Evolution of D-SNP Models for Dual Eligible Beneficiaries

Growth, evidence, and key questions for research and policy

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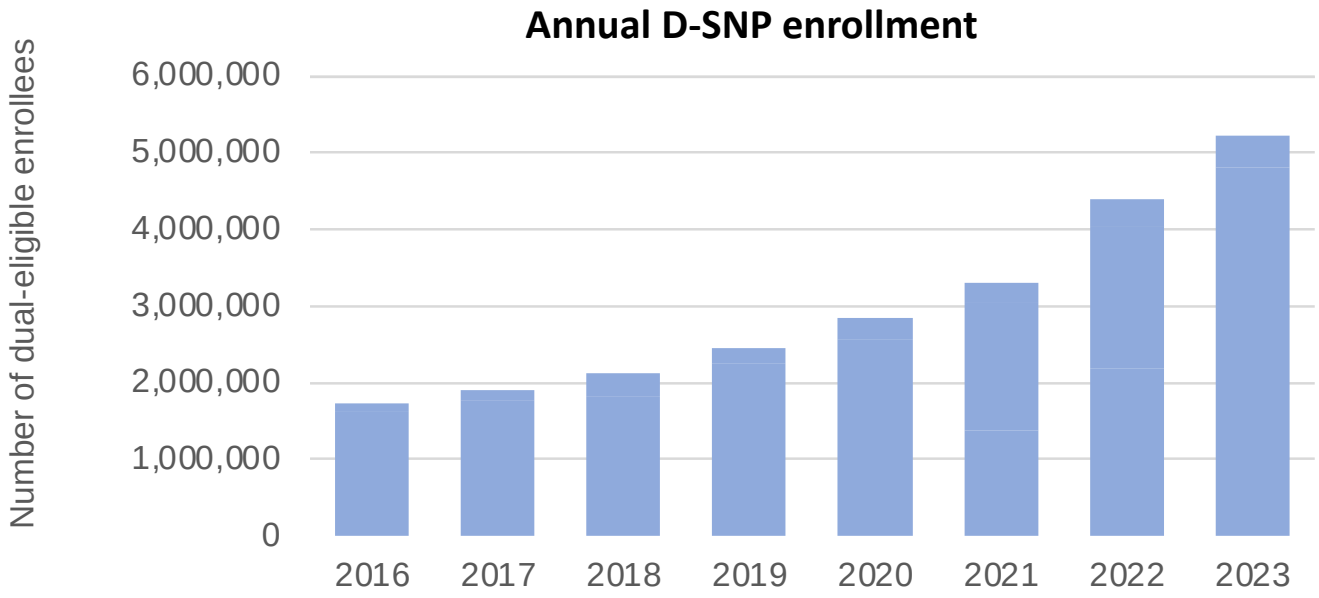
Outline

1. Context: growth of D-SNPs and characteristics of enrollees
2. Evidence on the performance of D-SNPs
3. Evidence on integrated coverage models, including Fully Integrated D-SNPs (FIDE-SNPs)
4. Research gaps needed to inform policy and practice
5. Threats to integrated coverage

Context: growth of D-SNPs and characteristics of enrollees

Growth of D-SNPs

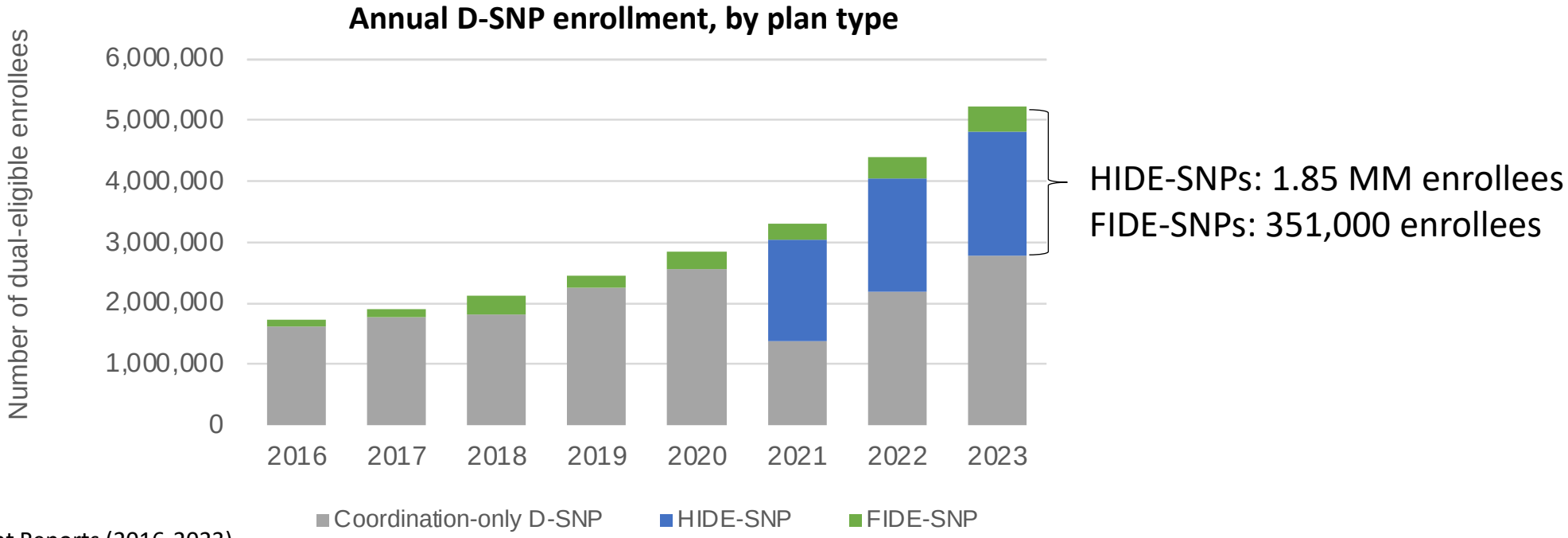
- **D-SNP enrollment has tripled since 2016**
  - As of Q1:2023, 392 D-SNP contracts covered 5.2MM dual eligible beneficiaries (42% of all dual eligibles) in 49 states plus DC



