SNP Alliance 2021 Member Profile Brief

SNP Alliance

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The SNP Alliance

A National Nonprofit Leadership Organization of Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs)

WHO WE ARE

The SNP Alliance is a national leadership organization of plan and allied members and is dedicated to improving policy and practice for special needs populations. The Alliance represents more than 260 Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs) with an enrollment of more than 2.2 million people.

WHAT WE DO

The SNP Alliance—

- Provides *shared learning and capacity building* opportunities for member plans.
- Proactively advances changes in *public policy* for high-risk populations.
- Enables the *integration* of payment, policy, and delivery for dually eligible beneficiaries and other complex care beneficiaries.
- Promotes meaningful *performance measurement* of care for individuals with complex care needs.
- Disseminates person-centered *best practice* information.

MORE INFORMATION

WWW.SNPALLIANCE.ORG

ABOUT THIS REPORT

This *SNP Alliance Member Profile Brief* provides findings from our 2020 Annual Member Survey on enrollment, utilization, quality measurement, and social determinant of health characteristics. The *Brief* also offers highlights from a special survey the Alliance conducted on integration issues.

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Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs)

SNPs and MMPs are a subset of Medicare Advantage (MA) plans. SNPs and MMPs are specifically authorized and designed to meet special care needs of Medicare beneficiary sub-groups, including:

- *Chronic condition SNPs* (C-SNPs)- Focus on people with severe or disabling chronic conditions (e.g., HIV-AIDS, CHF, COPD). ***The SNP Alliance plans represent 86% of national enrollment in C-SNPs.***

- *Institutional SNPs* (I-SNPs) - Focus on people who are at a "nursing home level of care" and live either in a facility or in a community setting. ***The SNP Alliance plans represent 79% of national enrollment in I-SNPs.***

- *Dual eligible SNPs* (D-SNPs)- Focus on people covered by both Medicare and Medicaid. ***The SNP Alliance plans represent 58% of national enrollment in D-SNPs.***

- *Fully Integrated Dual Eligible SNPs* (FIDESNPs)–A specific type of D-SNP with extra requirements for integration. ***The SNP Alliance plans represent 69% of national enrollment in FIDE-SNPs.***

- *Medicare-Medicaid Plans* (MMPs) – Under a CMMI demonstration, these plans exclusively serve dually-eligible individuals and have additional requirements around state agency contracting. ***The SNP Alliance plans represent 38% of all national enrollment in MMPs.***

Overall, SNP Alliance plans represent 60% of all SNP and MMP enrollment nationally as of January 2021 (Source: CMS; monthly enrollment statistics)

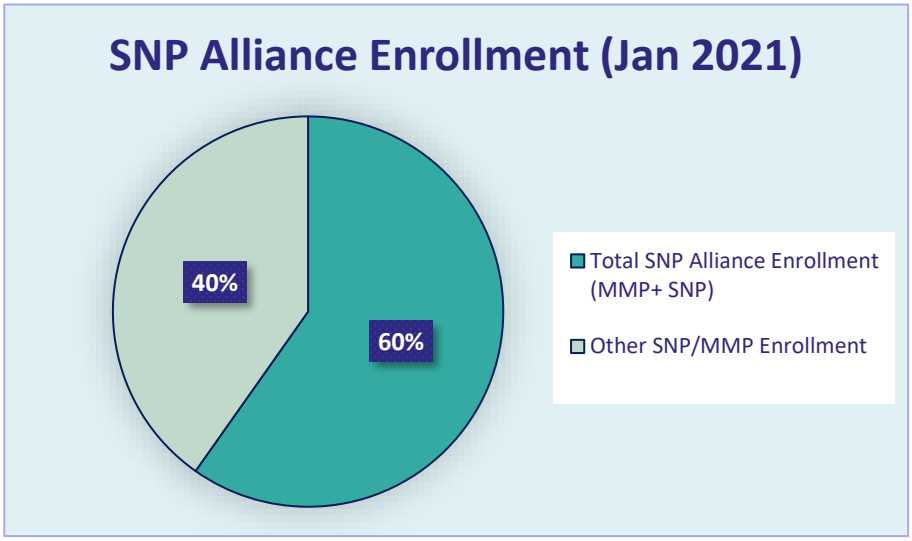
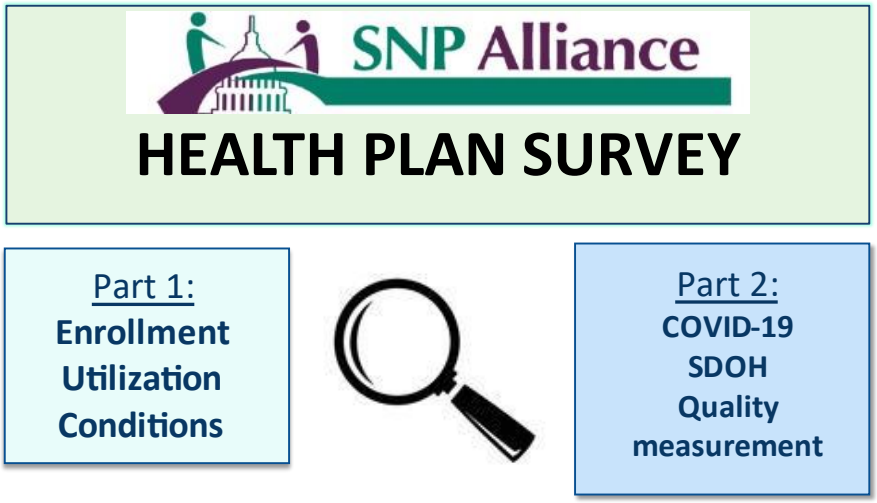


