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Improving Integration for Dual Eligible Beneficiaries: The Role of D-SNPs

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KEY HIGHLIGHTS

- Dual eligible beneficiaries typically have poorer health status and limited economic resources compared to non-duals and face challenges navigating fragmented benefits across two insurance programs.
- Dual Eligible Special Needs Plans (D-SNPs) offer states a continuum of options to better integrate care and services compared to what is available through the unmanaged fee-for-service system.
- Early results indicate that state partnerships with D-SNPs have improved access and quality, reduced fragmentation, and lowered the cost of care while also providing a better beneficiary experience.

Contents

Overview

There are a number of paths that states can pursue to integrate benefits and coordinate care for individuals who are eligible for both Medicare and Medicaid benefits ("dual eligible beneficiaries" or "duals").[1]

Medicare is the primary funding source for the medical services that dual eligible beneficiaries receive while Medicaid pays for services and supports that are only partially covered by Medicare or not covered at all (e.g., long-term care).[2] This paper focuses on the role that Dual Eligible Special Needs Plans (D-SNPs) can play in improving care delivery and health outcomes across the Medicare and Medicaid programs.

Special Needs Plans, created as part of the Medicare Modernization Act of 2003, are a type of Medicare Advantage Plan that serve specific groups of beneficiaries.[3] D-SNPs—one type of these special needs plans—enroll only beneficiaries eligible for both Medicare and Medicaid. The D-SNP model offers states a continuum of options with increasing levels of integration and coordination, through the adoption of more active and expansive contracting strategies.

D-SNPs can play an important role in **improving care delivery and health outcomes** across the Medicare and Medicaid programs.

In examining states' experiences with D-SNPs, as well as the results of several early studies, this paper finds that D-SNPs can offer a number of benefits that advance whole person health for dual eligible beneficiaries, including:

- Improvements in beneficiary experience and care coordination;
- Greater use of primary care services and access to certain benefits;
- Simplifications for providers serving dual eligible beneficiaries; and,
- Opportunities to better integrate long-term services and supports (LTSS).

Integration Opportunities for Dual Eligible Beneficiaries

A 2012 survey of all 50 states and the District of Columbia found that two-thirds of states were interested in implementing a range of new initiatives to better integrate and coordinate care and services for dual eligible beneficiaries.[4] As of January 2020, there were 551 D-SNPs serving over 2.8 million dual eligible beneficiaries across 42 states, the District of Columbia, and Puerto Rico.[5]

In addition, since 2013, 11 states have tested the flexibility offered by the Financial Alignment Initiative or "duals demonstration." The demo provides access to two models—a managed fee-for-service model and a capitated model, also known as a Medicare-Medicaid Plan (MMP). As of February 2020, demonstrations in nine states serve a combined enrollment of about 371,000 dual eligible beneficiaries.[6] In April 2019, the Centers for Medicare & Medicaid Services (CMS) announced that states could expand the geographic scope of certain demonstrations or issue multi-year extensions; CMS also announced it was allowing new states to join the demo.[7]

States' interest in integrating care stems from the recognition that **dual eligible beneficiaries experience fragmented care in the fee-for-service system.**

States' interest in integrating care stems from the recognition that dual eligible beneficiaries experience fragmented care in the fee-for-service (FFS) system. Further, states continue to face high costs for duals in FFS without seeing meaningful improvements in outcomes and quality. Recent evidence shows that D-SNPs can enhance whole person health by improving dual eligible beneficiaries' experience and health outcomes, especially when Medicare and Medicaid benefits are more fully aligned or integrated.[8]

Long-Standing Challenges with Serving Dual Eligible Beneficiaries

Dual eligible beneficiaries' healthcare services and supports are often costly and complex. Relative to non-duals, they have poorer health status and limited economic resources, along with the challenges they face in navigating fragmented benefits across two insurance programs; the result is higher federal and state costs.[9]

Policymakers have long focused on ways to improve the quality of care and health outcomes for dual eligible beneficiaries while simultaneously providing more holistic, cost-effective care.

