

Chapter 2:

# Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

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## Recommendations

- 2.1 The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.
- 2.2 Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

## Key Points

- Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integrating care for this high-cost, high-need population has the potential to improve care and reduce federal and state spending, but only about 10 percent of dually eligible beneficiaries are enrolled in integrated care programs.
- MACPAC's work is focusing on strategies to increase enrollment in integrated models, make integrated products more widely available, and promote greater integration in existing products. The Commission has heard from a variety of stakeholders about innovative and successful efforts to integrate care as well as about the challenges associated with implementing these programs.
- Given lower than expected enrollment in Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative, changes in policy are needed to promote higher enrollment and retention of enrollees. The Commission's recommendation would allow eligible beneficiaries to enroll into MMPs at any time but limit opportunities to change plans and disenroll.
- States face resource constraints and competing priorities that impede the development of essential Medicare expertise and limit their ability to finance the up-front costs of establishing integrated care models. To enhance state capacity, the Commission recommends additional federal funding to train state staff in Medicare and to cover up-front costs of designing and implementing new models.
- The Commission's work in this area is a multiyear project that will focus on a range of policy options that further integrated care. For example, we are planning additional work to understand state use of default enrollment as a tool to increase enrollment in dual eligible special needs plans (D-SNPs) aligned with managed long-term services and supports. We also expect to explore how the MMP model could be made more widely available and how states can maximize their contracting authority to tailor D-SNP contracts.

## CHAPTER 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

Individuals who rely on both Medicaid and Medicare for coverage may experience fragmented care and poor health outcomes when delivery of health services and administration of benefits are not coordinated across the two programs. These 12.2 million dually eligible beneficiaries represent about one-third of total costs to the federal government and to states in each program (CMS 2020a). Integrating care has the potential to improve their health and reduce federal and state spending. Higher rates of morbidity and mortality from COVID-19 among individuals who are older or have underlying health conditions—many of whom may be dually eligible—suggest an even greater need for care coordination during this pandemic (CDC 2020).

States and the federal government have been working together to develop and implement a variety of integrated care models and increase the number of beneficiaries enrolled in them. Although some models have been in use for many years and newer options are maturing, the number of beneficiaries enrolled in integrated care remains relatively low, at about 10 percent of dually eligible beneficiaries, or about 1 million people (CMS 2020a).

There is also room for growth in the number of states participating in various integrated care models and the number of enrolled beneficiaries:

- Medicare-Medicaid Plans (MMPs), the most highly integrated option tested and available to the largest share of dually eligible beneficiaries, are available in only nine states.
- Dual eligible special needs plans (D-SNPs), including fully integrated dual eligible special needs plans (FIDE SNPs), that are aligned with managed long-term services and supports

(MLTSS) programs, allowing high levels of coordination between Medicaid managed care and Medicare Advantage (MA) plans, are available in 15 states (Appendix 1A, Table 1A-1).

- States can increase integration through default enrollment of existing Medicaid managed care enrollees into affiliated D-SNPs when they become newly eligible for Medicare (previously referred to as seamless conversion); seven states currently do so (ICRC 2020a).

In the Commission's view, increasing both the availability of integrated care and the number of people enrolled in integrated models is a path to better care for individuals and more effective and efficient coordination between Medicaid and Medicare. The Commission also supports increasing the level of integration in existing models where possible to achieve an improved care experience for beneficiaries and to eliminate conflicts between Medicaid and Medicare rules and processes as well as misaligned financial incentives. Over the past year, MACPAC has focused its examination of integrated care on four key areas: increasing enrollment in integrated care, making integrated products available to more dually eligible beneficiaries, promoting greater integration in existing products, and exploring the future of coverage for dually eligible beneficiaries under a new program.

States are key actors in integrating care for dually eligible beneficiaries; their leadership in designing and implementing models appropriate to the health care needs of their residents and the available resources in their communities is crucial. At its public meetings, the Commission heard directly from states about innovative and successful efforts to integrate care. We also heard about the constraints states face, some of which the recommendations in this chapter would address. Similarly, we heard from a panel of experts representing health plan, provider, and beneficiary advocate perspectives about the challenges and opportunities associated with increasing integration.

States can use current law to promote integration, particularly through models that align MLTSS with D-SNPs; from the Commission's perspective, states should use existing authorities to the greatest extent possible. Specifically, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provides states with the authority to design integrated care contracts with D-SNPs that go beyond minimum requirements. Along with new requirements for integration under the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), states have a great deal of flexibility to tailor contracts that meet the specific needs of dually eligible beneficiaries in their states and that reflect the nature of their managed care markets. We also note that some states may be interested in making greater use of existing authorities but do not have sufficient Medicare expertise to do so effectively.

The Commission also recognizes that states do not operate in a vacuum. We are troubled by the emergence and growth of D-SNP look-alike plans, traditional MA plans that do not coordinate Medicaid and Medicare benefits but appear to be drawing dually eligible beneficiaries away from integrated care products. Stakeholders have commented that state contracting decisions may be driving such growth. The Centers for Medicare & Medicaid Services (CMS) has recently finalized regulatory changes to restrict D-SNP look-alike growth, which could alleviate concerns about the unintended consequences of strengthening D-SNP contracts with states. Still, as states consider leveraging existing authorities, they should be mindful about the potential for growth in D-SNP look-alike plans.

The Commission's work in these areas is still developing and there are a number of policy options to promote in integrated care (discussed later in this chapter) that we will be focused on in the future. In this chapter, we make two recommendations, which we consider to be modest but important steps toward increasing the availability of, and enrollment in, integrated care models. Specifically, the Commission recommends the following:

- The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.
- Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Future Commission work on integrated care will further examine approaches to increase enrollment in integrated products, make those products more widely available, and promote greater integration in existing products. We are planning additional work to understand the role of Medicare agents and brokers in bringing eligible people into integrated products and state use of default enrollment as a tool to increase enrollment in D-SNPs aligned with MLTSS. We expect to explore ways that the MMP model could be made more widely available. We will also review how states are using MIPPA authority and plan to explore any potential issues around differing network adequacy standards between Medicaid and Medicare. We anticipate taking a deeper look at the effects of enrolling partial-benefit dually eligible beneficiaries in integrated products and the potential benefits of limiting state contracts with D-SNPs to those whose parent organization offers an MLTSS plan. We will also continue to track the growth of D-SNP look-alike plans to assess how they may be affecting integration efforts.

The chapter focuses on three themes that have guided our work:

- increasing enrollment in integrated models,
- making integrated products more widely available, and

- promoting greater integration in existing products.

We also describe our analytic plan for the future. Finally, the Commission presents the rationale for its recommendations and their expected impact on federal and state spending and on stakeholders, including beneficiaries, plans, and providers.

## Increasing Enrollment in Integrated Models

Despite federal and state efforts to develop integrated care programs, only about 1 million dually eligible beneficiaries, or about 10 percent, are enrolled in integrated care models (CMS 2020a). Enrollment has been lower than expected in the Financial Alignment Initiative (FAI); of the nine states operating capitated models, only Ohio, with about 68 percent of eligible beneficiaries enrolled, had a participation rate above 50 percent as of June 2017 (MedPAC 2018).<sup>1</sup> California and Texas both had participation rates below 30 percent. Factors associated with low enrollment in the FAI include the unwillingness of long-term services and supports (LTSS) providers to participate and the ability of beneficiaries to make frequent plan changes, including disenrolling at any time (Lipson et al. 2018). As is discussed later in this chapter, stakeholders have also expressed concern that D-SNP look-alike plans are drawing beneficiaries away from integrated care models. On the other hand, the use of default enrollment into D-SNPs has helped facilitate integration in some states. It requires Medicaid managed care and may be easiest with an MLTSS program and data sharing processes that are not in place in every state.

Given these challenges, the Commission has focused its attention over the past year on policies that could increase both enrollment of eligible individuals into integrated products and state development of integrated care models. At this time, the Commission is ready to make a modest but important recommendation to increase

enrollment in MMPs through an exception to the special enrollment period (SEP), described in more detail later in this chapter.

The Commission's inquiry has surfaced some additional opportunities to increase enrollment in integrated models, but more analysis is needed to understand their dynamics. The Commission is also working to understand the role of Medicare agents and brokers in potentially directing dually eligible beneficiaries to non-integrated products. Below we share some preliminary thoughts regarding default enrollment and Medicare agents and brokers.

### Default enrollment

Under current law, default enrollment, previously known as seamless conversion, is the primary automatic enrollment mechanism available to states and MA plans for enrolling Medicaid managed care beneficiaries into affiliated D-SNPs when they become eligible for Medicare but is not widely used.<sup>2</sup> As of March 2020, only seven states are using this tool. Arizona, Colorado, Kentucky, Oregon, Pennsylvania, Tennessee, and Virginia each have at least one D-SNP approved for default enrollment (ICRC 2020a). The limited take-up may be due to a lack of infrastructure needed for implementation, such as Medicaid managed care plans and D-SNPs operating under the same parent company.

**State authority under current law.** Default enrollment into D-SNPs requires state approval. Individuals eligible for default enrollment into a D-SNP are Medicaid beneficiaries who retain their eligibility for full Medicaid benefits after they become eligible for Medicare and remain enrolled in a comprehensive Medicaid managed care plan (Stringer and Kruse 2019).<sup>3</sup> Under Medicare rules, beneficiaries can opt out of default enrollment and instead receive their Medicare benefits through Medicare fee for service (FFS) or another MA plan.

**Data sharing.** States seeking to increase integration could make default enrollment into D-SNPs easier by establishing a process to obtain

Medicare eligibility data and sharing it with D-SNPs. States can do this by identifying the CMS data they will use, reviewing data at least monthly to monitor future eligibility for Medicare, and determining both the mechanism and the frequency with which the state will share data with D-SNPs (Stringer and Kruse 2019).

