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

MARCH 2017

Contents

Introduction ................................................................................................................ 2
States Are Focused on Integration Opportunities for Dual Eligible Beneficiaries .......... 2
Long-Standing Challenges with Serving Dual Eligible Beneficiaries ....................... 3
D-SNPs Offer States Flexible Options for Integration .............................................. 4
D-SNPs Can Help States Improve Beneficiary Care and Experiences ...................... 7
Key Takeaways ........................................................................................................ 10
Conclusion ............................................................................................................. 11
INTRODUCTION

A growing number of states are examining the role that dual eligible special needs plans (D-SNPs) can play in improving care delivery and health outcomes for individuals who are eligible for both Medicare and Medicaid benefits, also known as “dual eligibles.” D-SNPs provide an existing, flexible framework to better coordinate care and align benefits for dual eligibles, while also offering states options for varying levels of integration and oversight. The combination of these factors can be attractive to states seeking to improve care coordination for dual eligibles with a relatively small initial commitment of resources. Further, D-SNPs offer an opportunity for states to increase coordination and integration of Medicaid benefits for dual eligibles through more active contracting strategies as states gain experience in using this model.

This paper describes the value that D-SNPs offer states that desire a program for full benefit dual eligible beneficiaries that better integrates and coordinates care and benefits across Medicare and Medicaid. In examining states’ experiences with D-SNPs, as well as the results of several early studies of D-SNPs, this paper finds that D-SNPs can offer a number of benefits, including:

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

Drawing from interviews with current and former state Medicaid program staff in states that have used D-SNPs for greater program integration, as well as policy experts in this area, this paper also highlights key takeaways for states working with D-SNPs to drive integration of benefits and care delivery for dual eligible beneficiaries.

STATES ARE FOCUSED ON INTEGRATION OPPORTUNITIES FOR DUAL ELIGIBLE BENEFICIARIES

A 2012 survey of all 50 states and the District of Columbia found that two-thirds of states were interested in implementing a range of new initiatives to better integrate and coordinate care for dual eligibles. Indeed, more than half of states expressed initial interest in the new flexibility offered by the Financial Alignment Initiative (FAI) or “duals demonstration,” even though ultimately the FAI model was not the right fit for many of those states.

States’ interest and focus on options for integrating care stems from the recognition that dual eligibles experience difficulties in accessing benefits and care in a coordinated manner. Further, states continue to face high costs for dual eligible beneficiaries without meaningful improvement in outcomes and quality. While states grapple with the common challenge of better serving dual eligibles, they are considering a range of options—including opportunities that existing programs afford—in an effort to develop customized programs that reflect the unique needs of their states and the beneficiaries they serve.

As a result, a growing number of states are reexamining the role of D-SNPs in helping drive duals integration, particularly for full benefit dual eligibles (those that are eligible for full Medicaid benefits in their states, including LTSS as needed). Recent evidence shows that D-SNPs can be used successfully to improve dual eligibles’ experience receiving care and health outcomes, especially when Medicare and Medicaid benefits are more fully aligned or integrated. Figure 1 provides an overview of the levels of integration that can be achieved through D-SNPs.
LONG-STANDING CHALLENGES WITH SERVING DUAL ELIGIBLES DRIVE STATES’ CONTINUED INTEREST IN GREATER INTEGRATION

Dual eligibles are a costly and complex population to serve. Relative to non-dual eligible beneficiaries, dual eligibles’ poorer health status and limited economic resources, along with the challenges they face in navigating fragmented benefits and care delivery across the two insurance programs, result in higher federal and state costs. As a result, policymakers have long focused on ways to improve the quality of care and health outcomes for dual eligibles while simultaneously providing more cost effective care.

Not only are dual eligibles by definition a low income population, they also tend to have significant health issues. More than twice as many dual eligible beneficiaries as non-dual Medicare beneficiaries report being in poor health (19 percent compared to 7 percent). Further, 41 percent of dual eligibles have at least one mental health diagnosis, while 60 percent have multiple chronic conditions. Seventeen percent of dual eligibles report living in an institution, compared to only 2 percent of non-dual Medicare beneficiaries.