Figure 1: SNP Alliance Enrollment as % of National SNP & MMP Enrollment

Part One: Annual Survey of Health Plans -2020

The SNP Alliance conducts an *Annual Survey* of its member plans. The survey captures key *enrollment and utilization characteristics* as well as information on *quality measurement* issues unique to these populations and to SNPs and MMPs. The survey also gathers information on *social determinant of health risk factors* . In 2020 the survey included questions about *the impact of COVID-19.* [Survey methods are described at the end of this report.]



Respondents

Overall response rate to the 2020 Annual Survey was 84% or 21 organizations reporting. Most health plans operated more than one type of SNP/MMP. Four organizations operated a C-SNP, eleven operated a D-SNP, twelve had a FIDE-SNP, four had an I-SNP, and eight had an MMP. The enrollment represented by these organizations' plan products is shown in Table 1.

Table 1. 2020 Annual Survey Respondents – Quantitative Portion (Part 1)

SNP type	*Enrollment Represented*
C-SNPs	57,000 members
D-SNPs	390,000 members
FIDE-SNPs	93,600 members
I-SNP	9,800 members
MMPs	243,000 members

Enrollment Characteristics

Age distribution of enrollment varies by SNP type.
Characteristics of plan enrollment differ across plan types. Consistent with prior years' survey results, the age distribution of plan enrollment differs from one plan type to another.

Key Fact:
Characteristics of enrolled populations differ across plan types.

For example, Institutional SNPs (I-SNPs) and Fully Integrated Dually Eligible SNPs (FIDE-SNPs) typically have the oldest populations. Plans reported their average age of enrolled individuals (as of December 2019) in the 2020 Survey.

I-SNPs reported 47% of their enrolled population were age 85 or older and FIDE-SNPs reported 17% over age 85. This compares to a national proportion of 11% who are 85+ (among all Medicare beneficiaries) in 2019.

(Source: CMS; See: MDCR ENROLL AB 6 (cms.gov))

MMPs and D-SNPs typically serve a higher proportion of younger people—individuals who are eligible for Medicare due to disability. MMPs and D-SNPs reported that they had 44% of their enrolled population under age 65 (Table 2.) This age distribution profile is consistent with that we've observed over the last five years of surveying our member health plans.