Source: CMS SNP Enrollment Reports (2016-2023).

Growth of financially integrated D-SNPs

- **Increasing diversity among D-SNPs, including their level of Medicaid integration**
  - D-SNPs that are financially integrated with Medicaid (HIDE-SNPs and FIDE-SNPs) now make up 46% of D-SNP enrollment



Source: CMS SNP Enrollment Reports (2016-2023).

Characteristics of D-SNP Enrollees in 2020

D-SNPs serve a demographically diverse population

- One-half of D-SNP enrollees are Black or Hispanic (vs. 38% of all duals)
- 87% of D-SNP enrollees live in urban areas (vs. 79% of all duals)

Characteristic		%
Type of Dual Eligibility Status		
	Full Dual Eligible	73%
	Partial Dual Eligible	27%
Age		
	<55	18%
	55-64	18%
	65+	64%
Gender		
	Male	37%
	Female	63%
Rurality		
	Urban	87%
	Rural	13%

Characteristic		%
Race and ethnicity		
	Non-Hispanic White	40%
	Non-Hispanic Black	26%
	Hispanic	24%
	Other	10%
Social Vulnerability Index		
	1st Quartile	8%
	2nd Quartile	20%
	3rd Quartile	38%
	4th Quartile	34%

Appendix link to detailed demographic characteristics.

Source: 2020 Medicare Beneficiary summary File

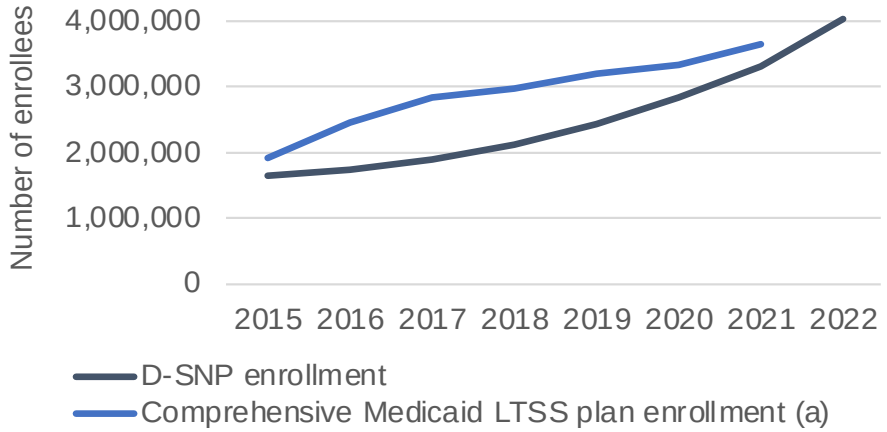
D-SNPs poised for continued growth

- Growth of D-SNPs follows broader trend of expanding Medicare Advantage enrollment (poised to exceed 50% in next year)
- Medicare-Medicaid Plans (demonstration models tested under FAI) will be wound down and converted into D-SNPs by 2025
- New restrictions on *non-D-SNP* MA plans that serve a majority of dual-eligible enrollees (‘look alike’ plans) expected to further shift enrollment towards D-SNPs

D-SNPs poised for further Medicaid integration

- More states implementing Medicaid managed care programs for older adults/disabled individuals receiving LTSS
  - One prominent example is Pennsylvania's Community Health Choices program (implemented from 2018-20)
  - Increases opportunities for alignment/ financial integration of D-SNPs with Medicaid managed care

Growing opportunities for alignment of D-SNPs and Medicaid managed care plans



Source: CMS SNP Enrollment Reports (2016-2023).