Dual eligibles represent a disproportionate share of Medicare and Medicaid spending relative to their share of enrollment in each program. In 2011, dual eligibles represented approximately 20 percent of Medicare beneficiaries but accounted for about 35 percent of Medicaid spending. In Medicaid, they accounted for an estimated 14 percent of enrollment but 33 percent of total spending. Average per-beneficiary total spending for dual eligibles is about twice that for non-dual eligibles.
Many dual eligibles experience challenges in navigating their healthcare benefits because they are covered by two different programs, often with two different provider networks. Medicare covers acute care services and prescription drugs, while Medicaid covers LTSS; augmented behavioral health services; additional “wrap” services that may include non-medical transportation, dental and vision benefits; and payment of some or all Medicare premiums and cost-sharing. As a result of uncoordinated benefit and payment systems, care delivery is often splintered, which can result in poor quality and less than optimal health outcomes.

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

**D-SNPs Offer States Flexible Options for Integration**

**Content Highlight**

D-SNPs offer states a continuum of options, allowing states to advance integration in a way that best meets their needs.

In the last several years, as states have looked to health plans to test new approaches to integrating care for dual eligibles, D-SNPs have become an increasingly important option for states. This is particularly true in light of some of the limitations of the FAI. For instance, some states did not have the resources required to support their participation in the demonstration.
And even among states that are participating, there are challenges with the model, including that enrollment has lagged behind expectations. In part because of these limitations, more states have turned to the flexible model in D-SNPs, and use of D-SNPs has increased. As of July 2016, there were 350 D-SNPs serving over 1.8 million dual eligible beneficiaries.\(^\text{18}\)

In 2010, the Affordable Care Act officially authorized fully integrated dual eligible special needs plans (FIDE-SNPs), which are D-SNPs where the state includes all Medicaid services in the contract with the plan, including coverage of LTSS. FIDE-SNPs have the highest degree of benefit integration under the D-SNP model. FIDE-SNPs are required to have policies and procedures that better coordinate or integrate enrollment processes, member materials, communications, grievance and appeals, and quality improvement. It is important to highlight that FIDE-SNPs offer a single source of coverage for all Medicare and Medicaid benefits. FIDE-SNPs also have flexibility to offer supplemental benefits not typically covered by Medicare not otherwise covered by Medicaid. Certain FIDE-SNPs are eligible for additional payments to account for the frailty of their enrollees.

*Figure 3. History of D-SNPs, 1990s-2015\(^{19,20,21}\)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990s</td>
<td>MN, AZ developed early integration programs for dual eligibles</td>
</tr>
<tr>
<td>2003</td>
<td>MMA created new MA plans for “individuals with special needs” including D-SNPs for dual eligibles; SNPs were authorized through 2008</td>
</tr>
<tr>
<td>2004</td>
<td>SNPs received one-time enrollment boost through passive enrollment, plan transfers, and conversion of existing plans and demonstration plans to SNPs</td>
</tr>
<tr>
<td>2006</td>
<td>SNPs extended through 2009, but moratorium imposed on new or expanded SNPs for CY 2009</td>
</tr>
<tr>
<td>2007</td>
<td>ACA reauthorized SNP program through 2013, codified the FIDE-SNP, and paved the way for the FAI</td>
</tr>
<tr>
<td>2008</td>
<td>MIPPA added new contracting requirements for D-SNPs, lifted moratorium on new or expanded SNPs for CY 2010, and reauthorized program through 2010</td>
</tr>
<tr>
<td>2010</td>
<td>SNPs authorized annually; legislative vehicle varied</td>
</tr>
<tr>
<td>2013-14</td>
<td>MACRA extended SNP program through 2018</td>
</tr>
<tr>
<td>2015</td>
<td>SNP s extended through 2009, but moratorium imposed on new or expanded SNPs for CY 2009</td>
</tr>
</tbody>
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Notes: MMA=Medicare Modernization Act, SNP=Special Needs Plan, MIPPA=Medicare Improvements for Patients and Providers Act, ACA=Affordable Care Act, FIDE-SNP=Fully Integrated Dual Eligible SNP, FAI=Financial Alignment Initiative, MACRA=Medicare Access and CHIP Reauthorization Act