Dual eligible beneficiaries tend to have more significant healthcare needs in comparison to other Medicare beneficiaries. Three times as many duals compared to non-duals report being in poor health (18 percent compared to 6 percent).[11] Further, 41 percent of dual eligible beneficiaries have at least one mental health diagnosis, while 68 percent have multiple chronic conditions.[12] Twenty-one percent of duals report living in an institution, compared to only 5 percent of non-duals.[13]

Dual eligible beneficiaries represent a disproportionate share of Medicare and Medicaid spending relative to their share of enrollment in each program.[14] In 2013, duals represented approximately 20 percent of Medicare beneficiaries but accounted for about 34 percent of Medicare spending. In Medicaid, they accounted for an estimated 15 percent of enrollment but 33 percent of total spending.[15] Average per-beneficiary total spending for dual eligible beneficiaries is more than twice that for non-duals.[16]

Many duals experience challenges in navigating their healthcare benefits, particularly when separately enrolled in FFS Medicare and Medicaid, because they are covered by two different programs, often with two different provider networks. Medicare covers inpatient and outpatient healthcare services and prescription drugs, while Medicaid covers LTSS, augmented behavioral health services, additional "wrap" services that may include non-medical transportation, dental and vision benefits, and payment of some or all Medicare premiums and cost-sharing.[17] The uncoordinated and often confusing benefit and payment systems in FFS can lead to fragmented care delivery and worse health outcomes for individuals.

Likewise, the administration and delivery of services for dual eligible beneficiaries in FFS is complicated by differing and sometimes conflicting policies, rules, and requirements between Medicare and Medicaid. This is further compounded by the divergent centers of control and accountability for the two programs, since Medicare is administered solely by the federal government and Medicaid is administered by each state within a federal framework. The resulting regulatory and administrative complexity has hampered the development of a truly integrated benefit package for dual eligible beneficiaries.

Dual Eligible Beneficiaries Face Significant Health Challenges[10]

have multiple chronic conditions

have at least one mental health condition

report living in an institution

report having "poor" health status

have Alzheimer's disease or related dementia

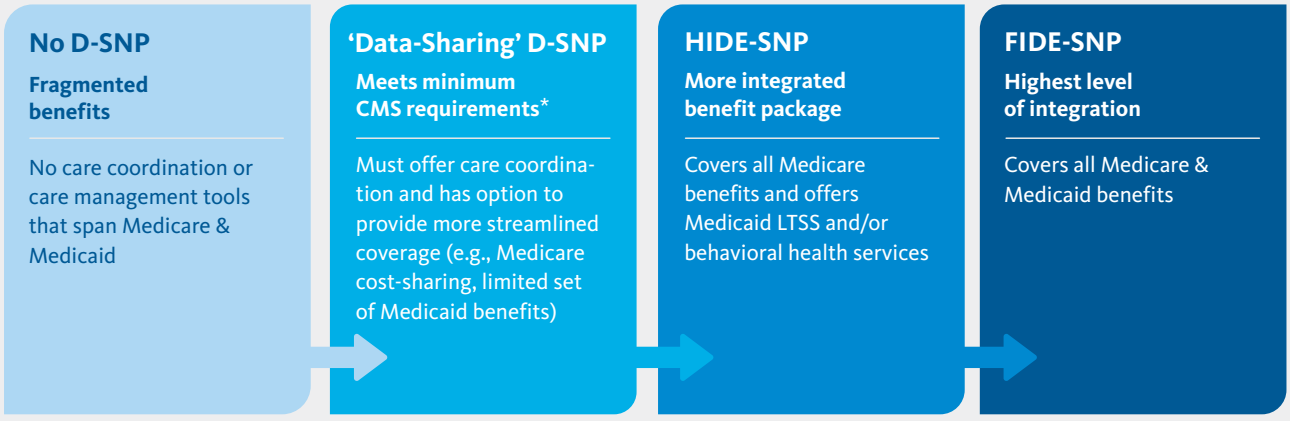
D-SNPs Offer States Flexible Options for Integration

States have long been focused on improving coordination of care and services for dual eligible beneficiaries, with demonstration efforts dating back to the 1990s.[18] The initial efforts included relatively small demonstration programs in a handful of states but, over the past 20 years, these initiatives have grown in number and scope.

D-SNPs were created by the Medicare Modernization Act in 2003[19] and now operate in 42 states, the District of Columbia, and Puerto Rico.[20] In 2018, the Bipartisan Budget Act (BBA) permanently authorized SNPs, following about a decade of annual or bi-annual reauthorization.[21]

There are three types of D-SNP plans, two of which reflect higher levels of integration. (Figure 1) D-SNPs that meet CMS' minimum requirements for data sharing offer the least integrated approach available. These "data-sharing" D-SNPs do not integrate Medicare and Medicaid benefits. Instead, data-sharing D-SNPs must notify the state when a specified group of high-risk beneficiaries are admitted to a hospital or skilled nursing facility (SNF)—to support Medicare-Medicaid coordination across care settings.[22] D-SNPs' contracts with states must also specify the timeline and process for providing this notice.

