanently authorized.

The Commission examined how well SNPs performed on quality measures compared with other MA plans and concluded that, in certain cases, SNPs were one way to better integrate care for beneficiaries with special health care needs. The Commission recommended that the Congress permanently reauthorize D-SNPs that are highly integrated with Medicaid and allow the authority for other, less integrated D-SNPs to expire (Medicare Payment Advisory Commission 2013).

Program of All-Inclusive Care for the Elderly (PACE)—In 2012, the Commission examined PACE, which serves individuals who are 55 or older and eligible for nursing home care. The program's goal is to keep people living in the community instead of long-term care facilities, and almost all enrollees are dual eligibles. The program completely integrates the financing and delivery of Medicare and Medicaid benefits and gives PACE providers strong incentives to properly coordinate and manage care.

Although research suggests that PACE improves the quality of care for its enrollees, the program has always been limited in scope and has about 41,000 enrollees. The Commission made a series of recommendations to broaden the use of PACE, including extending eligibility to people younger than 55, developing appropriate quality measures to enable PACE providers to participate in the MA quality bonus program, and establishing an outlier protection policy for new PACE providers that serve beneficiaries with unusually high costs (Medicare Payment Advisory Commission 2012b).³³

The financial alignment demonstration—In 2012, the Commission sent a letter to CMS that discussed the financial alignment demonstration, which was then being developed. In its letter, the Commission expressed support for the goals of the demonstration, including the proposed use of passive enrollment.

However, the Commission also expressed several concerns about the demonstration. One area of concern was its potential size. At the time, CMS had said it was interested in enrolling as many as 1 million to 2 million dual eligibles in the demonstration, which the Commission felt amounted to a program change instead of a demonstration. The Commission believed that the demonstration's two new models of care should be tested on a smaller scale before being used more broadly.

The Commission also suggested that the demonstration first aim to improve quality and care coordination for dual eligibles and only after that aim to reduce Medicare and Medicaid spending, and we expressed concern that states might participate in the demonstration as a way to use Medicare funds to supplement Medicaid funds (Medicare Payment Advisory Commission 2012a). ■

2 percent or less of total D-SNP enrollment. Several of these states (Arizona, Massachusetts, Minnesota, and New Jersey) have been leaders in using D-SNPs to improve Medicare-Medicaid integration and do not allow their D-SNPs to cover partial-benefit dual eligibles (Verdier et al. 2016). At the other end of the distribution were eight states

where partial-benefit dual eligibles represented more than 50 percent of total D-SNP enrollment. The figure for the state with the highest share, Alabama, was 69 percent.

Medicaid spending on partial-benefit dual eligibles is a fraction of its spending on full-benefit dual eligibles. In

2013, the most recent year of data available, Medicaid spent \$117 billion on full-benefit dual eligibles and \$2 billion on partial-benefit dual eligibles, not including spending on Medicare premiums. On a per capita basis, Medicaid spent an average of \$15,222 on full-benefit dual eligibles and \$695 on partial-benefit dual eligibles (see Table 9-1, p. 246). Medicaid coverage for partial-benefit dual eligibles is sufficiently limited that states typically exclude them from Medicaid managed care programs and continue covering them on an FFS basis.

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 regular MA plan. However, partial-benefit dual eligibles may not need a specialized MA plan given the limited nature of their Medicaid coverage. About half of partial-benefit dual eligibles receive assistance with the Part B premium only, which does not involve the MA 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.³⁴ Some states provide a monthly capitated payment to D-SNPs to cover this cost sharing, but, even in these situations, the role of the plans is still limited, and beneficiaries still receive the same assistance with cost sharing if they are enrolled in regular MA plans. In either case, the need to coordinate Medicare's coverage with Medicaid coverage of important services such as LTSS and behavioral health simply does not exist. Policymakers may thus want to consider limiting enrollment in D-SNPs to full-benefit dual eligibles.

One objection to such a limit on D-SNP enrollment is that some partial-benefit dual eligibles will ultimately become full-benefit dual eligibles and then could benefit from the greater coordination of Medicare and Medicaid that D-SNPs provide compared with regular MA plans. However, the share of partial-benefit dual eligibles who later qualify for full Medicaid benefits is relatively small. As an example, we identified the beneficiaries who were partial-benefit dual eligibles in January 2013 and looked at subsequent changes in their Medicaid eligibility. The share of beneficiaries in this cohort who had become full-benefit dual eligibles was 6 percent in January 2014 (one year later), 9 percent in January 2015 (two years later), and 10 percent in January 2016 (three years later). Other cohorts of partial-benefit dual eligibles followed a similar pattern.