Despite the lack of a permanent federal authorization for the SNP program, D-SNPs offer a valuable option for states to work towards better integration and alignment. In many ways, D-SNPs offer greater flexibility for states compared to the more complex Medicare-Medicaid plans that a state could develop under the Centers for Medicare & Medicaid Services’ FAI, and they may require fewer state resources to either start or expand a state’s dual eligible integration efforts. The National Association of Medicaid Directors (NAMD) has observed that D-SNP “contracts do not require demonstration authority and thus are well suited to become a preferred pathway to achieve meaningful improvements for beneficiaries.”\(^{22}\)
Improving Value for Dual Eligible Beneficiaries: The Role of D-SNPs

The continuum of options available to states wishing to contract with D-SNPs, from the minimum contracting requirements mandated by MIPPA to full integration of Medicare and Medicaid benefits under a FIDE-SNP, provides the necessary flexibility for states to develop a program that best fits their needs and populations. As shown below in Figure 4, states vary in their approach to D-SNPs, with states like Maine, Oregon, and Pennsylvania contracting only on the MIPPA requirements, while states like Florida, New York, and Texas cover some Medicaid cost sharing or benefits under their contracts. Finally, a number of states such as Massachusetts, Minnesota, New Jersey, and Wisconsin have used D-SNPs to integrate all Medicare and Medicaid benefits for dual eligibles.

**Figure 4. Continuum of D-SNP Contracting: Levels of Integration for Full Benefit Dual Eligibles**

It is important to note that while the focus of this paper is on full benefit dual eligibles, these options for contracting, especially those on the left side of Figure 4 can be easily employed to improve coordination for dual eligibles who receive assistance only for Medicare premiums and cost sharing and not full Medicaid benefits.

Each state—depending on its existing Medicaid infrastructure and programs, available administrative resources, and competing priorities—will carve its own unique path towards integration. The diversity of states using D-SNPs underscores that, regardless of differences across states, D-SNPs are an adaptable tool for advancing integration.
MOVING ALONG THE D-SNP CONTRACTING CONTINUUM CAN HELP STATES IMPROVE BENEFICIARY CARE AND EXPERIENCES

Content Highlight

D-SNPs offer meaningful benefits for dual eligible beneficiaries, providers, and states and can drive improvements in care and beneficiary experience.

Aligning benefits and services across Medicare and Medicaid continues to be a challenge. Some states have examined pathways for achieving greater alignment and are finding that D-SNPs offer the most flexible and accessible option, especially at a time of limited resources and multiple competing priorities. D-SNP contracts allow states to add plan requirements that enhance coordination across Medicare and Medicaid, including provisions for training staff on LTSS benefits, reporting key Medicare information to the state, aligning eligibility and enrollment processes, and facilitating benefits coordination for members. In contrast, some states that considered participating in the FAI concluded that it was not feasible due to the required sustained intensity of state resources, uncertainty in financial modeling, and short timeframes for implementation, among other reasons.

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

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

- In Minnesota’s Senior Health Options (MSHO) program, dual eligible beneficiaries in the integrated MSHO plans are less likely than dual eligible beneficiaries in a non-integrated plan to utilize hospital or emergency department (ED) services, and are more likely to use primary care or other outpatient services. Additionally, beneficiaries in the MSHO program were more likely to use home and community-based long-term care services.

- In New Jersey, early experience suggests improved beneficiary satisfaction, as well as lower hospital readmission rates after the first year of their multi-year integration effort that used D-SNPs to transition to FIDE-SNPs over time.

- In Arizona, D-SNP enrollees have lower rates of hospitalization and ED use compared to dual eligible beneficiaries in Medicare fee-for-service (FFS).

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

D-SNPs Can Improve Beneficiary Experiences

States can use D-SNP contracting strategies to create a benefit structure that works better for dual eligibles, allowing beneficiaries to access a broader, yet targeted, set of benefits and services more seamlessly. D-SNPs also offer members assistance in navigating the entirety of their benefits. For instance, states and D-SNPs can work together to simplify things such as referrals for care or cost sharing under an integrated D-SNP, and the D-SNP can serve as a “one-stop shop” for beneficiaries as they access services.

D-SNPs also provide a single point of care coordination for covered services. Plans are able to track and help manage the services that members receive, which can be especially important for dual eligibles. Therefore D-SNP members may have an easier time accessing needed services or avoiding duplicative care and costs.