**Medicaid eligibility redeterminations.** States using default enrollment must also promptly redetermine Medicaid eligibility so D-SNPs have enough time to notify beneficiaries at least 60 days in advance of default enrollment, as required by law. Federal regulations require states to periodically review Medicaid eligibility and make redeterminations promptly if necessary (Stringer and Kruse 2019).<sup>4</sup> In states that redetermine Medicaid eligibility when an individual becomes eligible for Medicare, that redetermination should occur before the default enrollment process begins (Stringer and Kruse 2019). At that time, the state can notify the D-SNP that the individual will become eligible for Medicare and remain eligible for Medicaid. Potential D-SNP enrollees who do not retain Medicaid coverage upon enrolling in Medicare will not be dually eligible and therefore do not qualify for enrollment in a D-SNP.

**State take-up.** States that contract with at least one D-SNP that offers a Medicaid managed care plan are best positioned to use default enrollment because D-SNPs must link to a Medicaid managed care entity to implement default enrollment (ICRC 2020a). States with MLTSS programs and D-SNPs that have overlapping parent companies are best positioned to use this mechanism.

**Ongoing Commission work.** The Commission plans to examine use of default enrollment in states, particularly those with MLTSS programs, and opportunities for facilitating its use. As part of this work, the Commission will work to identify barriers to default enrollment, given that the authority to use this mechanism is already in place under current law.

## Understanding the role of Medicare agents and brokers

Medicare agents and brokers can affect enrollment in integrated products but the role they play in doing so is not well documented or understood.<sup>5</sup> Some policymakers have voiced concerns that Medicare agents and brokers acting on behalf of companies that contract with Medicare may have incentives to steer dually eligible beneficiaries away from integrated products (Lipson et al. 2018). MA plans rely heavily on Medicare agents and brokers who market directly to potential beneficiaries and receive compensation from multiple plans for doing so (Verdier and Chelminsky 2017).

In contrast, this type of unsolicited direct marketing is generally not permitted under Medicaid managed care (Verdier and Chelminsky 2017). State Medicaid programs typically contract with enrollment brokers who are independent of plans and thus work on behalf of beneficiaries in helping them choose a plan. However, these Medicaid enrollment brokers may be unfamiliar with Medicare and may not be prepared to assist beneficiaries in enrolling in Medicare products (Verdier and Chelminsky 2017). The Integrated Care Resource Center (ICRC), a national initiative of CMS to provide technical assistance to states interested in developing integrated care programs, published technical assistance for states participating in the FAI aimed at improving the effectiveness of Medicaid enrollment brokers in counseling beneficiaries on Medicare products (Chelminsky et al. 2017).<sup>6</sup>

MMPs have generally been prohibited from compensating brokers for steering eligible beneficiaries toward their plans, but in 2018, CMS provided an exception in California, allowing compensation in the state (CMS 2018a). It is too early to know the impact of this policy. States may benefit from additional clarification, either in federal regulation or in guidance, regarding the role of Medicare agents and brokers in the FAI and more broadly, including when compensation is permissible.

**Ongoing Commission work.** The Commission will focus on the role of Medicare agents and brokers in the next report cycle. As part of this work, we will explore compensation for agents and brokers employed by a single plan or by multiple plans and the effect on plan enrollment.

## Exception to the special enrollment period for dually eligible beneficiaries in MMPs

Federal regulations at 42 CFR 423.38 permit dually eligible beneficiaries to qualify for an SEP for MA plans and Medicare Part D that allows them to enroll, switch plans, or disenroll outside of the annual open enrollment period. Until January 1, 2019, that SEP was continuous, meaning that dually eligible beneficiaries could enroll, disenroll, or switch plans monthly; after that date, the SEP was modified to once per quarter for the first nine months of the year (i.e., three times per year) (CMS 2018b, ICRC 2018). Although the SEP is an MA policy, it also applies to MMPs under the FAI (CMS 2018b, ICRC 2018).

States participating in a capitated model under the FAI were given the option to waive the narrower SEP, and all states did so for 2019 and 2020, primarily because of concerns that the narrower SEP would reduce opportunities for beneficiaries to enroll at any time (ICRC 2018, Lakhmani 2020). Thus, unlike other dually eligible beneficiaries, beneficiaries in MMPs can enroll, switch between MMPs, and disenroll at any time through the end of 2020.

The Commission's recommendation, which is described in greater detail below, would maintain the continuous SEP for purposes of enrolling in MMPs, but apply the narrower SEP to switching plans or disenrolling. This change would allow MMP-eligible individuals to benefit from the continuity of care that the narrower SEP was intended to promote while continuing to allow eligible beneficiaries to enroll at any time.

CMS made a similar proposal in the Medicare-Medicaid Coordination Office (MMCO) fiscal year

(FY) 2019 annual report to Congress (CMS 2020a). The proposal would limit the SEP to dually eligible beneficiaries seeking to switch plans after being auto-assigned to a Medicare Part D prescription drug plan or to enroll in an integrated product (CMS 2020a). For all other coverage changes, dually eligible beneficiaries would use the same annual enrollment period as all other MA beneficiaries.<sup>7</sup> It appears that this legislative proposal also applies to MMPs because it does not explicitly exempt them from the change. The CMS proposal goes further than MACPAC's recommendation in that it applies to all beneficiaries enrolled in MA plans, rather than only dually eligible beneficiaries enrolled in MMPs, and it sets more limits on coverage changes. Because it requires a change in Medicare policy, a step which is beyond MACPAC's statutory authority to recommend, our recommendation focuses on MMPs. The Commission may examine the implications of this broader policy on Medicaid in the future.

**Ongoing Commission work.** In this chapter, the Commission recommends continuing to allow monthly enrollment into MMPs but applying the narrower SEP to switching plans and disenrolling (Recommendation 2.1). In future work, the Commission will continue to look for ways to increase enrollment in integrated care models.

## Making Integrated Products More Widely Available

The goals of integrated care programs—to improve the quality of care (including the beneficiary experience) and program efficiency—can only be achieved if these models are widely available to beneficiaries. Many beneficiaries, however, do not have access to an integrated care model. The Commission is exploring policies that would make integrated products more widely available to dually eligible beneficiaries or position states to take advantage of existing opportunities to integrate care. Although MMPs are the most highly integrated model outside of the Program of All-Inclusive Care

for the Elderly (PACE), they are not widely available. As noted above, only nine states operate MMPs and, in most cases, only in a portion of the state; only Rhode Island has a statewide MMP (EOHHS 2020). In the other FAI states with capitated models, MMPs are generally located in population centers with the largest share of dually eligible beneficiaries (MACPAC 2020a). CMS encouraged additional states to participate in the FAI in an April 2019 letter to state Medicaid directors, but states have expressed little interest in pursuing this opportunity (CMS 2019a, Gifford et al. 2019).

Other integrated options are similarly limited in terms of take-up; for example, even in states that operate MLTSS programs aligned with D-SNPs, D-SNPs are not always available statewide. According to our analysis of CMS data on D-SNP availability in 2020, D-SNPs are available in 42 states and the District of Columbia, and are offered statewide in 23 states (Appendix 1A, Table 1A-1, MACPAC 2020a). However, in 19 states, D-SNPs are only available in certain counties. Where D-SNPs are unavailable, beneficiaries are generally limited to receiving their Medicare benefits only through FFS or a traditional MA plan (including D-SNP look-alike plans), neither of which coordinates with beneficiaries' Medicaid benefits.

## Improving state capacity on Medicare

Integrating care for dually eligible beneficiaries requires states to design programs and develop D-SNP contracts; doing so requires expertise in Medicare both at program launch and on an ongoing basis. Because Medicaid and Medicare operate largely independently of each other, there has not been much incentive for state staff to develop such expertise. States have no role in administering the Medicare program and are not necessarily familiar with its rules and regulations. States have not typically coordinated coverage of Medicaid services with Medicare, in part because the dually eligible population, even today, mostly receives their services through FFS (MACPAC and MedPAC 2018). Although states can coordinate

care for dually eligible beneficiaries in the FFS environment, such as by using health homes, formal integrated care models have primarily been implemented under the umbrella of managed care (CMS 2020a).

Many states do not have resources to invest in gaining Medicare expertise (Kruse and Soper 2020). States have many competing priorities related to high-cost, high-need populations, including implementation of both electronic visit verification for personal care services and the home- and community-based services (HCBS) settings rule (MACPAC 2019a, 2019b). In addition, staff responsible for integrated care activities are often also responsible for other managed care programs or LTSS initiatives (Kruse and Soper 2020). In many states, expansion to the new adult group under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) continues to be a focal point for Medicaid agency staff.

CMS, directly and through the ICRC, has made technical assistance on Medicare available to states, including webinars, sample contract language, and technical briefs (ICRC 2020b, 2019, 2017, Libersky et al. 2017). However, technical assistance is often not a sufficient substitute for dedicated in-house expertise in state agencies; officials from Arizona and Virginia—states with long histories of integrated care efforts—told the Commission in 2018 about the importance of having state staff who are knowledgeable about Medicare (Betlach and Kimsey 2018). Arizona has staff assigned to Medicare issues such as D-SNP contracting, commenting on regulations regarding D-SNP quality, and interacting with plans. Similarly, Virginia developed a Medicare unit to inform its work with D-SNPs; the state defined this as a priority need and reassigned positions to achieve its goal. The Virginia official noted that additional funds would be useful to assist state efforts, because not every state has the same level of support from its administration and legislature (Betlach and Kimsey 2018).



In the Commission's view, providing states with additional resources to finance the development of Medicare expertise would advance integrated care efforts (Recommendation 2.2). Similar efforts were made for states interested in the FAI in 2011, when CMS granted 15 states up to \$1 million each to develop new care models for dually eligible beneficiaries (CMS 2011). States used those funds to develop proposals to participate in the demonstration as well as to hire staff, engage external contractors, and support data analytics. New resources could help states overcome existing capacity limits, as described in the recommendations section later in this chapter.

**Ongoing Commission work.** In this chapter, the Commission recommends additional federal funding for states to help them develop the Medicare expertise necessary to integrate care for their dually eligible populations. The Commission will continue to monitor state capacity to implement integrated care programs and how it is affected by new demands, including responding to the COVID-19 pandemic.