Some beneficiaries may move the other way—from full Medicaid eligibility to either partial Medicaid eligibility or no Medicaid eligibility at all. In these cases, CMS allows beneficiaries to remain in D-SNPs for up to six months if they are expected to regain their eligibility.

Another objection to limiting D-SNP enrollment is the disruption that this change would cause for the partial-benefit dual eligibles now enrolled in D-SNPs. One way to address this concern would be to give these plans' sponsors an opportunity to transfer these beneficiaries to a regular MA plan (i.e., an MA plan that is not a special needs plan).³⁵ In 2016, 93 percent of the partial-benefit dual eligibles in D-SNPs were in plans where the parent company offered a regular MA product in the same county. Plan sponsors could be required to meet certain conditions before they could transfer partial-benefit dual eligibles to a regular MA plan, such as ensuring that the provider networks for the two plans are similar and that the regular MA plan does not charge a Part D premium that exceeds the amount of Part D's low-income subsidy, which all partial-benefit dual eligibles receive.

Expand the use of passive enrollment

One major obstacle to using managed care to better integrate care for dual eligibles is that CMS and states cannot require dual eligibles 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. Expanding the use of passive enrollment could be one way to encourage more dual eligibles to enroll 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 with earlier demonstrations in Minnesota and Wisconsin that developed integrated plans and relied entirely on voluntary enrollment, passive enrollment has resulted in higher enrollment than most states would have been able to achieve with a purely voluntary model.³⁶

The use of passive enrollment could be expanded in ways that would affect different parts of the dual-eligible population. One variant that has received increasing attention is an option for MA plans known as default enrollment or seamless conversion. 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. Plan sponsors must obtain both CMS and state approval before using default enrollment. Beneficiaries who do not want to enroll in their assigned D–SNP can select a different MA plan or FFS coverage.

Default enrollment can be used to encourage some dual eligibles to receive their Medicare and Medicaid services from the same parent company. Without default enrollment, individuals who are in comprehensive Medicaid plans and become eligible for Medicare often go from having one source of coverage to three: Medicare FFS coverage, a stand-alone Part D plan, and the Medicaid plan (which would continue to cover non-Medicare services such as LTSS). With default enrollment, the individual would instead be enrolled in the same company’s Medicaid plan and D–SNP. Supporters argue that default enrollment promotes care coordination and is less disruptive for beneficiaries because they are already familiar with the parent company and can largely continue seeing their existing providers since many providers accept patients for all of a given company’s products.

The use of default enrollment for dual eligibles is currently limited to about 30 D–SNPs (Centers for Medicare & Medicaid Services 2016d). Many of those plans are located in Arizona and Tennessee, which require their MLTSS plans to offer companion D–SNPs and obtain CMS approval to use default enrollment. In October 2016, CMS suspended approval of new requests to use default enrollment while it reviewed its policies on the issue (Centers for Medicare & Medicaid Services 2016e). At the time, default enrollment was also being used for individuals who were not dual eligibles, such as individuals who had commercial coverage and were being passively enrolled in regular MA plans when they qualified for Medicare. In April 2018, the agency issued new regulations limiting the use of default enrollment to individuals who are in comprehensive Medicaid managed care plans and D–SNPs (Centers for Medicare & Medicaid Services 2018a). The use of default enrollment will likely grow in the future as more states develop Medicaid MLTSS programs, where plans are often required to offer a companion D–SNP.

States that use default enrollment for dual eligibles report that opt-out and disenrollment rates are low. Both Arizona and Tennessee (which have passively enrolled about 7,000 and 5,300 dual eligibles, respectively) found that about 5 percent of beneficiaries opted out before their

passive enrollment in a D–SNP took effect and another 5 percent disenrolled within the first 3 months (Arizona Health Care Cost Containment System 2018, National Association of Medicaid Directors 2018). There have also been very few beneficiary complaints about the default enrollment process. Texas began using default enrollment in mid-2017 to enroll dual eligibles in the MMPs in its financial alignment demonstration. During our site visit there, the plan representatives we interviewed all indicated that these beneficiaries had noticeably lower opt-out and disenrollment rates than other beneficiaries who had been passively enrolled, although they did not provide any supporting data.