Table 2: Age Distribution, by SNP Type

	D-SNP *Approx. 390,000 members*	C-SNP *Approx. 57,000 members*	I-SNP *Approx. 9,800 members*	MMP *Approx. 243,000 members*	FIDE-SNP *Approx. 93,600 members*	Nat'l Data: Medicare-only beneficiaries (1)	Nat'l Data: Dual Eligible Beneficiaries (2)
< Age 65	44%	14%	5%	44%	1%	15%	39%
65-84	51%	77%	48%	48%	82%	73%	61%
85+	5%	9%	47%	5%	17%	11%	

Enrollment- weighted mean was used to aggregate and report

Highlights:

- ***I-SNPs have the highest proportion of members of advanced age (47% at 85+)***
- ***FIDE-SNPs have the greatest proportion of members age 65+ (98%)***
- ***MMPs and D-SNPs have similar member profiles in terms of age distribution, with nearly 45% of membership under age 65***

Sources for National Data: (1) MedPAC, ***A Data Book, Health Care Spending and the Medicare Program*** , July 2020
(2) MACPAC, ***Report to Congress on Medicaid and CHIP,*** June 2020

Proportion of enrollment dually-eligible also varies by SNP type.

The proportion of enrollment made up of dually eligible (DE) beneficiaries varied across SNP types. Among these organizations, C-SNPs had the lowest proportion of their enrollment who were dually eligible (26%), with I-SNPs next (41%). Conversely the other SNP types (D-SNPs, FIDE-SNPs, and MMPs) were basically at 100% of their enrollment being dually eligible. Temporary loss of Medicaid eligibility within the course of the calendar year suppresses this from reaching 100% for the whole year. All SNPs and MMPs had a higher portion of their enrolled population being dually-eligible as compared to general Medicare Advantage plans (12% DE across all MA plans).

Table 3: Proportion of Enrollment Dually Eligible, by SNP Type

	D-SNP	C-SNP	I-SNP	MMP	FIDE-SNP	*All MA Portion DE*
Duals as a Proportion of Total Enrollment (Weighted Average)	13 plans with sufficient data to report **96%***	***Among these plans most enrollees were not dually eligible*** **26%**	***Among these plans less than half of enrollees were dually eligible*** **41%**	9 plans with sufficient data to report ***All had 97-100% duals*** **99%**	***9 plans out of 12 had 100% duals*** **98%***	**12%**

*Temporary loss of Medicaid eligibility within the course of the calendar year suppresses this being at 100%.

Sources for National Data: (1) MedPAC, ***A Data Book: Health Care Spending and the Medicare Program*** , July 2020
(2) MMCO, ***People Dually Eligible for Medicare and Medicaid, Fact Sheet*** , March 2020

This is important since dually eligible beneficiaries are generally in poorer health and have health costs twice as high as non-dual Medicare beneficiaries.

According to the CMS Medicare-Medicaid Coordination Office, 70% of dually eligible individuals have three or more chronic conditions as compared to 52% of Medicare-only beneficiaries. In addition, disability status is much higher among dually eligible enrollees than Medicare-only beneficiaries (Source: CMS Medicare-Medicaid Coordination Office FY2019 Report to Congress).

Individuals in SNPs and MMPs have complex chronic conditions.

The Annual Survey requests information on proportion of enrollment with specific complex chronic conditions. Looking at complex chronic conditions surveyed, D-SNP populations had the highest proportion with Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Vascular Disease, Thrombosis, Congestive Heart Failure, Major Depression, and Drug or Alcohol Dependence (Table 4).

Table 4: Proportion of Enrollment with Selected Chronic Conditions

	D-SNP *Approx. 390,000 members*	C-SNP *Approx. 57,000 members*	I-SNP *Approx. 9,800 members*	MMP *Approx. 243,000 members*	FIDE-SNP *Approx. 93,600 members*	*All MA Plans* (includes SNPs)
Diabetes w/Complications	39%	33%	11%	20%	22%	20%
COPD	29%	11%	10%	15%	12%	14%
Vascular, Thrombosis	31%	20%	28%	15%	19%	19%
CHF	20%	9%	11%	12%	11%	12%

Highlights:

- ***D-SNP populations had a much higher prevalence of all of these chronic conditions as compared to all MA plans***
- ***MMP and FIDE -SNPs showed similar rates as all MA plans for these chronic conditions***

Source for National Data: (1) MedPAC, ***A Data Book: Health Care Spending and the Medicare Program*** , July 2020, Chart 9 -14.