Evidence on the performance of D-SNPs

Evidence on D-SNP performance

- We still know relatively little about how well D-SNPs perform, as measured on cost, clinical care management, or patient-reported outcomes
- Main take-aways from what is known so far:
  - In some areas, D-SNPs are associated with slower spending growth, better clinical care management, and improved patient experiences with care
  - However, research does not show that D-SNP enrollment is associated with consistently better care for dual eligibles
- Substantial gaps remain in our understanding of D-SNPs
  - This includes limited understanding of the performance of financially integrated D-SNPs (FIDE-SNPs) vs. non-integrated plans
  - Limitations of research designs for evaluating integrated D-SNP models

Summary of evidence on D-SNP performance

Study/outcome(s) examined	Scope, data, and period	Principal findings
Spending		
Zhang and Diana (*HSR,* 2018)	National, MMLEADS, 2007-11	• 1% increase in county-level D-SNP penetration associated with 0.2% reduction in Medicare spending per beneficiary • No association between D-SNP penetration and Medicaid spending
Patient experience and satisfaction with care		
Haviland et al. (*HSR,* 2021)	National, MA-CAHPS, 2015-19	• Dual eligibles in D-SNPs reported better experiences with/access to care vs. traditional Medicare and non-D-SNP MA plans in 2 areas: 1) ratings of prescription drug coverage and 2) receipt of an annual flu immunization • However, patient experiences with timely access to care were slightly poorer in D-SNPs vs. other Medicare plan types • D-SNP performance improved slightly from 2012-14 to 2015-19
Roberts and Mellor (*Health Affairs,* 2022)	National, MCBS, 2015-19	• Dual eligibles in D-SNPs reported greater satisfaction with access to specialists and out-of-pocket costs vs. non-D-SNP MA plans and traditional Medicare • However, gains were seen primarily among non-Hispanic White beneficiaries

Summary of evidence on D-SNP performance

Study/outcome(s) examined	Scope, data, and period	Principal findings
Healthcare Access and Use		
Roberts and Mellor (*Health Affairs,* 2022)	National, MCBS, 2015-19	• Dual eligibles in D-SNPs more likely to report getting needed dental care vs. dual eligibles in other plan types • However, gains were seen primarily among non-Hispanic White beneficiaries
Feng et al. (ASPE Report, 2021)	National, administrative data, 2015	• Dual eligibles in D-SNPs had lower rates of hospital and nursing facility admissions, and higher HCBS use, vs. dual eligibles in non-D-SNP MA plans • Emergency department visit rates among dual eligibles were higher in D-SNPs vs. other plan types