Default enrollment can be used for only some dual eligibles—those who qualify for Medicaid first and then for Medicare—and applies only when they first qualify for Medicare. Nevertheless, about half of all dual eligibles qualify for Medicaid first, so more widespread use of default enrollment could ultimately affect a significant number of dual eligibles.

Passive enrollment could also be used more widely for certain beneficiaries in the other half of the dual-eligible population—those who qualify for Medicare first and then for Medicaid. For example, CMS and states could use a strategy that is analogous to default enrollment for beneficiaries who are enrolled in a regular MA plan and later qualify for Medicaid. These individuals could either be automatically enrolled in the parent company’s Medicaid plan and transferred from their current MA plan to the company’s D–SNP, or they could be enrolled in an integrated plan like an MMP. The rationale for using passive enrollment in these situations would be similar to the rationale for default enrollment: improved care coordination and continuity of care. However, using passive enrollment in this manner would likely affect a much smaller number of dual eligibles than default enrollment because many companies that offer MA plans in a state may not offer a Medicaid managed care plan or a fully integrated plan like an MMP.

Finally, passive enrollment could also be used for other types of dual eligibles such as those with Medicare FFS coverage or those enrolled in MA plans where the parent company does not have any Medicaid-related plans. However, the experience with the financial alignment demonstration suggests that passively enrolling these beneficiaries would be more challenging because they would be more likely to lose access to some of their existing providers. States have tried to mitigate this

difficulty by assigning dual eligibles to MMPs that have all or most of their providers in their networks, but the effectiveness of these “intelligent assignment” efforts is somewhat limited.³⁷ Some states also needed to revise their beneficiary notices to make them easier to understand, and even then, several stakeholders we interviewed said that some dual eligibles did not realize they had been passively enrolled until after their MMP coverage had started.

Conclusion

Managed care plans that provide both Medicare and Medicaid benefits for dual eligibles could serve as a vehicle to better integrate the two programs, improve the quality of care, and reduce both federal and state spending. The development of these integrated plans has

been the primary focus of CMS’s financial alignment demonstration. Delays in completing the demonstration’s evaluations are a significant concern given the widespread interest in understanding its impact on access to care, service use, costs, and quality. Nevertheless, much of the information that is currently available, while limited, is relatively positive.

Despite the demonstration’s progress, only 8 percent of full-benefit dual eligibles are enrolled in highly integrated plans. However, more states are enrolling dual eligibles in Medicaid managed care, and interest in developing integrated plans is likely to grow. Federal policymakers may want to reexamine the array of Medicare plans (D-SNPs, FIDE SNPs, MMPs, and PACE) that serve dual eligibles. These plans differ in important respects, such as the degree to which they integrate Medicare and Medicaid, and can sometimes compete against each other. Policy changes to better define their respective roles or consolidate them in some fashion may be needed. ■