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

**D-SNPs Can Drive Care Improvements for Dual Eligibles**

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

Recent data from Minnesota and Arizona highlight positive outcomes for enrollees in D-SNPs. Compared to dual eligibles not in an integrated plan, dual eligibles enrolled in Minnesota’s MSHO program were:

- 48 percent less likely to have a hospital stay;
- 6 percent less likely to have an ED visit;
- 2.7 times more likely to have a primary care visit, but if they had a primary care visit had 36 percent fewer primary care visits overall (likely because primary care doctors were better able to provide more coordinated care in fewer visits); and
- 16 percent less likely to use assisted living or nursing home facilities, but more likely to use home and community based services (HCBS).³²

In Arizona, dual eligibles in aligned health plans compared to dual eligible beneficiaries in Medicare FFS had:

- 31 percent lower rate of hospitalization;
- 43 percent lower rate of days spent in a hospital;
- 9 percent lower rate of ED use; and
- 21 percent lower readmission rate.³³

In New Jersey, early experience with D-SNP integration indicates that D-SNP members have access to enhanced benefits such as unlimited days in nursing facilities when appropriate, a comprehensive dental benefit, zero-dollar copayments at pharmacies, integrated MLTSS, and HCBS.³⁴

D-SNPs may offer improved access to certain providers, including those that may not typically serve Medicaid members. D-SNPs can more easily include in their networks providers that participate in Medicare and/or Medicaid. D-SNPs may also be able to leverage network relationships from other lines of business to include providers that may not otherwise serve Medicaid members.

**D-SNPs Can Create Efficiencies for Providers and Simplify Processes for Providers and States**

Moving along the D-SNP contracting spectrum towards greater integration can improve the experience of physicians and other health care providers that care for dual eligibles. Including coverage for Medicaid cost sharing under a D-SNP contract simplifies provider billing practices so that providers do not have to bill Medicare and Medicaid separately. Further, in more integrated models, providers work with a single entity that is responsible for all coverage determinations and reimbursement, which also helps streamline administrative processes.

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

D-SNPs also offer the opportunity to engage providers in new and innovative ways. For instance, D-SNPs can use risk-sharing arrangements that empower providers. D-SNPs can work with providers to develop global risk arrangements where providers receive payments for both the Medicare and Medicaid services and take the risk for better, more holistic management across both programs.
Finally, while D-SNPs may initially require an investment of state time and resources, a more integrated D-SNP program is likely to reduce the demand on the state for certain Medicaid FFS or vendor contracting and claims processing services.

**States Can Add Medicaid Acute and LTSS Benefits to D-SNP Contracts as They Are Ready**

As states and plans gain experience with increasing levels of integration, additional Medicaid benefits, including LTSS can be folded into D-SNPs’ contracts over time. Some states are beginning to examine how D-SNPs are impacting Medicaid costs for dual eligible beneficiaries. For instance, recognizing that Medicare utilization is tied to Medicaid LTSS spending, states are more closely examining these linkages to make the case for integration of all Medicaid benefits. Plans can support states in their efforts to quantify the value of D-SNPs as a vehicle for integration, as well as drive performance improvement over time.

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

*Figure 5. Continuum of D-SNP Contracting: Value of Increasing Integration*
KEY TAKEAWAYS: D-SNPS ARE AN ATTRACTIVE VEHICLE FOR CREATING AN INTEGRATED BENEFIT

Content Highlight
States interested in using D-SNPs can build off of the experiences of other states that have used this model to advance integration for dual eligibles.

There are a growing number of states working with D-SNPs to strengthen care for dual eligible beneficiaries. Their experiences can serve to guide other states interested in contracting with D-SNPs for the first time, or augmenting their existing contract requirements, to drive towards greater integration of care and benefits for dual eligibles.

States Can Build on the D-SNP Contracting Requirements in MIPPA
MIPPA contracting requirements are a floor which states can build upon—even in a stepwise manner—by adding benefits over time. Some states have taken gradual paths to integration using D-SNPs, starting with a discrete pilot population and, once challenges and issues were addressed, expanding to a broader group of beneficiaries. Other states have expanded existing contracting requirements for D-SNPs to require coordination with LTSS. For states considering managed LTSS, it may be helpful to consider the role of D-SNP contracting as part of long-term plans.