Delving into some key findings…

Differences in care patterns and mortality among dual eligibles by plan type

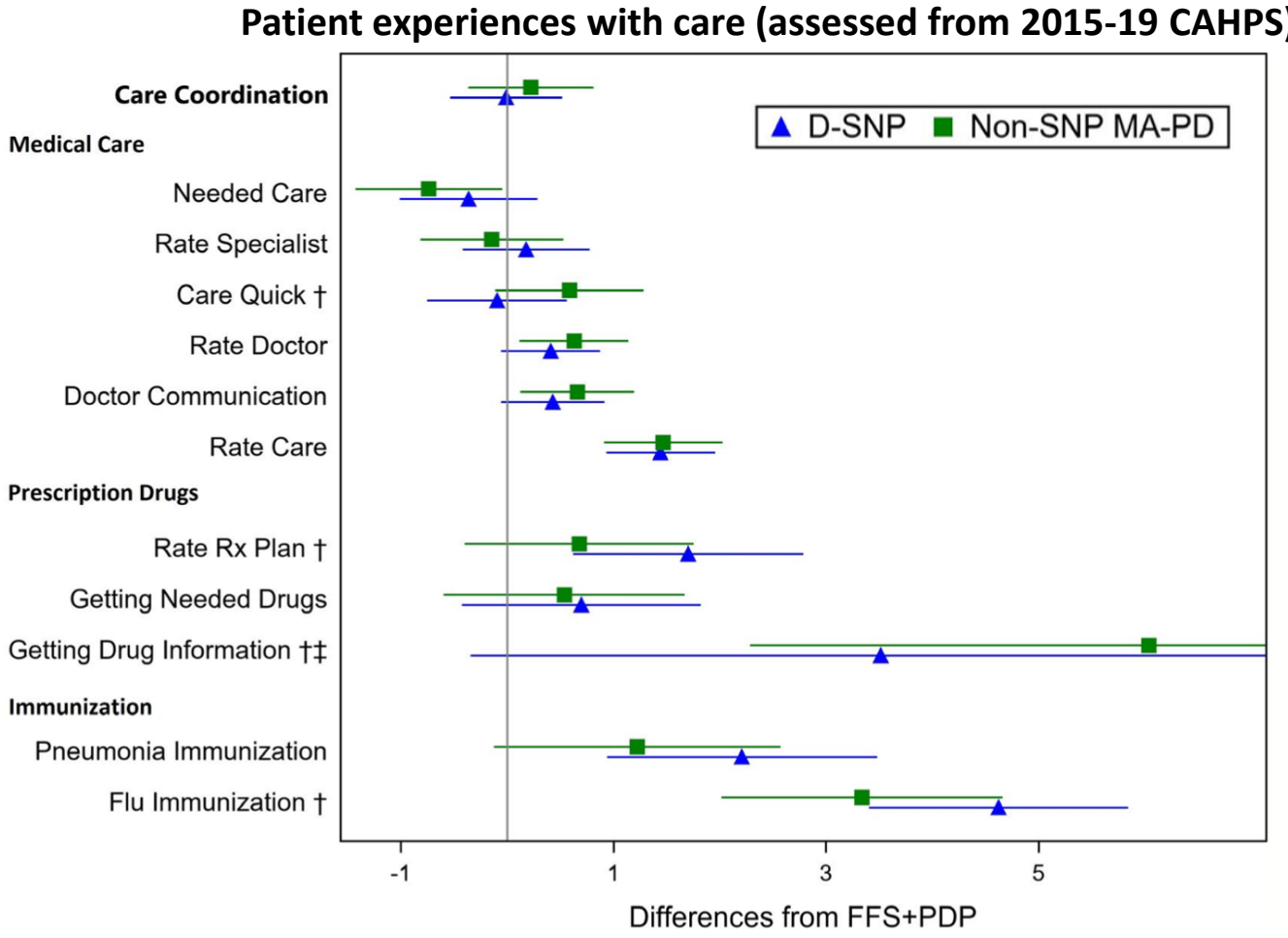
- Enrollees in D-SNPs had lower odds of inpatient and nursing admissions, but higher odds of ED use, vs. dual eligibles in non-D-SNP MA plans

Outcome	Odds Ratio (D-SNP vs. non-D-SNP MA Plans)	95% CI
Inpatient admission in 2015	**0.97**	**(0.96, 0.98)**
ED visit in 2015	**1.16**	**(1.15, 1.17)**
Nursing facility admission in 2015	**0.13**	**(0.12, 0.13)**
Any HCBS use in 2015	**1.05**	**(1.03, 1.06)**

Green = result favorable to D-SNPs (vs. non-D-SNP MA plans)
Red = result unfavorable to D-SNPs