Endnotes

- 1 Activities of daily living (ADLs) include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.
- 2 Medicare is the primary payer for any services that are covered by both programs, such as inpatient care and physician services.
- 3 Minnesota is testing new ways to integrate Medicare and Medicaid administrative functions in its Minnesota Senior Health Options (MSHO) program, which integrates care for dual eligibles using Medicare Advantage dual-eligible special needs plans and companion Medicaid managed care plans. The MSHO program is otherwise unchanged (Centers for Medicare & Medicaid Services 2013).
- 4 None of the demonstrations that have tested integrated plans have used random selection to determine which beneficiaries participate. The available studies on integrated plans therefore compare the beneficiaries with a “control” group of dual eligibles with similar demographics and health status. However, the absence of random selection means that the two groups may differ in other, unobserved ways that affect the study’s results.
- 5 Colorado’s managed FFS demonstration had enrolled dual eligibles in a network of care coordination organizations that the state has developed to serve its Medicaid population. The state has continued to enroll dual eligibles in these organizations after the end of the demonstration, so the impact on their care should be minimal (Colorado Department of Health Care Policy & Financing 2017). Virginia has replaced its capitated demonstration with a program that requires dual eligibles to enroll in managed care for their Medicaid benefits and promotes the integration of Medicare and Medicaid by requiring the sponsors of these Medicaid plans to offer companion Medicare Advantage dual-eligible special needs plans (Virginia Department of Medical Assistance Services 2017).
- 6 CMS typically requires states to have at least two MMPs available to conduct passive enrollment. The second New York demonstration has only one MMP and has never used passive enrollment. Rhode Island also has just one MMP, but dual eligibles who had been enrolled in a Medicaid managed care plan offered by the same parent company were transferred to the MMP, a form of passive enrollment known as crosswalking. Rhode Island has not otherwise used passive enrollment.
- 7 Under the demonstration, dual eligibles can leave an MMP at any time. Beneficiaries who choose to leave remain enrolled in the MMP until the end of the month, and their new coverage starts the following month. When beneficiaries disenroll from an MMP, they can switch to FFS or enroll in an MA plan for their Medicare coverage.
- 8 We stratified beneficiaries based on the total number of months they were enrolled in an MMP, even if that crossed into other years. For example, a beneficiary who was enrolled from November 2014 through June 2015 was counted as someone who had been enrolled for a total of eight months.
- 9 These beneficiaries are “healthier” only when compared with the other dual-eligible beneficiaries who can participate in the demonstration. The risk scores in Table 9-5 (p. 253) are all well above 1.0, indicating that the dual eligibles in the demonstration are expected to be much more costly than the average Medicare beneficiary.
- 10 These studies are much older because states have largely moved in the years since to make enrollment in Medicaid managed care mandatory. Favorable selection is thus less of an issue in Medicaid managed care than it once was.
- 11 RTI has also issued annual evaluations for the first year of the demonstrations in Washington, which is testing the managed FFS model, and Minnesota, which is testing an alternate model.
- 12 The number of MMPs reporting CAHPS data is smaller than the total number of MMPs in the demonstration because plans with fewer than 600 enrollees are not required to conduct the survey.
- 13 We excluded MA enrollees in Kaiser plans from our analysis because those plans are outliers with much better performance than other plans. For example, MMPs perform poorly on potentially preventable hospital admissions when Kaiser enrollees are included in the comparison group of MA enrollees, but perform at about the same level when Kaiser enrollees are excluded. Kaiser plans account for about 6 percent of the full-benefit dual eligibles enrolled in MA plans.
- 14 The 2016 increase applied only to the MMPs. In 2017, CMS raised payment rates for all full-benefit dual eligibles, including those in MA plans, by adopting a new version of the risk adjustment model (Centers for Medicare & Medicaid Services 2016a).