## Funding up-front costs of establishing integrated care models

States interested in establishing new integrated care programs may not have sufficient financial resources to plan and implement those programs. Integrating care for dually eligible beneficiaries requires states to make up-front investments to design programs and build infrastructure. States also incur ongoing expenses to maintain programs once they are launched. Even when there is interest in integrating care, however, states have many competing priorities, and resources are often tight. For example, it may be difficult for states to dedicate existing staff to a new integrated care model when staff time is already committed to other Medicaid initiatives, particularly in states where there is no specific unit or division in the Medicaid agency dedicated to dually eligible beneficiaries. Staff must be pulled in from a number

of different units or new staff may be needed to both set up and maintain these programs.

Creating a dedicated funding source could also help additional states develop a managed fee-for-service (MFFS) model; for instance, when Washington State developed its MFFS model under the FAI, the state was able to take advantage of other resources to launch its program. Washington's model includes a retrospective shared savings component in which the state and CMS share savings generated by the demonstration, a feature that may be attractive to other states (Archibald et al. 2019a). Because any shared savings would be retrospective, however, the up-front investment required by this model may pose challenges for many states. Washington was able to overcome this issue because it was also launching a health homes program at the same time as it established its demonstration. The health homes option under section 1945 of the Social Security Act includes an enhanced federal medical assistance percentage (FMAP) available for two years. States not incorporating health homes into their MFFS models would not have access to the enhanced FMAP, so creating a dedicated funding source could help pay for staff and other up-front costs in states seeking to develop an MFFS model.

In 2019, CMS issued guidance outlining opportunities for states to develop alternative models to the existing capitated options (CMS 2019a). CMS expressed willingness to consider state suggestions as well as MFFS models such as the one developed by Washington State (CMS 2019a). States may be more likely to pursue a new model if funding is made available.

**Ongoing Commission work.** In Recommendation 2.2, the Commission recommends additional funding for states. In the future, the Commission will continue to monitor state needs and how available funding affects state action on integrated care.

## Strengthening Medicare-Medicaid Plans

The MMPs operating under the FAI represent the most fully integrated model currently available to the largest number of dually eligible beneficiaries; coverage under the two programs is seamless to the beneficiary, who is enrolled in just one plan. Financing for MMPs is integrated because CMS and the states jointly develop Medicaid and Medicare capitation rates as part of their contract negotiations (CMS 2020b). MMPs operate in the nine states with capitated models and have 386,331 enrollees as of February 2020 (ICRC 2020c). In this section, we discuss potential options to strengthen MMPs and explore the possibility of expanding the MMP model beyond the FAI.

Studies have obtained feedback from beneficiaries about their experiences in the MMPs: The CMS evaluations, conducted by RTI International (RTI), included findings from beneficiary focus groups and found that beneficiaries who used care coordinators were pleased with the service (Ptaszek et al. 2017). An analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey that MMPs are required to conduct every year, found that 63 percent of enrollees gave their MMPs the highest possible rating in 2017. Beneficiaries also noted improvements in overall health care quality and ease of making appointments and obtaining prescription drugs (MedPAC 2018). In the CAHPS, MMPs ranked similarly to other MA plans and Medicare FFS (MedPAC 2018). Other studies found mixed results around care coordination, with some beneficiaries reporting positive experiences with their care coordinators, such as improved goal setting and fewer disruptions in health care coverage, while others could not identify their care coordinators (MACPAC 2019c).

**Strengthening MMPs.** Because of the high level of integration possible in MMPs, the Commission is interested in exploring ways to strengthen existing MMPs and to expand the MMP model beyond the FAI. One approach would be to create a frailty

adjustment to the capitation rate to account for the population mix an MMP may serve.<sup>8</sup> Such an adjustment could offset some of the costs to plans associated with providing coverage to a high-cost, high-need population like dually eligible beneficiaries. The Commission may also explore the value of creating a permanent authority for MMPs or an MMP-like model pending completion of the remaining FAI evaluations. We will also look into current limitations on MMP enrollment, including limits on who may enroll (e.g., individuals under age 65) and limits on what services are covered (e.g., carving out behavioral health services).

**Expanding the MMP model.** MMPs provide Medicare-covered services and Medicaid-covered services and they are required to provide care coordination (CMS 2020b). All MMPs operate under a three-way contract with the state and CMS (CMS 2020b). To apply the MMP model to health plans outside of the FAI, the Secretary of the U.S. Department of Health and Human Services (the Secretary) could be authorized to establish health plans similar to MMPs. The Commission will investigate the possibility of establishing plans outside of the FAI that are based on the MMP model.

**Ongoing Commission work.** The Commission plans to explore ways to strengthen the MMPs as described above. This work could include discussions with CMS to understand the possibility of applying a frailty adjustment to an MMP and discussions with states, to the extent feasible, to gauge interest in expansions of the MMP model.

## Addressing network adequacy standards for D-SNPs

As noted earlier, D-SNPs are not available statewide in 19 states. There are no federal requirements that D-SNPs be made available in every county although states can include requirements in their MIPPA contracts that plans serve certain geographic areas (42 CFR 422.107, Verdier et al. 2016). Medicare network adequacy requirements may be a barrier to

plan entry into some areas (Archibald et al. 2019b). A 2019 report released by the U.S. Department of Health and Human Services notes concerns from states and plans that MA network adequacy standards do not fully account for state geography (Archibald et al. 2019b). In one instance, state officials noted that D-SNPs were told by CMS to include providers located across a lake. While the distance across the lake was short, getting there by road required a full day's drive; the state had accounted for this in its own Medicaid network adequacy standards, but CMS had not (Archibald et al. 2019b).

The Commission is concerned that the reach of integrated care programs is limited in part because D-SNPs cannot meet network adequacy requirements in certain areas where they could otherwise likely provide sufficient beneficiary access to services. One solution might be to develop a process for state input into CMS review of D-SNP networks (Archibald et al. 2019b). This approach has been used at least once before: Archibald and colleagues (2019b) report that CMS consults with the state of Minnesota on network standards as part of the administrative alignment model under the FAI demonstration. In particular, CMS took the state's input into consideration as it assessed provider networks and reviewed network exceptions requests. Both CMS and the state's FIDE SNPs gave positive feedback on this process and its effects (Archibald et al. 2019b).

Another potential solution would be to allow D-SNPs to operate in areas where they meet certain Medicaid requirements, even if they do not meet Medicare requirements.<sup>9</sup> Finally, in assessing D-SNP networks, CMS could take into account the extent to which the Medicaid non-emergency medical transportation benefit (NEMT) can help enrollees access providers in a broader geographic area.

**Ongoing Commission work.** The Commission plans to explore the feasibility of these options and their potential effects on D-SNP availability and beneficiary access to care. This work might include interviews with states and plans to understand the

effects of differing network adequacy standards in Medicaid and Medicare. Other planned MACPAC work on NEMT may also shed light on the extent to which this benefit is addressing access concerns.

## Promoting Greater Integration in Existing Products

Since the late 1990s, Congress has provided states with a variety of authorities to integrate care for dually eligible beneficiaries, including the Balanced Budget Act of 1997 (P.L. 105-33) which established the PACE program and MIPPA, which established D-SNP contract requirements. A continuum of integrated care has evolved from these authorities. At the least integrated end of that continuum are D-SNPs that only meet minimum requirements for state contracts under MIPPA. These requirements ensure that a relationship with the Medicaid agency exists, but they do not require D-SNPs to cover any Medicaid benefits (42 CFR 422.107). Some states have pursued greater integration by aligning their D-SNP contracts with MLTSS programs; D-SNPs may or may not cover Medicaid benefits in these arrangements, but MLTSS and D-SNP contracts are coordinated to promote integration. D-SNPs that assume capitation for certain Medicaid benefits include FIDE SNPs and highly integrated special needs plans (HIDE SNPs). An alternative to capitated models relying on D-SNPs is the MFFS model that Washington currently operates under the FAI. At the highest end of the integration continuum are PACE and MMPs under the FAI. For descriptions of each model and how they are being used by states, see Chapter 1 of this report.

Many states have pursued multiple paths to integrating care for dually eligible beneficiaries; for example, Ohio participates in the FAI and has PACE sites. As noted earlier under the FAI, nine states operate a capitated model, Washington operates an MFFS model, and Minnesota has an alternative model. State approaches to D-SNP contracting include 11 states with FIDE SNPs and 12 that align

MLTSS and D-SNPs. (Some states have both.) PACE programs operate in 31 states (Appendix 1A, Table 1A-1).

State choices regarding integrated care options are guided by a variety of factors. In addition, as states gain experience with integrated care, their programs may evolve. For example, it may be difficult for states with no integrated products to move directly to a HIDE SNP or FIDE SNP. Instead, they might engage in D-SNP contracting aligned with a new or existing MLTSS program, building upon MIPPA requirements over time to tailor contracts that best meet their needs. Having plans manage LTSS or behavioral health services may then become a logical next step after those initial efforts.

It is the Commission's view that federal policy should support state efforts to move along the integrated care continuum. We have been studying several policies that could promote greater integration for dually eligible beneficiaries in models that already exist, such as those using D-SNPs. Moving forward, we will explore ways to encourage states to make better use of existing contracting

authorities and selectively contract with D-SNPs, seek further insight into the growth of D-SNP look-alike plans, and examine the potential of limiting enrollment in D-SNPs to full-benefit dually eligible beneficiaries only.

## Maximizing state use of D-SNP contracting authorities

D-SNP contracting authorities were delineated under MIPPA and refined in BBA 2018. As described below, some state D-SNP contracting activities go beyond these requirements.

**MIPPA.** MIPPA required D-SNPs to have a contract with a state Medicaid agency to operate in that state, and specified certain requirements for those contracts; these were further detailed in regulation (42 CFR 422.107, CMS 2019b). For example, contracts between D-SNPs and state Medicaid agencies must document the plan's responsibility for coordinating Medicaid benefits, the Medicaid benefits and cost-sharing protections covered under the D-SNP, and the service area covered (Box 2-1).