Figure 1
Continuum of D-SNP Contracting Options



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*Minimum integration requirements set forth by the Bipartisan Budget Act of 2018.
All D-SNP types must provide Medicare Part A and B benefits and offer Part D prescription drug benefits.

Flexibility available in the continuum of available D-SNP options provides states with the **opportunity to develop a program that best fits their needs and populations.**

Highly Integrated Dual Eligible SNPs (HIDE-SNPs), created by the BBA in 2018, must integrate LTSS, behavioral health services, or both. HIDE-SNPs require more integration of Medicare and Medicaid benefits than data-sharing D-SNPs.

Fully Integrated Dual Eligible SNPs (FIDE-SNPs), officially authorized by the Affordable Care Act in 2010, are D-SNPs with state contracts that include all Medicaid services, including LTSS.[23] FIDE-SNPs have the highest degree of benefit integration under the D-SNP model, offering a single source of coverage for all Medicare and Medicaid benefits.

FIDE-SNPs are required to have policies and procedures that better coordinate or integrate enrollment processes, member materials, communications, grievances and appeals, and quality improvement. FIDE-SNPs also have flexibility to offer supplemental benefits not typically covered by Medicare and not otherwise covered by Medicaid.[24] Certain FIDE-SNPs are eligible for additional payments to account for the frailty of their enrollees. (See page 8 for more information on these three types of D-SNP plans.)

D-SNPs offer a valuable option for states to move toward better integration and alignment, especially now that they are authorized permanently. D-SNPs offer flexibility for states and may require fewer state resources to start or expand than a demonstration program would require. The National Association of Medicaid Directors (NAMD) has observed that D-SNPs "are well suited to become a preferred pathway to achieve meaningful improvements for beneficiaries."[25]

The continuum of options available to states wishing to contract with D-SNPs, from the minimum requirements to full integration of Medicare and Medicaid benefits under a FIDE-SNP, is intended to provide the necessary flexibility for states to develop a program that best fits their needs and populations.

Each state—depending on its existing Medicaid infrastructure and programs, available administrative resources, and competing priorities—will carve its own unique path towards integration. The diversity of states using D-SNPs underscores that, regardless of differences across states, D-SNPs are an adaptable tool for advancing integration and promoting whole person health for beneficiaries.

New Integration Requirements for D-SNPs

In the BBA of 2018, Congress imposed new requirements for D-SNPs. These go beyond prior requirements for contracts between states and D-SNPs in order to increase integration of Medicare and Medicaid benefits. Subsequent rulemaking, finalized by CMS in April 2019, implemented the requirements set forth in the BBA. Under this rulemaking, beginning in 2021, D-SNPs must meet at least one of the following (or be subject to sanctions in the form of an enrollment freeze): [26, 27]

1 Meets CMS requirements as a FIDE-SNP

Medicare and Medicaid benefits are provided under a single entity that:

- ✔ Has a contract with CMS to operate as an MA plan
- ✔ Has a contract with the state to operate as a Medicaid MCO
- ✔ Coordinates care delivery and coordinates or integrates certain administrative functions
- ✔ Covers Medicaid benefits consistent with state policy, including LTSS and nursing facility services for a minimum of 180 days during each plan year

2 Meets CMS requirements as a HIDE-SNP

Entity provides Medicare benefits and coordinates provision of certain Medicaid benefits by:

- ✔ Having a contract with CMS to operate as an MA plan
- ✔ Covering Medicaid LTSS and/or behavioral health services, consistent with state policy, under a capitated contract between the state and
  - (a) the MA organization,
  - (b) the MA organization's parent organization, or
  - (c) another entity owned by the MA organization or parent organization

3 Meets CMS requirements for data sharing regarding hospital and SNF admissions

Entity has a contract with the state that specifies:

- ✔ Criteria for identifying the high-risk group of dual eligible beneficiaries subject to the notification process
- ✔ Process for notifying the state agency or its designee(s) when an admission occurs
- ✔ Timeframe for when notification must be provided
- ✔ Method by which notification will be provided

Advancing Integration Can Improve Beneficiary Care and Experience

Aligning benefits and services across Medicare and Medicaid continues to be a challenge. Some states have examined pathways for achieving greater alignment and are finding that D-SNPs offer the most flexible and accessible option, especially at a time of limited resources and competing priorities.