States are also using D-SNP contracts to strengthen program coordination, data reporting and exchange, and alignment of program processes. For example, some states require the submission of encounter data or prescription drug data to the state, or the coordination of quality improvement and external quality reviews.35

States Can Work with D-SNPs to Achieve More Seamless Care Coordination
States and experts point to strong care coordination as critical to better managing this population. D-SNPs, particularly D-SNPs offered by plans that have Medicaid managed care experience and have mature high-touch care management programs, can be partners in improving care coordination for dual eligibles and facilitating timely and individualized care for beneficiaries. States can use contracts to hold plans accountable for achieving improvements. Additionally, by encouraging enrollment of newly eligible beneficiaries in D-SNPs, integration and coordination can be a focus from the start.

D-SNPs Can Be Vehicles for Integrating the Full Range of Specialized Services for Dual Eligible Beneficiaries, including LTSS
States that already enroll dual eligible beneficiaries in Medicaid MCOs may find that D-SNPs offer flexibility for aligning Medicaid plan benefits and/or MLTSS with Medicare benefits. For instance, Minnesota and New Jersey made an upfront decision to include MLTSS in the D-SNP contracting process over time. Arizona and Tennessee, which already had MLTSS programs in place, moved to require their competitively procured MLTSS plans to operate a D-SNP.36 States are finding that better management of Medicare acute services in a more integrated, coordinated fashion can drive value for LTSS. Some states have used D-SNP contracting arrangements to integrate LTSS with acute care services and require coordination across the programs.

States with existing MLTSS programs may find that contracting with D-SNPs for more integrated arrangements is administratively easy and allows beneficiaries to access services more seamlessly. For instance, New Jersey strategically integrated LTSS within D-SNPs by first initiating MLTSS expansion and then progressing towards creation of FIDE-SNP contracts that include LTSS.37 Other states like Arizona and Minnesota have benefited from D-SNPs’ coordination efforts to manage home health spending.

Successful D-SNP Efforts Require Engagement with Key Stakeholders
States and plans have identified outreach to stakeholders, especially beneficiary and patient advocates and providers, as critical to success with D-SNPs. Outreach includes helping stakeholders understand the benefits of integration and securing their engagement early in the process. States can also involve local offices of State Health Insurance Assistance Programs (SHIPs) in educating beneficiaries about the benefits of integrated plan options.
Strong engagement with key stakeholders can help to improve or mitigate any technical challenges with coordinating benefits that do arise. For example, there can be differences in the data reporting requirements in a state’s Medicaid managed care contracts and federal Medicare Advantage contracts and in Medicaid and Medicare eligibility and plan enrollment processes. Early and frequent engagement with providers, beneficiary representatives, and other local stakeholders may help to mitigate some of these issues.

CONCLUSION

**Content Highlight**

D-SNPs offer states a flexible path forward on dual eligible benefit integration while providing real value for beneficiaries and states.

Wherever states are in their efforts to integrate and align care for dual eligibles, D-SNPs offer a vehicle that is flexible and provides a “glide path” towards greater integration. States can work with D-SNPs to achieve their goals, building on existing infrastructure or creating new infrastructure through enhanced contracting requirements.

Early evidence indicates that D-SNPs can help states improve the beneficiary experience through a more seamless combination of benefits and improvements in coordinating and managing care. States are beginning to see early results of working with D-SNPs to better integrate and align care, including improved care coordination, more appropriate access to and use of both acute and long-term care services, and easier alignment of administrative processes.

As states continue to gain experience in integrating Medicare and Medicaid benefits, their efforts demonstrate the value that D-SNPs can offer other states seeking to improve quality and reduce the cost of care for dual eligible beneficiaries. Through active contracting strategies, states can work with D-SNPs to meet their unique program goals and better serve dual eligible beneficiaries in their state, regardless of where the state is at in its Medicare and Medicaid integration efforts.

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*The Anthem Public Policy Institute gratefully acknowledges the support of CapView Strategies in the research and writing of this paper.*


23. 42 C.F.R. 422.108(c)


28. Ibid.


37. Ibid.
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