The survey also asks about a few behavioral health conditions that are considered high cost/complex, such as major depression. The proportion of people in SNPs and MMPs with these behavioral health conditions was high compared to general Medicare Advantage plans (Table 5).

Table 5: Behavioral Health Conditions

	D-SNP *Approx. 390,000 members*	C-SNP *Approx. 57,000 members*	I-SNP *Approx. 9,800 members*	MMP *Approx. 243,000 members*	FIDE-SNP *Approx. 93,600 members*	*All MA Plans* (includes SNPs)
Major Depression, BiPolar	27%	13%	18%	15%	17%	11%
Drug, Alcohol Dependence	14%	8%	11%	7%	4%	4%

Highlights:

- ***All SNP types had a higher percentage of members with major depression/bipolar disorder than the MA average***
- ***Most SNPs and MMPs have a higher percentage of members with drug/alcohol dependence than the MA average***

Sources for National Data: (1) MedPAC, ***A Data Book: Health Care Spending and the Medicare Program,*** July 2020, Chart 9 -14

Key Fact:

Behavioral Health conditions were more common among all SNP types and MMPs than among the general Medicare Advantage population.

Utilization Characteristics

Inpatient utilization rates are in line with rates reported nationally for Medicare

Despite having populations with more chronic conditions and higher social risk factors, SNPs and MMP had hospitalization rates that were in line with rates reported for traditional fee-for-service Medicare ("original Medicare"). The general hospitalization/inpatient admission rate reported by SNP Alliance members in 2019 was between a low of 14% (D-SNPs) of enrollment to 18% (FIDE-SNPs). The national rate was 16.3% for people in original Medicare in 2019. [Source: CMS.gov. Found at: CPS_MDCR_INPT_HOSP_1 (cms.gov)]

Table 6: Selected Utilization Among SNPs and MMPs

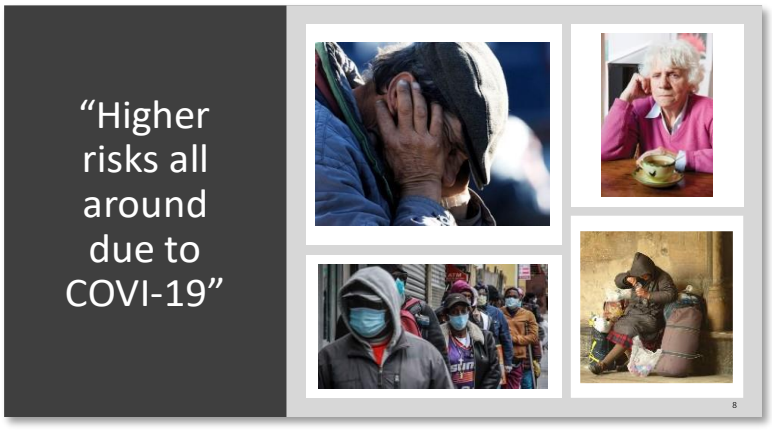
	D-SNP *Approx. 390,000 members*	C-SNP *Approx. 57,000 members*	MMP *Approx. 243,000 members*	FIDE-SNP *Approx. 93,600 members*	I-SNP **	Trends- over past 3 years for SNPs & MMPs reporting
% w/ Hosp Admission	14%	14%	16%	18%	**	Slight decrease
% w/ ER visits	37%	24%	34%	29%	**	Slight decrease
% w/ Observation stays	4%	6%	7%	7%	**	Steady

NOTE: ** I-SNPs did not havenough data to report

We compared these rates to those reported by SNP & MMP plans in our 2019 and 2018 SNP Alliance health plan surveys. There was a slight decrease in hospitalization rate and in proportion of enrollment with ER visits among these plans in calendar year 2019 (as reported in the 2020 Survey) compared to the last two years' survey data (2019 & 2018 Surveys).

Impact of COVID-19

We asked plans to describe the impact of COVID-19 on their members, as observed throughout 2020 . They responded that they saw and heard about food insecurity, isolation, reduced access to care and support, housing instability, and reduction in preventive and self-care. All plans indicated that they saw "higher risks all around due to COVID-19."