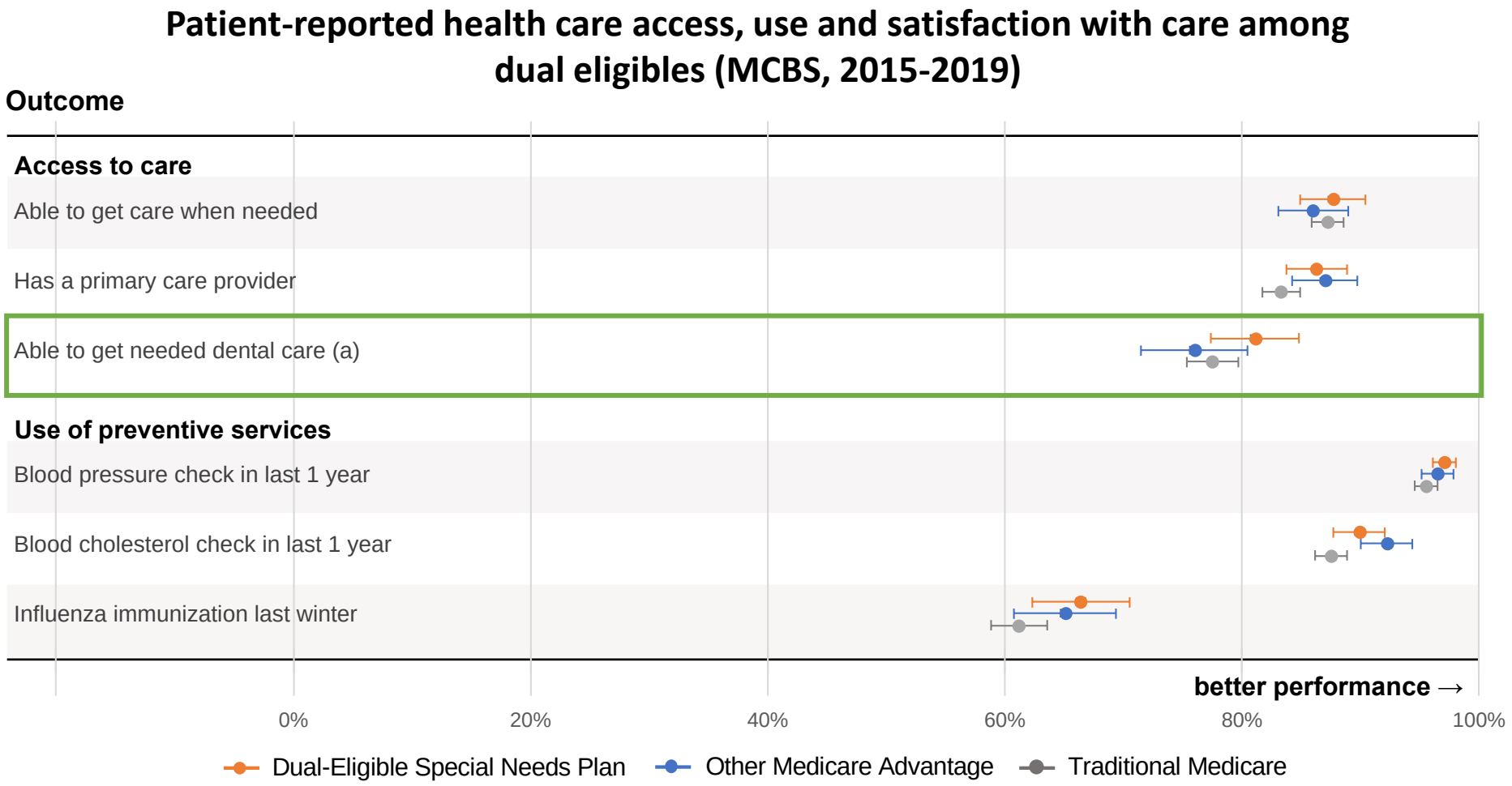
Source: Feng et al. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report," Assistant Secretary for Planning and Evaluation, September 2021.

D-SNP enrollees report better drug coverage, higher vaccination rates, but gains elsewhere are limited



Source: Haviland, Elliott, et al. "Do dual eligible beneficiaries experience better health care in special needs plans?" *Health Serv Res. 2021;00:1–11.*

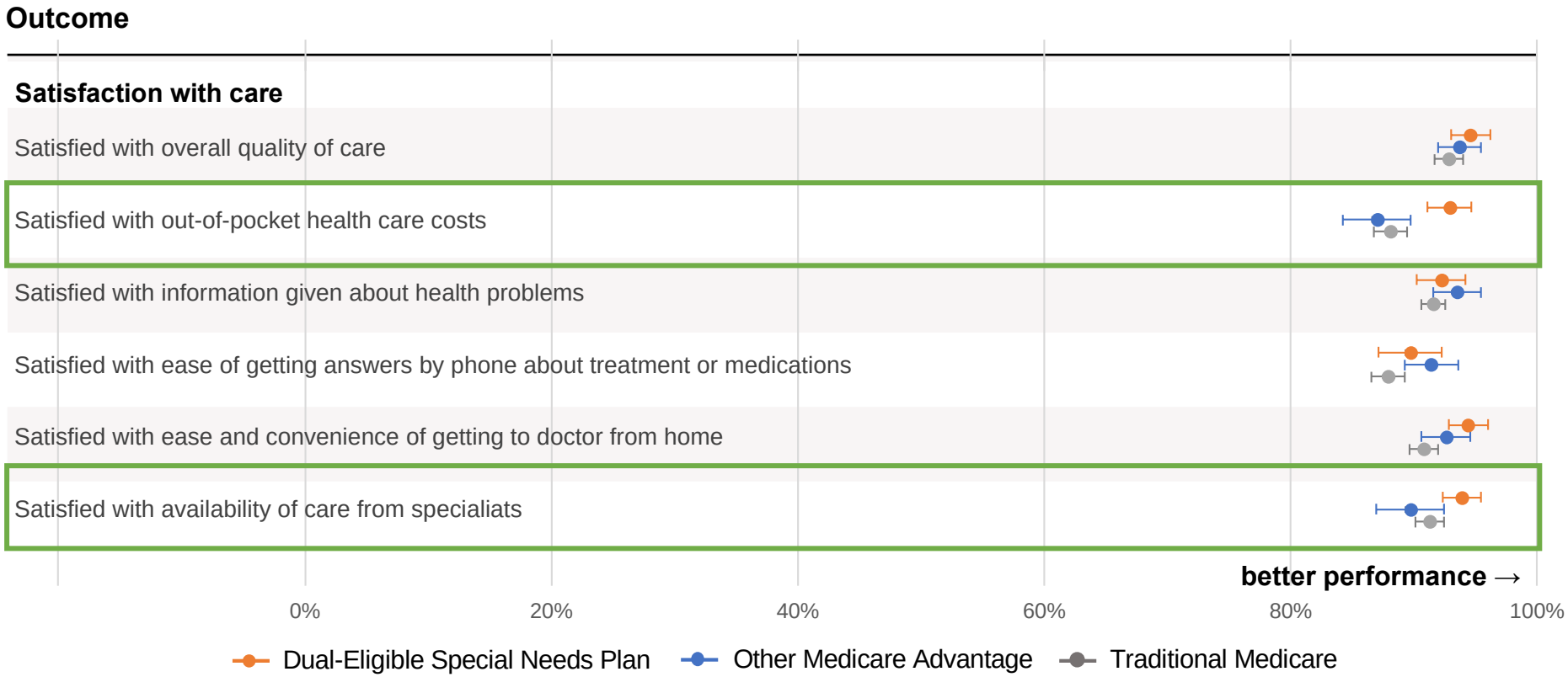
D-SNP enrollees report better dental care access, but few improvements in other areas of access/use