### **BOX 2-1. Regulatory Requirements for Dual Eligible Special Needs Plan Contracts with States**

#### **42 CFR 422.107 Special needs plans and dual eligibles: Contract with state Medicaid agency.**

- (a) *Definition.* For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA [Medicare Advantage] organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dual eligible individuals.
- (b) *General rule.* MA organizations seeking to offer a dual eligible special needs plan must have a contract consistent with this section with the State Medicaid agency.
- (c) *Minimum contract requirements.* At a minimum, the contract must document—
  - (1) The MA organization's responsibility to—
    - (i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and
    - (ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services.

## BOX 2-1. (continued)

(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP [special needs plan], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act.

(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in § 422.561, a requirement for the use of the unified appeals and grievance procedures under §§ 422.629 through 422.634, 438.210, 438.400, and 438.402.

(d) *Additional minimum contract requirement.* For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with this requirement.

(e) Date of Compliance.

(1) Effective January 1, 2010—

(i) MA organizations offering a new dual eligible SNP must have a State Medicaid agency contract.

(ii) Existing dual eligible SNPs that do not have a State Medicaid agency contract—

(A) May continue to operate through the 2012 contract year provided they meet all other statutory and regulatory requirements.

(B) May not expand their service areas during contract years 2010 through 2012.

(2) MA organizations offering a dual eligible SNP must comply with paragraphs (c)(9) and (d) of this section beginning January 1, 2021 (42 CFR 422.107).

**Note:** Paragraphs (c)(9), (d), and (e)(2) become effective January 1, 2021.

**BBA 2018.** BBA 2018 made the authority for special needs plans, including D-SNPs, permanent. It also mandated that D-SNPs meet at least one of three requirements regarding the integration of Medicaid and Medicare benefits beginning January 1, 2021.<sup>10</sup> CMS has further defined these requirements in regulation and guidance (42 CFR 422.107, CMS 2020c, 2019c):

- D-SNPs can meet requirements of FIDE SNPs if they are offered by a legal entity that has a state contract to provide Medicaid benefits, including LTSS and behavioral health services, consistent with state policy. Plans can still be considered FIDE SNPs if they do not cover behavioral health services in cases where the state has decided to carve out that benefit from the capitated rate, or where they have an LTSS carve out of a minimal scope.
- D-SNPs can meet the requirements of HIDE SNPs if the legal entity offering the D-SNP, parent organization, or a subsidiary of the parent organization has a contract with the state Medicaid agency to provide LTSS, behavioral health services, or both under capitation, consistent with state policy.
- If D-SNPs do not satisfy one of the criteria above, they must notify the Medicaid agency (or other entities or individuals designated by the Medicaid agency) of hospital and skilled nursing facility admissions for high-risk full-benefit dually eligible beneficiaries. States will select the subpopulations requiring D-SNP attention and establish their own notification procedures as well as protocols, time frames, and method of notification.

BBA 2018 also directed the Secretary to unify grievance and appeals procedures for D-SNPs. To do so, CMS has established a new process for unifying grievance and appeals procedures at the health plan level for a subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment in which one organization is responsible for both Medicaid and Medicare coverage, although that may

occur through separate contracts (CMS 2019c). CMS has given these plans until 2021 to unify appeals and grievances (CMS 2019c).

#### **State activities beyond minimum requirements.**

Many states have gone beyond the MIPPA requirements and have been using their D-SNP contracts to further integrate care. A MACPAC-funded analysis of care coordination requirements in integrated care models found that several states had detailed care coordination requirements in their D-SNP contracts (Barth et al. 2019). For example, Virginia requires that D-SNPs train care coordinators on Medicaid benefits, coordination of Medicaid and Medicare benefits, and cost sharing (Barth et al. 2019). Given that care coordination has been cited as a benefit of enrolling in an integrated care product, these provisions show that states can use contract authorities to strengthen the ability of D-SNPs to deliver integrated care (Barth et al. 2019).

A 2016 analysis of D-SNP contracts in 13 states provides further evidence of state actions that exceed the minimum MIPPA requirements, including review of marketing materials, encounter data submission, quality improvement and external quality review, and beneficiary cost-sharing protections (Verdier et al. 2016). For example, 8 of the 13 states required D-SNPs to submit marketing materials to the state for its review (Verdier et al. 2016). To analyze beneficiary service use across Medicaid and Medicare, nine states required that D-SNPs submit encounter data, which could be linked to Medicaid data (Verdier et al. 2016).

**Ongoing Commission work.** The Commission encourages states to use existing authorities to the greatest extent possible. MIPPA and BBA 2018 gave states a great deal of flexibility to tailor contracts to meet the specific needs of dually eligible beneficiaries in their states and reflect the nature of their managed care markets. The Commission plans to continue work to understand the variety of state MIPPA contracts and consider what states need to maximize their use of existing authorities. In addition, the Commission plans to track state and plan implementation of requirements in BBA

2018 that would move D-SNPs toward increased alignment with Medicaid.

## Increasing selective contracting with D-SNPs

Some states are using MLTSS and D-SNP contracting authorities to leverage D-SNPs in ways that best fit their integrated care approaches. Some require that their MLTSS contractors offer companion D-SNPs. Others require that a companion D-SNP continue to contract with other D-SNPs that do not have an MLTSS contract, while some states only contract with D-SNPs that are a companion to an MLTSS product (GAO 2020). A recent study of a sample of states with MLTSS and D-SNPs found that in 2019, Arizona, New Jersey, and Virginia limited D-SNPs to only those plans that had a companion MLTSS plan, while Pennsylvania and Tennessee contracted only with new D-SNPs that had a state contract, but maintained contracts with D-SNPs that had been in place prior to that policy change (GAO 2020).

Selective contracting can be beneficial because it enables dually eligible beneficiaries to receive Medicaid and Medicare benefits through plans operated by the same parent company. However, in 2019, only 44 percent (690,000 of almost 1.6 million) of full-benefit dually eligible beneficiaries were enrolled in D-SNPs in areas where the parent company also operated an MLTSS plan (MedPAC 2019a). Increasing that proportion could increase enrollment in integrated care programs.

On the other hand, selective contracting has its own challenges. First, some states may need more experience with D-SNP contracting in general before they are ready to engage in selective contracting. State procurements of MLTSS contracts also play a role, as states periodically rebid their MLTSS contracts through a competitive process that permits a limited number of plans to offer MLTSS; this may result in existing managed care organizations (MCOs) losing contracts and new MCOs entering the market. For the new MCOs to

have a companion D-SNP ready to launch, they must begin planning before knowing if they will be awarded an MLTSS contract. One plan association estimated it takes a minimum of 18 to 24 months to launch a companion D-SNP product in conjunction with an MLTSS procurement (SNP Alliance 2018). In states that do not selectively contract, plans might still be able to launch that D-SNP if they do not win an MLTSS contract. However, plans may not want to take the risk of investing in developing a D-SNP that will not be allowed to operate at all if the state only contracts with MLTSS awardees.

Selective contracting may also disrupt existing provider relationships. One recent study found two states that are now requiring MLTSS plans to have D-SNPs are continuing to allow existing D-SNPs to operate, and these states cite the potential disruption of beneficiary-provider relationships as the basis for that decision (GAO 2020). In addition, when an MLTSS contract is reprocured, and the state has chosen to align its MLTSS and D-SNP contracts, beneficiaries enrolled in a D-SNP offered by a parent company that loses its MLTSS contract will also have to change D-SNPs to remain in an integrated product. If the plan networks differ, beneficiaries will have to change providers; this is especially true if either D-SNP uses a narrow network. Finally, selective contracting may encourage the growth of D-SNP look-alike plans, discussed in the next section.

**Ongoing Commission work.** The Commission is interested in further exploring how states make decisions about their contracting strategies and how the dynamics of the MA bid process factor into those decisions.

## Diminishing the potential for D-SNP look-alike plans to affect integrated care programs

D-SNP look-alike plans are traditional MA plans that appear to offer benefits targeted to dually eligible beneficiaries, based on their cost-sharing structure and supplemental benefits (MedPAC 2019a, 2018).<sup>11</sup>

Even though these plans are not permitted to limit enrollment to subgroups of Medicare beneficiaries, a large share of their enrollment is comprised of dually eligible beneficiaries. However, they are not subject to the specific requirements for D-SNPs, such as having contracts in the states where they operate or an approved model of care (42 CFR 422.101, 42 CFR 422.107).

The primary concern about look-alike plans is that they draw beneficiaries away from integrated models, acting at cross purposes to federal and state efforts to promote integration.<sup>12</sup> Although enrollment growth in look-alike plans may be less of a concern in states that do not have MLTSS programs or are not participating in the FAI, awareness of the potential of encouraging look-alike plan growth may affect state willingness to pursue such strategies. The Commission previously voiced concerns about the growth in D-SNP look-alike plans in a December 2018 comment letter on proposed MA regulations (MACPAC 2018). It reinforced those statements in an April 2020 comment letter on proposed rules to address D-SNP look-alike plans (MACPAC 2020b).

#### **Availability of D-SNP look-alike plans in 2020.**

Look-alike plans were first identified in California, most notably in areas where the state is offering MMPs through the FAI (MedPAC 2018). To develop figures on the current availability of such plans nationally, MACPAC analyzed MA bid data, using methods consistent with prior analyses (MedPAC 2019a). In their bids, MA plans project their total member months and how many of those months will cover dually eligible beneficiaries.<sup>13</sup> We used the projected member months to estimate full-year equivalent (FYE) enrollees.<sup>14</sup> We considered D-SNP look-alike plans to be plans where dually eligible beneficiaries comprised over 50 percent of FYE enrollees (Table 2-1).

We found that:

- The number of traditional MA plans with projected enrollment of over 50 percent dually eligible beneficiaries increased from 94 in 2019 to 98 in 2020. The number of plans with projected enrollment of over 80 percent and over 90 percent dually eligible beneficiaries also increased over this time period.
- Projected D-SNP look-alike plan enrollment grew substantially from 2019 to 2020. Total projected enrollment in these plans in 2020 was 271,080, about 23.4 percent higher than enrollment in such plans in 2019. This projected growth far exceeded projected growth in enrollment in D-SNPs and other MA plans that had dually eligible beneficiary enrollment of 50 percent or less over the same time period.
- The only plan type with projected enrollment growth exceeding that of D-SNP look-alike plans was institutional special needs plans (I-SNPs), which limit enrollment to beneficiaries who need an institutional level of care.
- In contrast, plans that enrolled over 80 percent and over 90 percent of dually eligible beneficiaries were expected to draw fewer beneficiaries from 2019 to 2020. Although there were more plans that met this threshold in 2020, their average size was smaller.