Many comments focused on how the pandemic exacerbated existing disparities and difficulties experienced by the SNP and MMP enrollees. They talked about the virus' impact on people, medical and behavioral health access, provision of home support services, and on the wider community and said that the pandemic "widened the cracks already there in the system." A sample of quotes provided through the open-ended comment option are shown below.

QUOTES:

How has COVID-19 affected your SNP/MMP populations?

- ***"The pandemic widened the cracks already there in the system."***
- ***"Disproportionate impact of pandemic on minority populations."***
- ***"Higher needs for food because of concern about going to the store, or no money."***
- ***"[Meeting SDOH needs. . .] is more challenging due to sheltering at home and isolating to avoid risk. This includes obtaining medications."***
- ***"Food insecurity and housing instability became more pronounced, while resources became scarcer."***
- ***"Social isolation became more evident/worse."***
- ***"Behavioral health issues are exacerbated by the pandemic."***
- ***"Lack of available workers to come into the home for personal care/homemaking/other needs (or members not wanting to risk exposure)."***

The survey also asked for some examples of actions taken by plans in 2020 to address some of these challenges. A sample is provided below.

Actions taken in 2020 (examples):

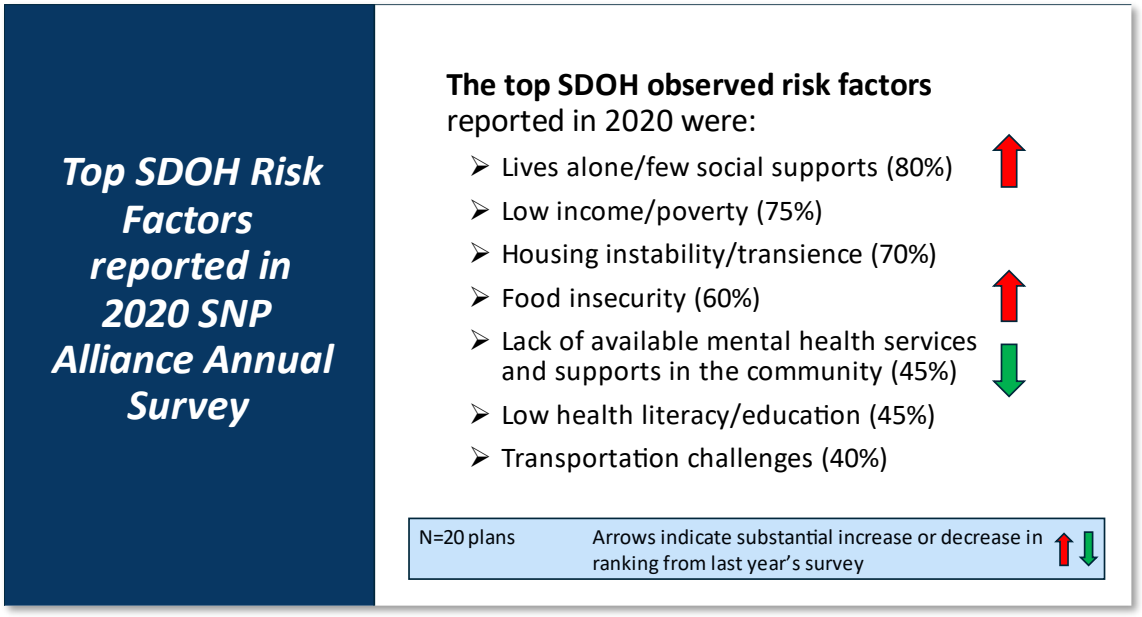
- Re-deployed staff- member outreach and multiple contacts/check-ins
- Telehealth support– equipment, coaching/teaching
- Home delivered meds, 90-day refills
- Home delivered meals, grocery items
- Care manager with PPE making home visits

Social Risk Factors – Characteristics & Implications

Frequent social risk factors

The SNP Alliance Annual Survey has had several questions pertaining to social determinant of health (SDOH) issues for the last four years. One item asks about the top social determinant of health risk factors plans observe among their member populations. Typically, the most frequent risk factor identified is that a high proportion of their population lives in poverty.