Source: Roberts and Mellor. "Differences In Care Between Special Needs Plans And Other Medicare Coverage For Dual Eligibles." *Health Affairs* 41.9 (2022): 1238-1247

Dual eligibles in D-SNPs do not consistently rate care better than in other Medicare plan types

Patient-reported health care access, use and satisfaction with care among dual eligibles (MCBS, 2015-2019)



Source: Roberts and Mellor. "Differences In Care Between Special Needs Plans And Other Medicare Coverage For Dual Eligibles." *Health Affairs* 41.9 (2022): 1238-1247

Disparities in who reports receiving better care in D-SNPs vs. other Medicare plan types

- Black and Hispanic dual eligibles are less likely to report better care in D-SNPs vs. other plan types, compared to White duals

Outcomes	Adjusted differences among dual eligibles of color[a] in D-SNPs versus:		Adjusted differences among non-Hispanic White dual eligibles[a] in D-SNPs versus:		Comparison of adjusted differences by race and ethnicity[b] in D-SNPs versus:	
	Traditional Medicare	Other MA	Traditional Medicare	Other MA	Traditional Medicare	Other MA
Access to care						
Able to get care when needed	–0.9	1.3	2.2	2.3	–3.2	–1.0
Has primary care provider	2.5	–1.0	3.5	–0.2	–1.0	–0.8
Able to get dental care when needed[c]	–1.2	–0.4	7.7**	10.7**	–8.9*	–11.1*
Satisfaction with care—satisfied with:						
Overall quality of care	0.4	–0.9	4.0***	3.3*	–3.6*	–4.2*
Out-of-pocket spending	3.8**	6.0**	6.5****	6.9***	–2.7	–0.9
Information given about health problems	–0.4	–2.5	2.5	0.7	–2.9	–3.2
Ease of getting answers by phone about treatment or medications	–0.2	–3.2	4.5*	0.4	–4.7	–3.6
Ease and convenience of getting to doctor from home	3.2**	–0.5	4.7***	5.3**	–1.6	–5.9**
Availability of care from specialists	0.5	–1.3	5.0***	10.7****	–4.5**	–12.0****

Source: Roberts and Mellor. "Differences In Care Between Special Needs Plans And Other Medicare Coverage For Dual Eligibles." *Health Affairs* 41.9 (2022): 1238-1247

Limitations

- Across studies, unmeasured differences in enrollee characteristics limit the ability to discern the true effects of D-SNP performance
- Studies reviewed so far aggregated all D-SNPs into a single category
  - Ignores heterogeneity by type of plan, including a D-SNP's level of integration with Medicaid
- Next: Evidence on financially integrated D-SNPs

Evidence on integrated D-SNPs

Integrated D-SNPs—background and theory

- Integrated D-SNPs (or their parent insurer) have capitation contracts with Medicaid programs to manage Medicaid spending
- **HIDE-SNPs,** introduced in 2021, have capitation contracts to cover Medicaid LTSS *or* behavioral health spending
- **FIDE-SNPs,** introduced in 2012, have capitation contracts to cover Medicaid LTSS *and* behavioral health spending
  - Some exceptions for behavioral health carve-outs (e.g., in Pennsylvania)
- Expectation is that managing Medicaid spending strengthens incentives to improve care coordination and manage use of resource-intensive care

Integrated D-SNPs—Evidence

- Some evidence suggests integrated D-SNPs may be effective in reducing nursing facility admissions by meeting dual eligibles' needs for long-term care and supportive services in the community
- No clear evidence that integrated D-SNPs improve on other dimensions of care management or reduce resource-intensive hospital use
- Much remains to be learned about whether integrated D-SNPs manage care more effectively than less-integrated models, particularly in higher-need subpopulations of duals
- Models also continue to evolve with regulatory changes, but research lags programmatic evolution