**TABLE 2-1.** Availability of and Projected Total Enrollment in Medicare Advantage Plan Types, 2019 and 2020

Plan type	Number of states where available		Number of plans			Projected total enrollment		
	2019	2020	2019	2020	Percent change	2019	2020	Percent change
D-SNPs	43	43	458	532	16.2%	2,363,748	2,691,834	13.9%
I-SNPs	40	45	125	150	20.0	90,102	116,360	29.1
C-SNPs	28	30	117	158	35.0	357,139	348,777	-2.3
D-SNP look-alike plans: More than 50 percent of enrollees are dually eligible beneficiaries	35	28	94	98	4.3	219,610	271,080	23.4
D-SNP look-alike plans: More than 80 percent of enrollees are dually eligible beneficiaries	13	22	54	66	22.2	193,483	182,561	-5.6
D-SNP look-alike plans: More than 90 percent of enrollees are dually eligible beneficiaries	11	18	35	44	25.7	66,231	62,479	-5.7
Other MA plans: 50 percent or less of enrollees are dually eligible beneficiaries	50	50	2,590	3,019	16.6	13,903,562	14,975,308	7.7

**Notes:** D-SNP is dual eligible special needs plan. I-SNP is institutional special needs plan. C-SNP is chronic condition special needs plan. MA is Medicare Advantage. D-SNP look-alike plans are defined as traditional MA plans in which dually eligible beneficiaries comprise greater than 50 percent of projected total enrollment. Other MA plans include traditional MA plans that are not D-SNP look-alike plans, D-SNPs, I-SNPs, or C-SNPs. Dually eligible beneficiaries include both full-benefit and partial-benefit dually eligible beneficiaries. Figures exclude plans that do not provide drug coverage as well as employer plans, Medical Savings Account plans, and plans that operate only in Puerto Rico. Total enrollment includes dually eligible and Medicare-only beneficiaries. Data may somewhat undercount projected enrollment of dually eligible beneficiaries due to how certain beneficiaries are classified in bid data; thus the number of look-alike plans may be undercounted.

**Source:** MACPAC, 2020, analysis of 2019 and 2020 Medicare Advantage bid data from the Centers for Medicare & Medicaid Services.

D-SNP look-alike plan availability differs by state.

- The state with the most look-alike plans was California, with 40, followed by 6 in Florida and Illinois.
- Of the 98 D-SNP look-alike plans offered in 2020, 14 (14.3 percent) were offered in states that do not have D-SNPs. For example, Nevada

does not contract with D-SNPs, but has three look-alike plans.

- States with multiple D-SNP look-alike plans include Arizona and Virginia. These states have integrated care programs that compete with D-SNP look-alike plans for enrollment.

- Multiple look-alike plans are also present in several states that do not have integrated care programs but where D-SNPs are available, including Connecticut, Louisiana, and Mississippi. We do not know if MCOs offering D-SNP look-alike plans first unsuccessfully pursued a D-SNP in these states, or if they chose to offer a D-SNP look-alike plan for other reasons. The effect of D-SNP look-alike plans in these states is unclear, as they are not competing with an integrated care program for beneficiaries.

Although we are unable to assess the effects of increasing enrollment in look-like plans on integrated care models, the fact that their enrollment growth exceeded D-SNPs is of concern, because many states are using D-SNPs combined with MLTSS plans as a model for integrating care for dually eligible beneficiaries.

**Supplemental benefits provided by D-SNP look-alike plans.** D-SNP look-alike plans may draw beneficiaries away from integrated care models due to their benefit design, including the supplemental benefits they offer (MedPAC 2019a). These supplemental benefits are not covered under Medicare FFS, but MA plans can choose to provide them using the rebate they receive if their bids are below a regional benchmark or bonuses they receive based on quality ratings (MedPAC 2019b).

Our analysis of data submitted by MA plans for their 2020 benefits packages shows that D-SNP look-alike plans provide certain supplemental benefits at rates similar to D-SNPs. For example, D-SNP look-alike plans cover non-emergency transportation and over-the-counter drugs at rates more similar to D-SNPs than to other MA plans that had dually eligible beneficiary enrollment of 50 percent or less (Table 2A-1). This suggests that D-SNP look-alike plans are tailoring their plans to provide benefits that are attractive to dually eligible beneficiaries, potentially drawing beneficiaries away from integrated products.

**Concerns about D-SNP look-alike plans.** The Commission has been concerned that state and federal efforts to integrate care for dually eligible beneficiaries are being undermined by the growth of D-SNP look-alike plans. In the Commission's view, it is important to understand whether enrollment growth in D-SNP look-alike plans is happening to the detriment of enrollment in integrated care plans. To gain insights into these concerns, MACPAC worked with RTI and the Center for Health Care Strategies to interview federal officials, state officials, consultants, health plan industry representatives, provider representatives, and beneficiary advocates.<sup>15</sup> From these interviews, we learned that:

- Stakeholders agreed that federal and state efforts to promote integrated care have inadvertently contributed to the growth of D-SNP look-alike plans. Federal efforts include regulations implementing provisions of BBA 2018 that include requiring D-SNPs to cover certain Medicaid benefits or share data on hospital and skilled nursing facility admissions of certain high-risk beneficiaries with states or the states' designees (CMS 2019b).
- Regarding state actions that might drive look-alike growth, several interviewees cited California's restrictions in the FAI, which did not allow new D-SNPs to be offered in demonstration counties (MedPAC 2018). Other state efforts cited by interviewees included selective contracting policies, discussed previously in this chapter, and state decisions not to contract with any D-SNPs.
- Stakeholders also indicated that incentives for Medicare agents and brokers put integrated products at a disadvantage and increase enrollment growth in D-SNP look-alike plans. In particular, MA plans can compensate the agents and brokers who sell their products, but this practice is often prohibited in the FAI. In addition, stakeholders shared anecdotes of misleading marketing practices by contracted agents and brokers for look-alike plans, such as marketing materials indicating a

relationship with the Medicaid program. This could lead a beneficiary to assume inaccurately that a level of coordination existed with the state to provide Medicaid benefits.

- Advocates said that beneficiary enrollment counselors, such as those with State Health Insurance Assistance Programs, are confused about what look-alike plans are and how to identify them. This is important because these counselors help dually eligible beneficiaries make plan choices and do not have financial incentives to enroll beneficiaries into specific plans.
- Stakeholders were concerned that D-SNP look-alike plans are affecting enrollment in integrated care programs. In particular, they often referred to the effects of D-SNP look-alike plans on enrollment in the FAI, particularly in California. Several also cited evidence of a small number of dually eligible beneficiaries in Minnesota disenrolling from D-SNPs to enroll in a look-alike product.
- State officials and beneficiary advocates raised concerns about the potential for negative effects on the dually eligible beneficiary care experience, although effects may depend on individual needs.

**Efforts to limit D-SNP look-alike plans.** CMS recently finalized regulatory changes affecting both D-SNPs and D-SNP look-alike plans (42 CFR 422.514). Beginning in 2022, CMS will not enter into an MA plan contract if 80 percent or more of projected enrollees in the plan bid are dually eligible beneficiaries. Beginning in 2023, CMS will not renew an MA plan contract if the plan has actual enrollment at this threshold as of January of the current year, unless the plan has been active for less than one year and has 200 or fewer enrollees. For example, CMS will review January 2023 plan enrollment and not renew for 2024 any plans that exceed this threshold. This requirement will apply only in states where D-SNPs or another product are authorized to exclusively enroll dually eligible beneficiaries (e.g., MMPs).

In comments submitted to CMS on the proposed rule, the Commission voiced support for a similar provision, which was in line with our prior comments urging the agency to monitor this issue and take action (MACPAC 2020b, 2018). The Commission suggested that after finalizing the rule, CMS should continue monitoring look-alike plans and, if plans under the 80 percent threshold continue to grow, consider whether a lower threshold is warranted.

**Ongoing Commission work.** The Commission will continue monitoring D-SNP look-alike availability and enrollment and any effects of CMS's finalized regulatory changes.

## Limiting D-SNP enrollment to full-benefit dually eligible beneficiaries

Some policymakers and stakeholders have suggested that limiting D-SNP enrollment to full-benefit dually eligible beneficiaries could improve integration of Medicaid and Medicare for this population (GAO 2020, MedPAC 2019a). Currently, state decisions affect whether partial-benefit dually eligible beneficiaries can enroll in D-SNPs; as of 2019, 35 states and the District of Columbia permitted such enrollment (MedPAC 2019a).<sup>16</sup> About one-third of partial-benefit dually eligible beneficiaries enrolled in MA plans chose a D-SNP.

**Benefits of excluding partial-benefit dually eligible beneficiaries from D-SNPs.** D-SNPs were designed to coordinate care across Medicaid and Medicare for dually eligible beneficiaries. Partial-benefit dually eligible beneficiaries may not benefit from this feature, because they are not eligible for the Medicaid services that could be coordinated across the two programs, such as LTSS and behavioral health services.

Allowing partial-benefit dually eligible beneficiaries to enroll in D-SNPs may dilute care coordination efforts designed for full-benefit dually eligible beneficiaries, because D-SNPs must develop a specific model of care for the population they intend to serve (42 CFR 422.101). When plan enrollees are eligible for different services, it is more difficult to

develop a single process for coordinating Medicaid and Medicare needs and to provide materials explaining benefits covered in integrated programs.