In 2020, low income/poverty was still one of the most frequently reported risk factors but the lack of social supports was even more often cited. Eighty percent of plans indicated that the most common observed risk factor among their members was "lives alone and/or has few social supports." This was a particularly acute risk factor for special needs populations as the pandemic shut down access to so many services throughout our society. The very real concern about contagion augmented the isolation of these individuals. The graphic below provides a summary of the top SDOH risk factors observed in 2020 by SNPs and MMPs. The arrows to the right of the item indicates if the risk factor is higher (more frequently identified) or lower—as compared to last year's response to this question (2019 Survey).



How to identify social risk

Understanding the specific risk factor characteristics of each person is important. Health plans have been mining various data sources and conducting member assessments to try to identify these risks among their enrolled populations.

We have seen an increase (over each previous Annual Survey results) in the proportion of health plans identifying SDOH risks and the variety of data sources used. In 2020, most health plans

reported using many sources for SDOH information. They are aware of the importance of understanding SDOH risks and are using these data sources to more accurately pinpoint the specific risk factors faced by each member.

Table 7: SDOH Data Sources

Data Source	% health plans reporting HAVING SDOH info within this data source	% health plans reporting USING this data source for SDOH
Health risk assessments	100%	60%
Internal care management records	100%	55%
Claims data including ICD10 "z" codes	90%	45%
Encounter data	80%	55%
Member surveys	75%	60%
Member services support contact & phone records/database	75%	45%
Enrollment forms	75%	60%

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Putting the information to use

SNP and MMP health plans are making use of this information in a variety of ways, including to adjust their Models of Care and care management strategies, member outreach approach, member services, member education, and risk stratification algorithms. The green arrows in the graphic below indicate where the plan action has increased over prior years' responses.

How Plans are Making Use of SDOH Information

1. To modify ***Model of Care & services – 60%*** ↑
2. For ***member outreach - 55%*** (same)
3. To modify ***care management strategies and methods – 55%*** ↑
4. To change their ***algorithm/stratification on identifying high risk groups – 55%*** ↑
5. Modify ***member materials and education – 55%*** (same)
6. To analyze ***utilization data, by social risk factor – 45%*** (same)
7. To modify ***customer service/member services protocols – 30%*** ↑

Plans report many challenges in finding and using SDOH data—starting with the lack of standardization of risk factor definitions, screening, scoring, and assessment tools. Other limitations are shown in the graphic to the right.

SDOH Data Limitations

- ***Lack of standard*** SDOH elements or screening tools; different definitions, time periods, and granularity of data
- ***Barriers to reaching and engaging*** the member; transience of living arrangements impacts person and participation; the individual may not wish to answer SDOH -related questions
- ***Timeframe, decay***, and ***sensitivity*** of information
- ***Multiple organizations*** and service providers asking about SDOH - who, when, what, how….burnout, information overlap or misalignment
- SDOH information may be ***hard to access, search, aggregate*** (e.g., written note in progress note or service/visit record)
- Concern about identifying needs without having the community or other resources ***able to respond timely, effectively —linking and building capacity important***

SDOH Partners

Health plans work together with community organizations, government agencies, advocates, and other stakeholders to help address social risk factors.

SNP & MMP Collaborative Partnerships

Q: For each of the key issue areas below, indicate if you currently have a collaborative initiative or partnership around that area for your SNP/MMP population aimed at addressing this risk factor to improve health outcomes:

2020 SNPA Survey results on partnerships show increase in the high risk SDOH areas exacerbated by COVID19:

- ***Food: 84%*** - up from 67% last year
- ***Language & Health Literacy: 72%/53%*** *up from 47% last year*
- ***Social Support: 67%*** - *up from 47% last year*
- ***Transportation: 65%*** - about the same as last year
- ***Housing: 44%*** - down from 56% last year

The Annual Survey has asked plans about their collaborative partnerships in this arena for the last four years. We've seen a rise in the number of plans reporting one or more collaborative efforts around SDOH issues each year. In 2020, food insecurity was the highest (most frequently reported) area for such collaborations. Social isolation was also much more frequently mentioned as a risk factor where the health plan was involved in a collaborative partnership. The graphic above presents this information in summary and shows how the 2020 responses compared to last year's survey.