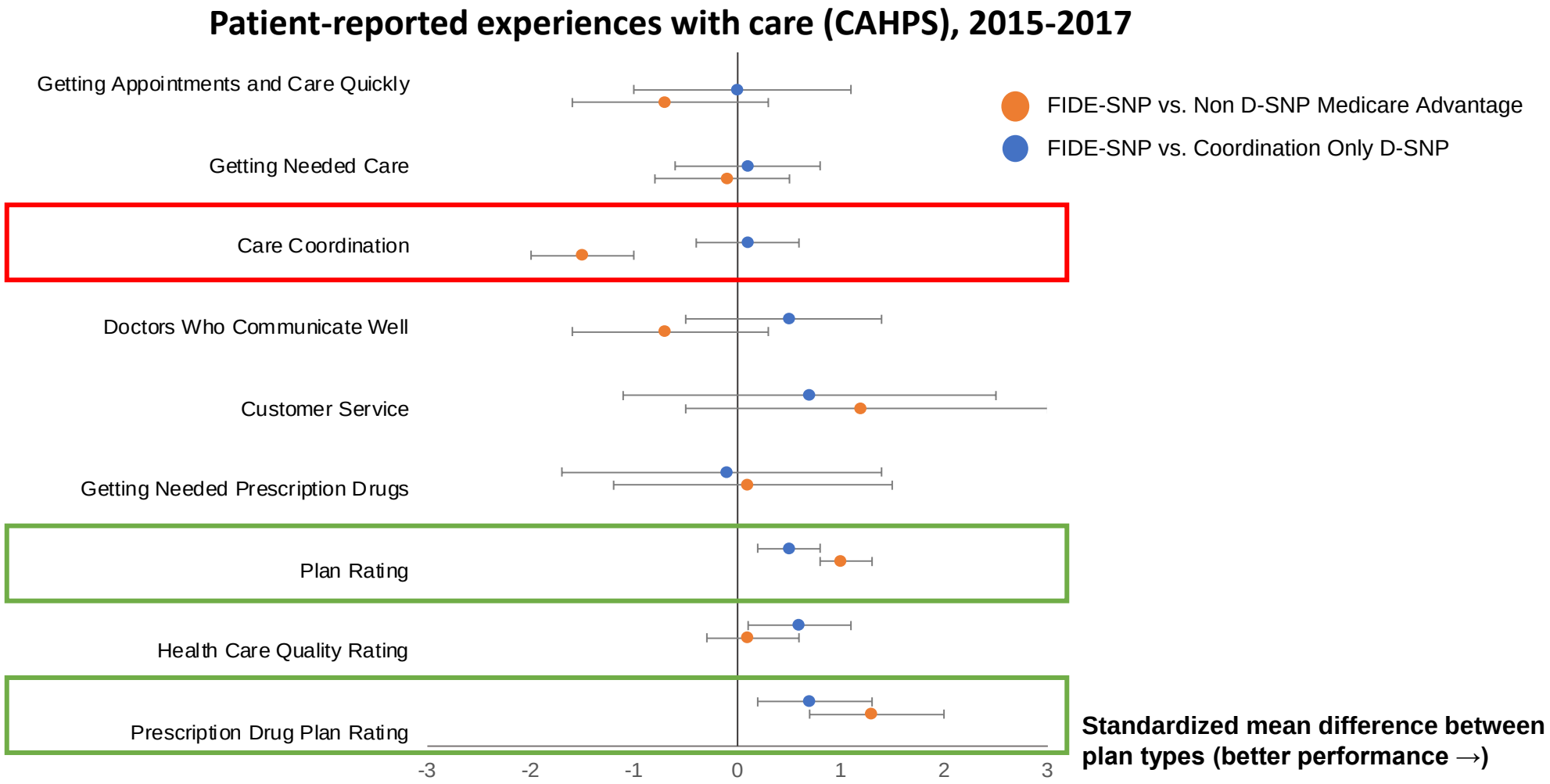
FIDE-SNPs associated with higher HCBS use, but not lower hospital use vs. other plan types

- Enrollees of *both* FIDE-SNPs and coordination-only D-SNPs have lower institutional care use and higher HCBS use vs. non-D-SNP MA plans
  - Suggests limited gains from being in a financially integrated D-SNP vs. coordination-only D-SNP

	D-SNP vs. non-D-SNP MA Plans		FIDE-SNP vs. non-D-SNP MA Plans	
Outcome	**Odds Ratio**	**95% CI**	**Odds Ratio**	**95% CI**
Inpatient admission in 2015	**0.97**	**(0.96, 0.98)**	**1.24**	**(1.10, 1.29)**
ED visit in 2015	**1.16**	**(1.15, 1.17)**	**1.14**	**(1.11, 1.17)**
Nursing facility admission in 2015	**0.13**	**(0.12, 0.13)**	**0.31**	**(0.30, 0.33)**
Any HCBS use in 2015	**1.05**	**(1.03, 1.06)**	**4.2**	**(4.09, 4.32)**

Source: Feng et al. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report," Assistant Secretary for Planning and Evaluation, September 2021.