**Benefits of maintaining state option to enroll partial-benefit dually eligible beneficiaries in D-SNPs.** There are several arguments for retaining state flexibility to enroll this population. First, partial-benefit dually eligible beneficiaries currently enrolled in D-SNPs may at some point have a change in eligibility status and become full-benefit dually eligible beneficiaries. If these beneficiaries cannot initially enroll in D-SNPs, there is greater potential for disruptions in care when they become eligible for full Medicaid benefits, because they would have to change plans to gain the benefits of integrated care. For example, over the course of three years, from January 2013 to January 2016, 10 percent of partial-benefit dually eligible beneficiaries had a change in eligibility status that qualified them as full-benefit dually eligible beneficiaries (MedPAC 2018).

Second, D-SNPs may be better positioned than traditional MA plans to provide support specific to partial-benefit dually eligible beneficiaries. Through a health risk assessment process, required of all D-SNPs, that is tailored to the dually eligible population, D-SNPs may recognize the additional benefits that partial-benefit dually eligible beneficiaries qualify for, such as a state HCBS waiver slot, or help connect them to other community resources (CMS 2014).<sup>17</sup> The D-SNP may even help a partial-benefit dually eligible beneficiary identify that they qualify for full Medicaid benefits and update their eligibility status. The member could then remain in the D-SNP with uninterrupted care.

Although removing currently enrolled partial-benefit dually eligible beneficiaries from D-SNPs may disrupt their care, this disruption could be mitigated if they are able to enroll in an MA plan offered by the same parent organization if it has a similar provider network (MedPAC 2018). In 2016, the parent organizations of 93 percent of D-SNP plans also offered a regular MA plan in the same service

area (MedPAC 2018). If partial-benefit dually eligible beneficiaries switch to the parent organization's regular MA plan, the providers available to them may not change, resulting in minimal disruption.

**Ongoing Commission work.** The Commission plans to explore the potential effects of limiting D-SNP enrollment to full-benefit dually eligible beneficiaries. This work might include studying the prevalence of churn between eligibility for full and partial Medicaid benefits. We also expect to examine alternative policy options, such as requiring plans to remove partial-benefit dually eligible beneficiaries from D-SNPs but allowing them to enroll such beneficiaries into a separate plan with a similar network that focuses on this population.

## Commission Recommendations

In this report, the Commission makes two recommendations to further integration efforts by making it easier for eligible individuals to enroll in integrated plans and enhancing state capacity to integrate care.

### Recommendation 2.1

The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

#### Rationale

Under current law, the SEP allows dually eligible beneficiaries to enroll, switch plans, or disenroll outside of the annual open enrollment period.

Until January 1, 2019, that SEP was open-ended or continuous, meaning that dually eligible beneficiaries could enroll, disenroll, or switch plans monthly. After that date, CMS modified the SEP to limit changes to coverage to once per quarter for the first nine months of the year (i.e., three times per year).

The SEP is an MA regulatory policy, but it also applies to MMPs under the FAI (CMS 2018b, ICRC 2018).<sup>18</sup> States participating in a capitated model under the FAI were given the option to waive the narrower SEP and all states did so for 2019 and 2020. As a result, unlike other dually eligible beneficiaries, beneficiaries in MMPs can enroll, switch between MMPs, and disenroll on a continuous basis. States waived the narrower SEP because it would limit enrollment to only three times per year. Given lower than expected enrollment in the MMPs across all participating states, states and plans are interested in policies that would increase enrollment. MACPAC's recommendation would maintain the continuous SEP for purposes of enrollment, but apply the narrower SEP for switching plans and disenrolling. This would allow MMP-eligible individuals to benefit from the continuity of care that the narrower SEP was intended to promote while retaining state preferences to enroll eligible beneficiaries on a continuous (monthly) basis. Federal officials told us this could be done without a regulatory change.

### Implications

**Federal spending.** This recommendation would not have a direct effect on federal spending.

**States.** This recommendation would require all states with MMPs to conform to the same standard regarding beneficiaries' ability to switch MMPs or disenroll from an MMP.

**Enrollees.** Beneficiaries would have less flexibility to switch between MMPs or to disenroll from an MMP but could benefit from the continuity of care possible with less plan switching.

**Plans and providers.** MMPs would experience more continuity of enrollment under this

recommendation, because beneficiaries could switch plans or disenroll quarterly for only the first three quarters of the year.

## Recommendation 2.2

Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

### Rationale

The Commission recommends additional federal funding to enhance state capacity to integrate care in two ways: by training state staff in Medicare and by financing the up-front costs of designing and implementing new models. States are operating with limited resources and additional federal funding could be used to help states interested in integrating care that have not yet established an integrated program. This funding would be made available to states interested in establishing any type of model identified by CMS, including capitated, MFFS, or an alternative, state-specific model (CMS 2019a).

Medicare expertise is essential for states interested in integrating care for their dually eligible beneficiaries. For example, states have discretion to set parameters for D-SNPs through contracts with the state Medicaid program, which are required for D-SNPs to operate in a state, but many states have not fully used their existing authorities, in part because of a lack of familiarity with the MA program. Designing a contract with a D-SNP requires expertise in Medicare eligibility rules, benefits, and processes (e.g., appeals and grievances) that may differ from Medicaid. It also requires familiarity with available authorities granted to states under laws like MIPPA, which allows states to establish requirements for D-SNPs before approving a contract. In addition, states have competing demands on their resources, and staff working on integrated care may have other substantial responsibilities, which make it difficult to devote resources to developing Medicare expertise.

New integrated care models require extensive planning and dedicated staff to establish them. The up-front costs may be substantial and state Medicaid agencies would generally need approval from state legislatures for the added Medicaid expense. Even if the new integrated model ultimately reduces state spending through better coordination of care, as has been shown in Washington State, states still need to finance the up-front costs of establishing the model before any potential savings can be realized.

The additional funding could take the form of an enhanced FMAP similar to the 90 percent FMAP available under current law for the transition to the Transformed Medicaid Statistical Information System (T-MSIS), available on a temporary or permanent basis. It could also be provided through a grant program, modeled after the \$1 million grants made available to states participating in the FAI to cover their up-front costs (CMS 2011).

### Implications

**Federal spending.** This recommendation would increase federal spending by the amount of the FMAP increase or the grant amount. It could also affect spending based on the extent to which states' strategies affect integration, although this may be difficult to quantify.

**States.** This recommendation would increase state Medicare expertise, reducing one of the barriers of moving to an integrated care model. It would enable states to leverage their MIPPA authority to integrate care through D-SNPs. It would also help states that are interested in participating in the FAI, whether they wished to use existing models or to establish a new model.

**Enrollees.** There is no direct effect on beneficiaries, but the eventual effect on beneficiaries will depend upon which actions states take.

**Plans and providers.** There is no direct effect on plans and providers, but states would be better informed in dealing with plans and might also be able to help providers adjust to new models.

## Looking Ahead

Improving the implementation of integrated care for dually eligible beneficiaries, understanding the challenges faced by state and federal policymakers, and developing viable solutions are high priorities for the Commission. As noted earlier, we view our work on integrated care for dually eligible beneficiaries as a multiyear project because of the difficulty of coordinating benefits between two distinct programs for a complex population. As such, we will continue exploring the policy options described above and assess the potential for making additional recommendations in future reports.

Addressing fragmented care and high costs associated with coverage for individuals enrolled in both programs is not an easy task. In this chapter, we have discussed the varying integrated care models currently in use but we have also shown that those models are not present in all states and that many beneficiaries who have access to integrated products are not enrolled. The challenges of integrating care in the current environment have led some stakeholders to begin exploring whether the future of health care coverage for dually eligible beneficiaries requires creating a new program that is uniquely focused on this population that would no longer require these beneficiaries to navigate two sets of confusing, and often conflicting, rules. In the years ahead, the Commission will review proposals that would restructure coverage for dually eligible beneficiaries in a more comprehensive way than is possible while maintaining separate programs.

## Endnotes

<sup>1</sup> The capitated model in the FAI establishes Medicare-Medicaid Plans (MMPs) through a three-way contract between states, health plans, and the Centers for Medicare & Medicaid Services (CMS). This model uses a capitated prospective monthly payment made to plans to provide services to enrollees. For more detailed information on the capitated model, see Chapter 1 in this report.

<sup>2</sup> See 42 CFR 422.66(c) for federal requirements for default enrollment.

<sup>3</sup> Individuals receiving Medicaid benefits through limited benefit plans or under other arrangements such as managed fee for service (MFFS) or health homes are not eligible for default enrollment (Stringer and Kruse 2019).

<sup>4</sup> Regulations at 42 CFR 435.916(d) require that states redetermine Medicaid eligibility promptly whenever the state receives information about a change that may affect Medicaid eligibility.

<sup>5</sup> For our purposes, the term Medicare agents and brokers is used to refer to entities that sell Medicare plans for companies that contract with Medicare, not employees of particular MA plans. They differ from Medicaid enrollment brokers who contract with states to assist Medicaid beneficiaries with selecting Medicaid managed care plans.

<sup>6</sup> The ICRC, coordinated by Mathematica and the Center for Health Care Strategies, provides technical assistance to states with support from CMS.

<sup>7</sup> Under CMS's proposal, dually eligible beneficiaries would use the same annual enrollment period as all other Medicare Advantage beneficiaries for everything related to coverage other than (1) switching after auto-assignment into a Part D plan or (2) enrolling in an integrated plan.

<sup>8</sup> This frailty adjustment would be similar to the adjustment applied to fully integrated dual eligible special needs plans (FIDE SNPs) under current law.

<sup>9</sup> In some cases Medicare requirements are broader than Medicaid requirements (Archibald et al. 2019b).

<sup>10</sup> BBA 2018 specifies that for 2021 through 2025, the Secretary may impose a sanction preventing a D-SNP

from enrolling new members if it does not meet the new integration standards. While sanctioned D-SNPs cannot enroll new members, they can continue to serve previously enrolled beneficiaries (CMS 2019b).

<sup>11</sup> The cost-sharing structures of D-SNP look-alike plans are not appealing to Medicare beneficiaries who do not receive the cost-sharing assistance that dually eligible beneficiaries do (MedPAC 2018).

<sup>12</sup> Two features of the MA market have implications for plan and beneficiary behavior relevant to the growth of look-alike plans: First, dually eligible beneficiaries may choose among FFS and multiple MA plans, including D-SNPs and others. Second, plan offerings (D-SNPs, look-alikes, and other MA plans) are the result of business decisions about different markets. In short, beneficiaries are not locked into certain types of plans and plans are not required to offer these options.