- 15 For example, one core measure in the later years of the demonstration is the flu vaccination rate—the share of beneficiaries who receive a flu shot. An MMP passes the measure if its performance (1) meets or exceeds the benchmark of 69 percent or (2) improves by an amount equal to 10 percent of the difference between the benchmark and the plan’s performance in the previous year. A plan that had a vaccination rate of 50 percent in the first year could thus pass the measure in the second year if its rate were 51.9 percent or better (i.e., the previous performance of 50 percent plus 1.9 percentage points, which is 10 percent of the difference between the benchmark of 69 percent and 50 percent).
- 16 For Washington, the estimated Medicare savings for the July 2013 to December 2014 period (\$35 million) are final, while the estimated savings for 2015 (\$32 million) are preliminary.
- 17 This figure is based on December 2016 enrollment in three types of plans that we consider highly integrated—MMPs, fully integrated dual-eligible special needs plans in MA, and PACE.
- 18 The Bipartisan Budget Act of 2018 requires the Secretary to unify the grievances and appeals processes for beneficiaries in MA dual-eligible special needs plans “to the extent feasible.” It is not yet clear how the Secretary will use this authority.
- 19 These figures are based on the states that had expanded coverage as of April 2017. In November 2017, voters in Maine approved a referendum to expand Medicaid coverage, but it has not yet been implemented.
- 20 The eight states were Arizona, Florida, Massachusetts, Michigan, Minnesota, New York, Texas, and Wisconsin.
- 21 States interested in developing programs that require dual eligibles to enroll in managed care must obtain a waiver under Sections 1115 or 1915(b) of the Social Security Act. CMS can approve these waivers for up to five years. However, these waivers are almost always renewed (although they may be modified over time) and effectively amount to permanent changes in a state’s Medicaid program.
- 22 The Bipartisan Budget Act of 2018 requires D–SNPs to meet new standards for Medicaid integration starting in 2021. However, the legislation leaves it to CMS to specify how some of those standards will be implemented, and at this point it is unclear what effect the legislation will have on the level of integration in D–SNPs. Similarly, the legislation requires the Secretary to unify the separate Medicare and Medicaid grievances and appeals processes for D–SNP enrollees “to the extent feasible,” and it is unclear how this authority will be used.
- 23 MMPs have a small number of beneficiaries (about 1,100 as of December 2016) who are partial-benefit dual eligibles. These beneficiaries lost their eligibility for full Medicaid benefits after joining their plan and remained enrolled during a grace period that plans can provide to beneficiaries who are expected to regain full Medicaid eligibility.
- 24 Roughly half of FIDE SNPs qualify for a frailty adjustment in any given year. The adjustment usually increases a plan’s Medicare payments by between 5 percent and 10 percent.
- 25 Illinois has since closed its D–SNPs by exercising its right to stop signing Medicaid contracts with them. Starting in 2018, the state now relies entirely on MMPs as its platform for greater Medicare–Medicaid integration (Integrated Care Resource Center 2017).
- 26 One consequence of this policy was that the beneficiaries who had been in these D–SNPs and subsequently opted out or disenrolled from MMPs could not return to the D–SNPs. They had to choose another MA plan or FFS coverage.
- 27 Three of the 10 companies that sponsor MMPs also offered a look-alike plan in 2017. The three look-alike plans have a combined enrollment of about 38,000 beneficiaries. During our site visit, an official with one of those companies said the company had decided to offer a look-alike plan so it could retain some of the beneficiaries who were opting out or disenrolling from its MMP.
- 28 The annual enrollment period runs from October 15 to December 7, and any changes take effect on January 1. Under the 21st Century Cures Act, starting in 2019, beneficiaries enrolled in MA plans will also have an “open enrollment period” that will run from January 1 to March 31. During this time, they will be able to make one change to their coverage, such as switching to another MA plan or electing FFS coverage.
- 29 These figures are lower than the switching rates that have been published in some other studies, such as Jacobson and colleagues (2016). Our analysis included FFS beneficiaries who did not change their coverage, while other studies may be limited to beneficiaries who are enrolled in plans. As a result, the denominator for our switching rates is larger, and the switching rates are correspondingly lower.
- 30 CMS does not appear to have the authority to fully apply the MA and Part D lock-in provisions to dual eligibles. The Part D statute requires the Secretary to provide a special enrollment period for dual eligibles, so it appears that CMS can limit the added flexibility that dual eligibles have to join, leave, or switch plans, but cannot eliminate it entirely.

- 31 Some partial-benefit dual eligibles also qualify for coverage of the Part A premium if they do not have enough work history to qualify for premium-free Part A coverage.
- 32 The remaining dual eligibles, both partial benefit and full benefit, were enrolled largely in special needs plans that serve beneficiaries with certain chronic conditions.
- 33 The Commission also found that Medicare payments to PACE plans were 17 percent higher than FFS spending on comparable beneficiaries and recommended that PACE plans be paid using the standard MA payment system.
- 34 Unlike medigap plans, Medicaid allows states to limit their coverage of cost sharing for dual eligibles to the difference (if any) between the state's Medicaid rate and the Medicare payment amount. Almost all states use this approach for at least some services.
- 35 CMS allows MA plan sponsors to transfer beneficiaries to new plans at the start of each year, but this process is subject to certain limits. For example, sponsors cannot transfer beneficiaries to a different type of plan (e.g., from an HMO to a preferred provider organization), and they cannot transfer beneficiaries from a SNP to a regular MA plan. However, an exception could be made because partial-benefit dual eligibles would no longer be eligible to enroll in a D-SNP.
- 36 For example, the Minnesota Senior Health Options program had about 5,600 enrollees in 2004, seven years after it started (Kane and Homyak 2004).
- 37 States in the demonstration have typically relied on FFS Medicare and FFS Medicaid claims data to determine which MMP provider network is the "best fit" for a dual eligible. However, there is an inherent lag before these data become available, and they may not capture more recent changes in a beneficiary's providers. States have also had to decide which providers take precedence in assigning dual eligibles to a particular MMP, with some states prioritizing primary care physicians and others prioritizing LTSS providers such as personal care attendants. We have found from our site visits that any algorithm inevitably has shortcomings because the care needs of the dual-eligible population are so diverse.

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