Quality Measurement

The Annual Survey requests response about quality measurement as applied to special needs populations. Key observations offered include insights about where the quality measures or measurement approach do not adequately fit plans' special needs populations—in terms of measure exclusions, case mix adjustment, methods to collect the data, or ways that the measure is scored in order to compare results across health plans.

Top concerns have consistently been around the Health Outcomes Survey, SDOH risk/case mix adjustment, and how the MA Star levels (from 1 to 5) rely on cut point thresholds that vary from year to year and, for certain measures, have little meaningful difference given that most plans are at the top of performance.

In 2020 a new concern dominated the responses on this question—and that was that the effects of COVID-19 have implications for measure results based on external events or population differences rather than true differences in plan quality or plan-controlled approach to care.

Responses on top concerns are summarized below.

Top Quality Measurement Concerns - 2020

What are your top concerns with regard to Medicare quality measures? *(weighted 1 through 5, with 1 being of utmost importance, having quality and financial implications)*

1. ***Effects of COVID-19*** *- Plans have evidence that COVID19 has substantially impacted quality and quality measure results in more than one Star measure;* 19/20 ranked 1 or 2 top concern **(95%)**
2. ***Varying Cut points*** *– Star measure cut points vary year to year, little difference between 3, 4, and 5 star thresh holds or are topped out;* 17/20 ranked 1 or 2 top concern **(85%)**
3. ***HOS-derived measures*** *- HOS self-report survey, measures, methods do not accommodate the SNP/MMP population;* 16/20 ranked 1 or 2 top concern **(80%)**
4. ***SDOH*** *- Measures are not adequately risk adjusted for social risk/SES factors which are prevalent in our SNP population;* 15/20 ranked 1 or 2 top concern **(75%)**

National Perspective

To put SNPs and MMPs in the national context, we look at Medicare Advantage trends. Enrollment in Medicare Advantage health plans versus "original" (fee-for-service) Medicare has been increasing steadily for the last ten+ years. As of 2021, about 40% of Medicare beneficiaries (over 24 million people) have chosen a Medicare Advantage plan rather than original Medicare.

Enrollment in special needs health plans also has been increasing. About 3.4 million beneficiaries are enrolled in special needs health plans, which is about 14% of all MA plan enrollment in 2021. However, there is wide variation in MA and SNP enrollment from one state to another, with more than a dozen states near or above 45% MA penetration (e.g., Hawaii, Florida, Oregon, Minnesota, Michigan, California, New York) and several states with less than 20% penetration in MA (e.g., Alaska, New Hampshire). (Source: CMS Monthly MA Enrollment by State/County).

In their August 2020 Issue Brief, the Medicaid and CHIP Payment and Access Commission (MACPAC) presented the following information pertaining to D-SNPs and alignment between the Medicare and Medicaid programs (MACPAC Issue Brief: *Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps,* August 2020, p. 4).

> *Aligned D-SNP and MLTSS plans were available in 12 states as of June 2020 (MACPAC 2020). Some D-SNPs meet CMS criteria that allow them to be designated as FIDE-SNPs. These plans provide beneficiaries with a single integrated plan that typically includes LTSS, behavioral health, and other Medicaid benefits.*
>
> *Approximately 143,000 dually eligible beneficiaries were enrolled in aligned D-SNP and MLTSS plans as of March 2018 (Chelminsky and Verdier 2018).*
>
> *As of February 2020, there were 280,000 individuals enrolled in FIDE-SNPs, with about 75 percent of all enrollees residing in three states: Massachusetts, Minnesota, and New Jersey (CMS 2020, MedPAC 2018).*

2020 Annual Survey Respondents

Thank you to these participating member health plans!

Annual Survey Methods

The SNP Alliance Annual Survey is comprised of two parts. Part 1 collects quantitative data on enrollment and utilization characteristics by plan type. Part 2 captures qualitative data and some numerical data on quality measurement, social risk factor, and data issues. The survey is administered in the Fall of each year (requesting calendar year enrollment and utilization data from the prior year). Responses are due by the end of the calendar year in which the survey was administered. Data review, analysis and aggregation occurs February-March and the results are presented to members in April.