<sup>13</sup> Companies interested in offering an MA plan for the next contract year undergo a variety of steps to gain approval, including submitting a bid pricing tool that contains information on the cost of providing MA benefits to enrollees (CMS 2019d, ICRC 2017).

<sup>14</sup> These figures do not represent actual enrollment, which would have to be obtained after the plan year begins.

<sup>15</sup> In total, 17 interviews were conducted from October 2019 to January 2020.

<sup>16</sup> The states offering D-SNPs that do not allow partial-benefit dually eligible beneficiaries to enroll are Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, and Virginia.

<sup>17</sup> To be eligible for an HCBS waiver, beneficiaries must meet certain functional criteria, which could be identified through the health risk assessment that D-SNPs must provide (CMS 2014, 42 CFR 422.101).

<sup>18</sup> See 42 CFR 423.38 for federal regulations on SEPs.

## References

- Archibald, N., K. Moses, and L. Rava. 2019a. *Using health homes to integrate care for dually eligible individuals: Washington State's experiences*. Washington, DC: Integrated Care Resource Center. [https://www.integratedcareresourcecenter.com/sites/default/files/Washington%20case%20study\\_Final.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/Washington%20case%20study_Final.pdf).
- Archibald, N., M. Soper, L. Smith, et al. 2019b. *Integrating care through dual eligible special needs plans (D-SNPs): Opportunities and challenges*. Washington, DC: Assistant Secretary for Planning and Evaluation (ASPE). <https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges>.
- Barth, S., S. Silow-Carroll, E. Reagan, et al. 2019. *Care coordination in integrated care programs serving dually eligible beneficiaries: Health plan standards, challenges and evolving approaches*. Report to the Medicaid and CHIP Payment and Access Commission. Lansing, MI: HMA. <https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf>.
- Betlach, T., and K. Kimsey. 2018. State experiences integrating care for dually eligible beneficiaries: Panel on state perspectives. Presentation before the Medicaid and CHIP Payment and Access Commission, October 26, 2018, Washington, DC. <https://www.macpac.gov/wp-content/uploads/2018/10/October-2018-Meeting-Transcript.pdf>.
- Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020. People who are at higher risk for severe illness. Atlanta, GA: CDC. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Medicare-Medicaid Coordination Office FY 2019 Report to Congress*. February 10, 2020. Baltimore, MD: CMS. <https://www.cms.gov/files/document/mmco-report-congress.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Financial alignment initiative. Baltimore, MD: CMS. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Memo from Sharon Donovan regarding “Additional guidance on CY 2021 Medicare-Medicaid integration requirements for Dual Eligible Special Needs Plans (D-SNPs).” January 17, 2020. <https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. Letter from Seema Verma to state Medicaid directors regarding “Three new opportunities to test innovative models of integrated care for individuals dually eligible for Medicaid and Medicare.” April 24, 2019. <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Medicare and Medicaid programs: Policy and technical changes to the Medicare Advantage, Medicare prescription drug benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid fee-for-service, and Medicaid managed care programs for years 2020 and 2021. Final rule. *Federal Register* 73, no. 83 (April 16) 15680–15844. <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019c. CMCS informational bulletin regarding “Medicare-Medicaid integration and unified appeals and grievance requirements for state Medicaid agency contracts with Medicare Advantage dual eligible special needs plans (D-SNPs) for contract year 2021.” November 14, 2019. <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111419-2.pdf>.



Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019d. Instructions for completing the Medicare Advantage Bid Pricing Tools for contract year 2020. Baltimore, MD: CMS. <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtSpecRateStats/Bid-Pricing-Tools-and-Instructions-Items/BPT2020>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. Memo from Lindsay P. Barnette regarding “California MMPs: Update to agent/broker compensation policy for contract year 2019.” June 11, 2018. [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAAgentBrokerCompensationPolicyUpdateCY2019\\_06112018.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/CAAgentBrokerCompensationPolicyUpdateCY2019_06112018.pdf).

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. Medicare program: Contract year 2019 policy and technical changes to the Medicare Advantage, Medicare Cost Plan, Medicare fee-for-service, the Medicare prescription drug benefit programs, and the PACE program. Final rule. *Federal Register* 83, no. 73 (April 16): 16440–16757. <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. *Medicare managed care manual: Chapter 5—Quality assessment*. Baltimore, MD: CMS. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. 15 states win contracts to develop new ways to coordinate care for people with Medicare and Medicaid. April 14, 2011, press release. Baltimore, MD: CMS. <https://edit.cms.gov/newsroom/fact-sheets/15-states-win-contracts-develop-new-ways-coordinate-care-people-medicare-and-medicare>.

Chelminsky, D., J. Stone, and C. Postman. 2017. *Tips for states using enrollment brokers in the Capitated Financial Alignment Demonstrations: Beneficiary FAQs and suggested responses*. Washington, DC: Integrated Care Resource Center. <https://www.integratedcareresourcecenter.com/sites/default/files/EnrollmentBrokersCFAMemo.pdf>.

Executive Office of Health & Human Services (EOHHS), State of Rhode Island. 2020. *Fact sheet: Neighborhood INTEGRITY, Rhode Island’s Medicare-Medicaid Plan*. Cranston, RI: EOHHS. [http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/IC12\\_FactSheet\\_v2.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/IC12_FactSheet_v2.pdf).

Gifford, K., E. Ellis, A. Lashbrook, et al. 2019. *A view from the states: Key Medicaid policy changes. Results from a 50-state Medicaid budget survey for state fiscal years 2019 and 2020*. Washington, DC: Kaiser Family Foundation and the National Association of Medicaid Directors. <http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes>.

Integrated Care Resource Center (ICRC). 2020a. Phone call with MACPAC. January 31.

Integrated Care Resource Center (ICRC). 2020b. Working with Medicare. Washington, DC: ICRC. [https://www.integratedcareresourcecenter.com/resource-library?&field\\_resource\\_type%5B0%5D=306&field\\_resource\\_type%5B1%5D=307](https://www.integratedcareresourcecenter.com/resource-library?&field_resource_type%5B0%5D=306&field_resource_type%5B1%5D=307).

Integrated Care Resource Center (ICRC). 2020c. *Monthly enrollment in Medicare-Medicaid Plans by plan and by state, February 2019 to February 2020*. Accessed March 2020. Washington, DC: ICRC. <https://www.integratedcareresourcecenter.com/resource/monthly-enrollment-medicare-medicare-plans-plan-and-state-february-2019-february-2020>.

Integrated Care Resource Center (ICRC). 2019. *Sample language for state Medicaid agency contracts with dual eligible special needs plans*. Washington, DC: ICRC. [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_SMACSampleLanguage\\_FINAL.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_SMACSampleLanguage_FINAL.pdf).

Integrated Care Resource Center (ICRC). 2018. *Enrollment periods for dually eligible beneficiaries in capitated model Financial Alignment Initiative (FAI) demonstrations*. Washington, DC: ICRC.

<https://www.integratedcareresourcecenter.com/content/enrollment-periods-dually-eligible-beneficiaries-capitated-model-financial-alignment>.

Integrated Care Resource Center (ICRC). 2017. *Key Medicare Advantage dates and action items for states contracting with dual eligible special needs plans*. Washington, DC: ICRC.

[https://www.integratedcareresourcecenter.com/sites/default/files/Key\\_MA\\_Dates\\_for\\_States\\_Contracting\\_with\\_D-SNPs.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf).

Kruse, A., and M.H. Soper. 2020. *State efforts to integrate care for dually eligible beneficiaries: 2020 Update*. Hamilton, NJ: CHCS. [https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries\\_022720.pdf](https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf).

Lakhmani, E.W., Mathematica. 2020. Email to MACPAC, January 31.

Libersky, J., J. Verdier, and R. Stringer. 2017. *Medicare basics: An overview for states seeking to integrate care for Medicare-Medicaid enrollees*. Washington, DC: Integrated Care Resource Center. [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_Medicare\\_Basics\\_Updated\\_June\\_2017.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Medicare_Basics_Updated_June_2017.pdf).

Lipson, D., E. Lakhmani, A. Tourtellotte, and D. Chelminsky. 2018. *The complex art of making it simple: Factors affecting enrollment in integrated care demonstrations for dually eligible beneficiaries*. Washington, DC: Mathematica. <https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Geographic availability of integrated care models for dually eligible beneficiaries. Presentation before MACPAC, January 23, 2020, Washington, DC. <https://www.macpac.gov/publication/geographic-availability-of-integrated-care-models-for-dually-eligible-beneficiaries/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Comment letter on proposed rule: CMS-4190-P Medicare and Medicaid Programs; contract year 2021 and 2022 policy and technical changes to the Medicare Advantage program, Medicare prescription drug benefit program, Medicaid program, Medicare Cost Plan program, and Programs of All-Inclusive Care for the Elderly (April 6, 2020). <https://www.macpac.gov/publication/comments-on-proposed-rule-on-medicare-advantage/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019a. *Electronic visit verification for personal care services: Status of state implementation*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/electronic-visit-verification-for-personal-care-services-status-of-state-implementation/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. *Implementation of the home- and community-based services settings rule*. Washington, DC: MACPAC. <https://www.macpac.gov/publication/implementation-of-the-home-and-community-based-services-settings-rule/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019c. *Evaluations of integrated care models for dually eligible beneficiaries: Key findings and research gaps*. July 2019 issue brief. Washington, DC: MACPAC. <https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Comment letter on proposed rule: CMS-4185-P Medicare and Medicaid programs; policy and technical changes to the Medicare Advantage, Medicare prescription drug benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid fee-for-service, and Medicaid managed care programs for years 2020 and 2021 (December 28, 2018). Washington, DC: MACPAC. <https://www.macpac.gov/publication/comments-on-proposed-changes-to-medicare-advantage-dual-eligible-special-needs-plans/>.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2018. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC and MedPAC. <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>.