D-SNP contracts allow states to add health plan requirements that enhance coordination across Medicare and Medicaid, including provisions for training staff on LTSS benefits, reporting key Medicare information to the state, aligning eligibility and enrollment processes, and facilitating the coordination of benefits and care management for members.[28]

Greater integration can reduce duplication of benefits and **deliver value to members while reducing program costs.**

As states consider the best approach to integration for dual eligible beneficiaries based on their unique needs and priorities, partnership with D-SNPs offers many potential benefits. D-SNPs can meet states "where they are" along the care continuum—or help states move to where they'd like to be—while advancing efforts to improve beneficiary care and experiences. Greater integration can also reduce duplication of benefits and deliver value to the member while reducing program costs.

States that have been testing and building on D-SNPs as a vehicle for integration are seeing positive results for their beneficiaries.

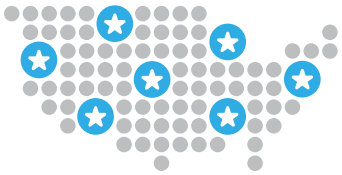
- In Minnesota's Senior Health Options (MSHO) program, dual eligible beneficiaries in the integrated MSHO plans are less likely than duals in a non-integrated plan to utilize hospital or emergency department (ED) services, and are more likely to use primary care or other outpatient services.[29] Additionally, beneficiaries in the MSHO program were more likely to use home and community-based long-term care services.[30]
- In New Jersey, initial data suggests improved beneficiary satisfaction, as well as lower hospital readmission rates after the first year of their multi-year integration effort that used D-SNPs to transition to FIDE-SNPs over time.[31]
- In Arizona, D-SNP enrollees have lower rates of hospitalization and ED use compared to dual eligible beneficiaries in FFS.[32, 33]

These early results from pioneering states indicate the potential value states can realize when using D-SNPs to drive alignment across Medicare and Medicaid.

D-SNPs Can Improve the Beneficiary Experience

States can use D-SNPs to create a structure that works better for dual eligible beneficiaries—providing individuals with seamless access to benefits and services that promote whole person care. D-SNPs assist members in navigating the entirety of their benefits. For instance, states and D-SNPs can work together to simplify things such as referrals for care or cost sharing, and the D-SNP can serve as a single point of access for beneficiaries as they access services.

D-SNPs also provide a single point of care coordination for covered services. Plans are able to track and help coordinate the services that members receive, which can be especially important for dual eligible beneficiaries. As a result, D-SNP members may have a more seamless experience accessing needed services or avoiding duplicative care and costs.



As states move to increasingly integrated models, **beneficiary experience can continue to improve.**

Beneficiary experience can continue to improve as states move to increasingly integrated models. In 2012, New Jersey began its duals initiative and has since moved to the FIDE-SNP model. Along the way, state officials cite positive impacts on beneficiary satisfaction and provider-patient relationships.[34] D-SNPs are positioned to help states monitor and evaluate beneficiary experiences such as by tracking enrollment (and disenrollment) rates as well as gathering data on beneficiary satisfaction.

The success of D-SNPs is dependent on early outreach to and engagement of stakeholders, especially beneficiary and consumer advocates and providers, early in the process. States can also involve local offices of State Health Insurance Assistance Programs (SHIPs) in educating beneficiaries about the benefits of integrated plan options.

D-SNPs Can Improve Care for Dual Eligible Beneficiaries

States can use their contracts with D-SNPs as a mechanism for improving care management activities across programs. Plans, especially those with experience serving members in Medicaid managed care organizations (MCOs), have deep experience in care coordination and can leverage their care management infrastructure and tools to provide meaningful coordination for dual eligible beneficiaries. Plan-based care coordinators can identify and meet beneficiary needs, authorize services, and act flexibly and quickly when new needs are identified.

Data from Minnesota and Arizona highlight positive outcomes for enrollees in D-SNPs. Compared to duals not in an integrated plan, dual eligible beneficiaries enrolled in Minnesota's MSHO program were:[35]

- 48 percent less likely to have a hospital stay;
- 16 percent less likely to use assisted living or nursing home facilities, but more likely to use home and community based services (HCBS);
- 6 percent less likely to have an ED visit; and,
- 2.7 times more likely to have a primary care visit (but those with at least one primary care visit had 36 percent fewer primary care visits overall—likely because primary care doctors were able to provide coordinated care in fewer visits).