Methods Part 1: Excel Spreadsheet macro template with plan reporting data for each item

SNPA team reviews, checks on potential data accuracy issues, aggregates by SNP type, calculates weighted enrollment means for each item

Health Plan - Team Respondents Include:

Key staff from: Analytics, Economics, Quality, Performance, Population health, Gov't Programs, Compliance, Medicare Programs, Clinical Operations, Finance, Business Products3

Methods Part 2: E-Survey
The SNPA team calculates frequencies for response options, and groups open-ended comments by theme.
Health Plan Team Respondents Include: Quality Leads, Clinical & Care management Services, Compliance, & Population health

References & Resources

Avalere Health How to Account for the Full Impact of Social Determinants of Health in Medicare Advantage Plans | Avalere Health

Better Medicare Alliance BMA-Data-Brief-March-2021-FIN.pdf (bettermedicarealliance.org) – SDOH characteristics in MA vs. all Medicare

CMS Medicare-Medicaid Coordination Office analytics webpage: About the Medicare-Medicaid Coordination Office | CMS

CMS MMCO, *People Dually Eligible for Medicare and Medicaid, Fact Sheet*, March 2020

Integrated Care Resource Center Search for Resources | Integrated Care Resource Center

Kaiser Family Foundation, A Dozen Facts About Medicare Advantage, 2020 A Dozen Facts About Medicare Advantage in 2020 | KFF

MACPAC, *Report to Congress on Medicaid and CHIP,* June 2020

MACPAC Evaluations of Integrated Care Models for Dually Eligible Beneficiaries Key Findings and Research Gaps (macpac.gov)

MedPAC Report to Congress, March 2021. http://medpac.gov/-documents-/reports

MDCR ENROLL AB 1 Total Medicare Enrollment: Total, Original Medicare, and Medicare Advantage and Other Health Plan Enrollment, Calendar Years 2014-2019 (cms.gov)

CMS Monthly MA Enrollment by State/County/Contract | CMS

Part Two: Integration Survey *Highlights*

The SNP Alliance conducted a special survey around Medicare-Medicaid integration issues in 2020. The survey included an electronic questionnaire and key informant interviews. Twenty member health plans participated. This summary provides highlights; for a full description of findings, contact Will Dede, Health Policy Associate, at wdede@snpalliance.org

- SNPs are working to ***match their Medicare & Medicaid footprints*** (service areas) in their regions and to integrate internal operations, particularly care coordination.
- SNPs are ***ready to assist States to work out complexities*** to better integrate care and services for dually eligible beneficiaries.
- ***Enrollment alignment*** is a major issue impacting progress toward integration; additional areas for work include: contracting, data sharing, and marketing.
- ***More capacity needed at the State level*** – Issues confronted by plans include: State leadership turnover, limited staff, lack of full understanding about the value of integration to the State between Medicare and Medicaid programs, and state law restrictions, such as on managed care, on marketing, on carve out policies (e.g., behavioral/mental health)
- There is a concern about ***market consolidation*** in both Medicaid and Medicare. Some states are drastically limiting procurement locking out some plans and restricting choice.
- ***Marketing barriers***, such as lack of education of brokers on integrated products and State limitations on marketing by health plans, restrict ability to enroll in one integrated plan product.
- ***Provider Networks*** – there is a mismatch between Medicare and Medicaid provider networks and requirements. Some providers refuse to contract with plans.

Table 8. Plan Coverage of Medicaid Services (N=20)

Do you cover Medicaid services beyond cost sharing?			PBPs with Medicaid LTSS or Behavioral Health (BH) included	
Yes	84%		MLTSS	74%
No	16%		BH	79%
For some of our products	16%		Both	68%

Most plans indicated that they already cover Medicaid services beyond cost-sharing and most plans had at least one plan benefit package (PBP) with Medicaid long term services and supports (MLTSS) or behavioral health (BH) services included.

More Information

For information about the SNP Alliance Annual Survey and this report, contact: Dr. Deborah Paone, Lead, Performance Evaluation & Policy Consultant, dpaone@snpalliance.org or visit the SNP Alliance website at www.snpalliance.org.