Medicare Payment Advisory Commission (MedPAC). 2019a. Chapter 12: Promoting integration in dual-eligible special needs plans. In *Report to the Congress: Medicare and the health care delivery system*. June 2019. Washington, DC: MedPAC. [http://www.medpac.gov/docs/default-source/reports/jun19\\_ch12\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0).

Medicare Payment Advisory Commission (MedPAC). 2019b. *Medicare Advantage program payment system*. Washington, DC: MedPAC. [http://www.medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_19\\_ma\\_final\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_19_ma_final_sec.pdf?sfvrsn=0).

Medicare Payment Advisory Commission (MedPAC). 2018. Chapter 9: Managed care plans for dual-eligible beneficiaries. In *Report to the Congress: Medicare and the health care delivery system*. June 2018. Washington, DC: MedPAC. [http://medpac.gov/docs/default-source/reports/jun18\\_ch9\\_medpacreport\\_sec.pdf](http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf).

Ptaszek, A., A. Chepaitis, A. Greene, et al. 2017. *Beneficiary experience: Early findings from focus groups with enrollees participating in the Financial Alignment Initiative*. Report to CMS, contract no. HHSM500201000021i TO 3. Baltimore, MD: Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/files/reports/fai-focusgroup-issuebrief.pdf>.

SNP Alliance. 2018. *Enrollment alignment is essential to fully integrated care for Medicare-Medicaid beneficiaries*. Washington, DC: SNP Alliance. <https://www.snpalliance.org/wp-content/uploads/2020/04/enrollment-alignment-and-integration-10-5-2018-002.pdf>.

Stringer, R., and A. Kruse. 2019. *Using default enrollment to align coverage for dually eligible Medicare-Medicaid beneficiaries*. Washington, DC: Integrated Care Resource Center. <https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries>.

U.S. Government Accountability Office (GAO). 2020. *Medicare and Medicaid: Alignment of managed care plans for dual-eligible beneficiaries*. Report no. GAO-20-319. Washington, DC: GAO.

<https://www.gao.gov/assets/710/705345.pdf>.

Verdier, J., and D. Chelminsky. 2017. *State and health plan strategies to grow enrollment in integrated managed care plans for dually eligible beneficiaries*. Washington, DC: Integrated Care Resource Center.

[https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_Growing\\_Enrollment\\_in\\_Integrated\\_Managed\\_Care\\_Plans\\_FINAL\\_6-01-17.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf).

Verdier, J., A. Kruse, R.S. Lester, et al. 2016. *State contracting with Medicare Advantage dual eligible special needs plans: Issues and options*. Washington, DC: Integrated Care Resource Center. [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_DSNP\\_Issues\\_\\_Options.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues__Options.pdf).

## Commission Vote on Recommendations

In MACPAC’s authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on integrating care for dually eligible beneficiaries. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 2.1 and Recommendation 2.2 on April 2, 2020.

### Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options

2.1 The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

Yes: Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno

16	Yes
1	Not present

Not present: Barker

2.2 Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Yes: Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Szilagyi, Weno

15	Yes
1	Abstain
1	Not present

Abstain: Scanlon

Not present: Barker

# APPENDIX 2A: Supplemental Benefits Offered by Medicare Advantage Plans

TABLE 2A-1. Selected Supplemental Benefits Offered in 2020, by Plan Type

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
<b>All plans</b>	<b>3,944</b>	<b>100%</b>	<b>98</b>	<b>100%</b>	<b>531</b>	<b>100%</b>	<b>150</b>	<b>100%</b>	<b>158</b>	<b>100%</b>	<b>3,007</b>	<b>100%</b>
<b>Hearing services</b>	<b>3,619</b>	<b>91.8</b>	<b>91</b>	<b>92.9</b>	<b>462</b>	<b>87.0</b>	<b>126</b>	<b>84.0</b>	<b>153</b>	<b>96.8</b>	<b>2,787</b>	<b>92.7</b>
Hearing exams	3,597	91.2	91	92.9	453	85.3	124	82.7	153	96.8	2,776	92.3
Hearing aids	3,375	85.6	91	92.9	458	86.3	126	84.0	151	95.6	2,549	84.8
<b>Dental services</b>	<b>3,704</b>	<b>93.9</b>	<b>76</b>	<b>77.6</b>	<b>476</b>	<b>89.6</b>	<b>113</b>	<b>75.3</b>	<b>158</b>	<b>100.0</b>	<b>2,881</b>	<b>95.8</b>
Preventive dental	3,687	93.5	74	75.5	466	87.8	108	72.0	158	100.0	2,881	95.8
Comprehensive dental	3,461	87.8	75	76.5	456	85.9	105	70.0	149	94.3	2,676	89.0
<b>Vision services</b>	<b>3,859</b>	<b>97.8</b>	<b>94</b>	<b>95.9</b>	<b>493</b>	<b>92.8</b>	<b>144</b>	<b>96.0</b>	<b>157</b>	<b>99.4</b>	<b>2,971</b>	<b>98.8</b>
Eye exams	3,831	97.1	94	95.9	470	88.5	143	95.3	157	99.4	2,967	98.7
Eyewear	3,612	91.6	94	95.9	491	92.5	143	95.3	157	99.4	2,727	90.7
<b>Preventive health services</b>	<b>3,852</b>	<b>97.7</b>	<b>97</b>	<b>99.0</b>	<b>497</b>	<b>93.6</b>	<b>105</b>	<b>70.0</b>	<b>156</b>	<b>98.7</b>	<b>2,997</b>	<b>99.7</b>
Annual physical exam	3,183	80.7	81	82.7	316	59.5	73	48.7	80	50.6	2,633	87.6
Health education	1,152	29.2	15	15.3	133	25.0	22	14.7	60	38.0	922	30.7
Nutritional or dietary benefit	385	9.8	5	5.1	43	8.1	1	0.7	32	20.3	304	10.1
Smoking and tobacco cessation counseling	1,014	25.7	11	11.2	172	32.4	6	4.0	32	20.3	793	26.4
Fitness benefit	3,593	91.1	85	86.7	456	85.9	29	19.3	149	94.3	2,874	95.6
Enhanced disease management	277	7.0	6	6.1	14	2.6	-	-	-	-	257	8.5

**TABLE 2A-1. (continued)**

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
Telemonitoring services	259	6.6%	6	6.1%	46	8.7%	3	2.0%	33	20.9%	171	5.7%
Remote access technologies	2,644	67.0	65	66.3	340	64.0	31	20.7	113	71.5	2,095	69.7
Bathroom safety devices	284	7.2	5	5.1	51	9.6	-	-	5	3.2	223	7.4
Counseling services	83	2.1	1	1.0	10	1.9	-	-	-	-	72	2.4
In-home safety assessment	141	3.6	6	6.1	7	1.3	1	0.7	7	4.4	120	4.0
Personal emergency response system	627	15.9	56	57.1	256	48.2	7	4.7	36	22.8	272	9.0
Medical nutrition therapy	406	10.3	12	12.2	127	23.9	1	0.7	21	13.3	245	8.1
Postdischarge in-home medication reconciliation	98	2.5	-	-	4	0.8	1	0.7	3	1.9	90	3.0
Readmission prevention	86	2.2	7	7.1	16	3.0	7	4.7	9	5.7	47	1.6
Wigs for hair loss related to chemotherapy	223	5.7	9	9.2	110	20.7	-	-	2	1.3	102	3.4
Weight-management programs	153	3.9	8	8.2	12	2.3	-	-	6	3.8	127	4.2
Alternate therapies	115	2.9	2	2.0	1	0.2	7	4.7	2	1.3	103	3.4
Therapeutic massage	186	4.7	3	3.1	35	6.6	2	1.3	12	7.6	134	4.5
Adult day health services	78	2.0	2	2.0	21	4.0	-	-	15	9.5	40	1.3
Home-based palliative care	55	1.4	-	-	3	0.6	-	-	-	-	52	1.7
In-home support services	209	5.3	15	15.3	73	13.7	1	0.7	26	16.5	94	3.1
Support for caregivers of enrollees	121	3.1	9	9.2	48	9.0	1	0.7	20	12.7	43	1.4

**TABLE 2A-1. (continued)**

Benefit	All MA plans		D-SNP look-alike plans		D-SNP		I-SNP		C-SNP		Other MA plans	
	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans	# of plans	% of plans
<b>Clinical services</b>	3,044	77.2%	90	91.8%	477	89.8%	134	89.3%	147	93.0%	2,196	73.0%
Chiropractic services	855	21.7	37	37.8	199	37.5	15	10.0	49	31.0	555	18.5
Podiatry services	1,566	39.7	63	64.3	316	59.5	131	87.3	113	71.5	943	31.4
Acupuncture	834	21.1	39	39.8	152	28.6	6	4.0	56	35.4	581	19.3
Nicotine replacement therapy	2,129	54.0	85	86.7	407	76.6	82	54.7	106	67.1	1,449	48.2
<b>Auxiliary services</b>	3,333	84.5	95	96.9	517	97.4	136	90.7	157	99.4	2,428	80.7
Non-emergency transportation	1,763	44.7	89	90.8	436	82.1	128	85.3	137	86.7	973	32.4
Meal benefit	1,909	48.4	49	50.0	390	73.4	8	5.3	111	70.3	1,351	44.9
Over-the-counter drugs	2,855	72.4	94	95.9	501	94.4	104	69.3	144	91.1	2,012	66.9

**Notes:** MA is Medicare Advantage. D-SNP is dual eligible special needs plan. I-SNP is institutional special needs plan. C-SNP is chronic condition special needs plan. D-SNP look-alike plans are defined as traditional MA plans in which dually eligible beneficiaries comprise greater than 50 percent of projected total enrollment. Other MA plans include traditional MA plans that are not D-SNP look-alike plans, D-SNPs, I-SNPs, or C-SNPs. Figures exclude plans that do not provide drug coverage as well as employer plans, cost plans, Medical Savings Account plans, and plans that operate only in Puerto Rico.

– Dash indicates zero.

**Source:** MACPAC, 2020, analysis of 2020 Medicare Advantage bid and plan benefits package data from the Centers for Medicare & Medicaid Services.