In Arizona, dual eligible beneficiaries in aligned health plans compared to those in Medicare FFS had:[36]

- 43 percent lower rate of days spent in a hospital;
- 31 percent lower rate of hospitalization;
- 21 percent lower readmission rate; and,
- 9 percent lower rate of ED use.

In New Jersey, D-SNP members have access to enhanced benefits such as unlimited days in nursing facilities when appropriate, a comprehensive dental benefit, zero-dollar co-payments at pharmacies, integrated MLTSS, and HCBS.[37]

D-SNPs may leverage network relationships from other lines of business and offer improved access to certain providers in-network, including those that may not typically serve Medicaid members. Also of note, D-SNPs can work closely with providers to implement promising practices focusing on cultural and linguistic competence. When plans and providers better understand and communicate with beneficiaries about their preferences and needs, greater member engagement and higher satisfaction are achieved.

D-SNPs Can Create Efficiencies for Providers and States

D-SNPs offer the opportunity to engage providers in **new and innovative ways that incentivize whole person care.**

Greater levels of integration in a D-SNP contract can improve the experience of physicians and other healthcare providers that care for dual eligible beneficiaries. For instance, including coverage for Medicaid cost sharing under a D-SNP contract simplifies billing practices because providers do not have to bill Medicare and Medicaid separately. In a FIDE-SNP, providers work with a single plan for all coverage determinations and reimbursement, which also helps streamline administrative processes.

Providers may also find it helpful to their own care management efforts to have access to the care coordination services that D-SNPs offer members. Working with a plan in an integrated environment can help align efforts on quality improvement and streamline reporting.

D-SNPs also offer the opportunity to engage providers in new and innovative ways that incentivize whole person care. For instance, D-SNPs can work with providers to develop global risk arrangements under which providers receive payments for both the Medicare and Medicaid services and take on risk for delivering improved outcomes and beneficiary experience.

The efficiencies that D-SNPs create through better coordination and care management across the Medicare and Medicaid program can also have a meaningful impact on program costs. One study found that a one percent increase in D-SNP enrollment led to a 0.2 percent decrease in Medicare spending per beneficiary.[38]

States Can Integrate New Benefits into D-SNP Contracts As They Are Ready

As states and plans gain experience working together, additional Medicaid benefits, including LTSS, can be added to D-SNPs' contracts over time. Some states are more closely examining the linkages between Medicare utilization and Medicaid LTSS spending to make the case for integration of all Medicaid benefits.

Also, D-SNPs can manage short-term skilled nursing home stays and then help beneficiaries return to the community using HCBS to reduce institutionalization. When plans manage LTSS, they can help members avoid or delay institutionalization and instead remain in the community and access services via HCBS.

While the BBA requires a minimum level of integration in D-SNPs, states retain flexibility to pursue greater integration and execute contracting arrangements best suited to their goals, resources, and care delivery systems. In fact, in its final rule implementing the BBA provisions, CMS stated that its intent is to "support states that are operating successful programs and assist those seeking to establish more integrated programs."[39] Indeed, the final rule also gave states that are not yet ready to stand up a FIDE-SNP—but that are seeking more integration than a standard D-SNP—the option of a HIDE-SNP.

Conclusion

States and plans should endeavor to provide the highest level of integration possible for dual eligible beneficiaries. Fully integrated and coordinated care that focuses on whole person health can improve outcomes and the wellbeing of beneficiaries.

D-SNPs offer states a partnership to increase access, improve quality, reduce fragmentation, and lower the cost of care.

Where feasible for the state, FIDE-SNPs are the optimal choice where health insurers have aligned Medicare and Medicaid plans. Otherwise, plans should partner with the state to offer HIDE-SNPs and/or data-sharing D-SNPs that comply with CMS requirements. In any of these instances, states and plans would be providing members with a better level of integrated care and services than what they receive through the unmanaged FFS system.

D-SNP plans offer states a partnership to increase access, improve quality, reduce fragmentation, and lower the cost of care for dual eligible beneficiaries. Early results point to improved care coordination, more appropriate access to and use of acute and long-term care services, and a better beneficiary experience.

Endnotes

1 Unless otherwise noted, this paper uses the term "dual eligible beneficiaries" or "duals" to refer to "full benefit" dual eligible beneficiaries, who are eligible for full Medicaid and Medicare benefits; not included are "partial benefit" dual eligible beneficiaries, who are eligible only for Medicaid payment of their Medicare cost-sharing amounts or Medicare Part B premiums.

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