Patient ratings of care not consistently higher in FIDE-SNPs vs. non-integrated plan types



Source: Meyers and Roberts. "Association of Dual Eligible Special Needs Plan Enrollment with Beneficiary-Reported Experiences with Care" (Under review, 2023).

Evidence from state-based integrated coverage models

- Minnesota Senior Health Options (MSHO) and Massachusetts Senior Care Options (Mass SCO) are integrated coverage models that became prototypes for FIDE-SNPs. Evaluations of these models found:

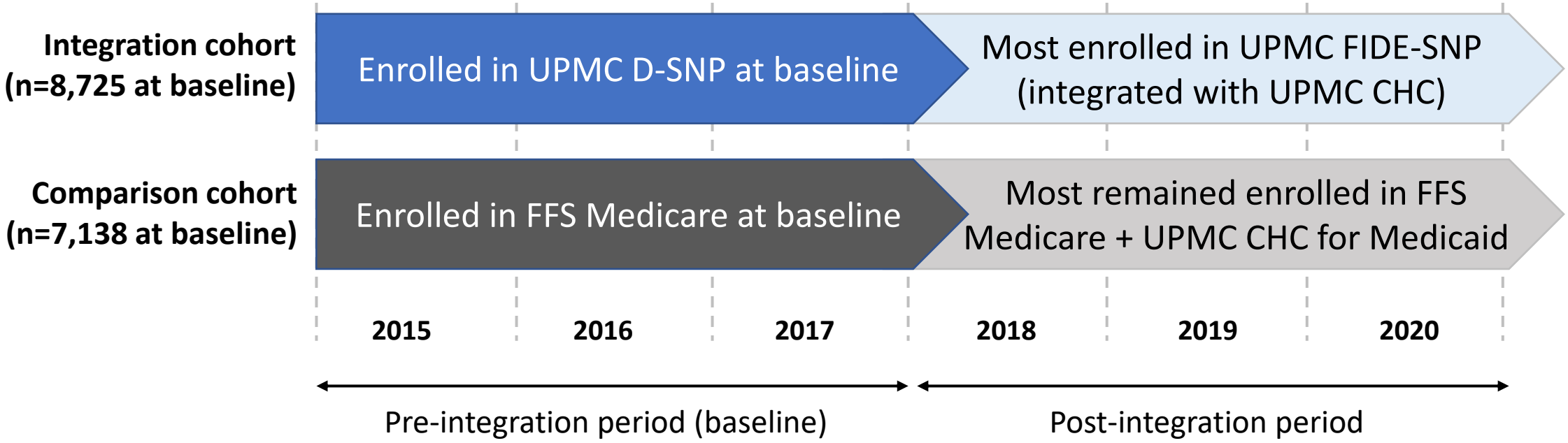
Setting/Evaluation	Comparison	Principal findings
Massachusetts SCO/ JEN Associates, 2013	Enrollment in Mass SCO vs. non-integrated FFS Medicare and Medicaid	• SCO enrollment associated with 16% lower rate of long-stay nursing home entry, particularly at end-of-life • No association of SCO with short-stay nursing facility use
Massachusetts SCO/ Jung et al., 2015	Enrollment in Mass SCO vs. non-integrated FFS Medicare and Medicaid	• SCO enrollment not associated with lower readmissions vs. comparison group
Minnesota MSHO/Anderson et al., 2020	Enrollment in MSHO (integrated plan) vs. Medicaid managed care with FFS Medicare	• MSHO enrollment associated with lower inpatient use, but no differences in long-term nursing facility stays • MSHO associated with greater use of home and community-based services

Effects of integration in UPMC FIDE-SNP (Pennsylvania)

- We are evaluating the effects of integrating coverage for dual-eligibles within a UPMC FIDE-SNP (largest FIDE-SNP in US by enrollment)
- Leverage a 2018 state policy change that introduced a mandatory Medicaid managed care program (Community Health Choices) for dual eligibles in Pennsylvania
- UPMC operates both a D-SNP and a companion Medicaid managed care plan for dual eligibles in Pennsylvania
  - Resulted in integration of coverage for most dual eligibles with established enrollment in UPMC's D-SNP
  - This plan became re-classified as a FIDE-SNP

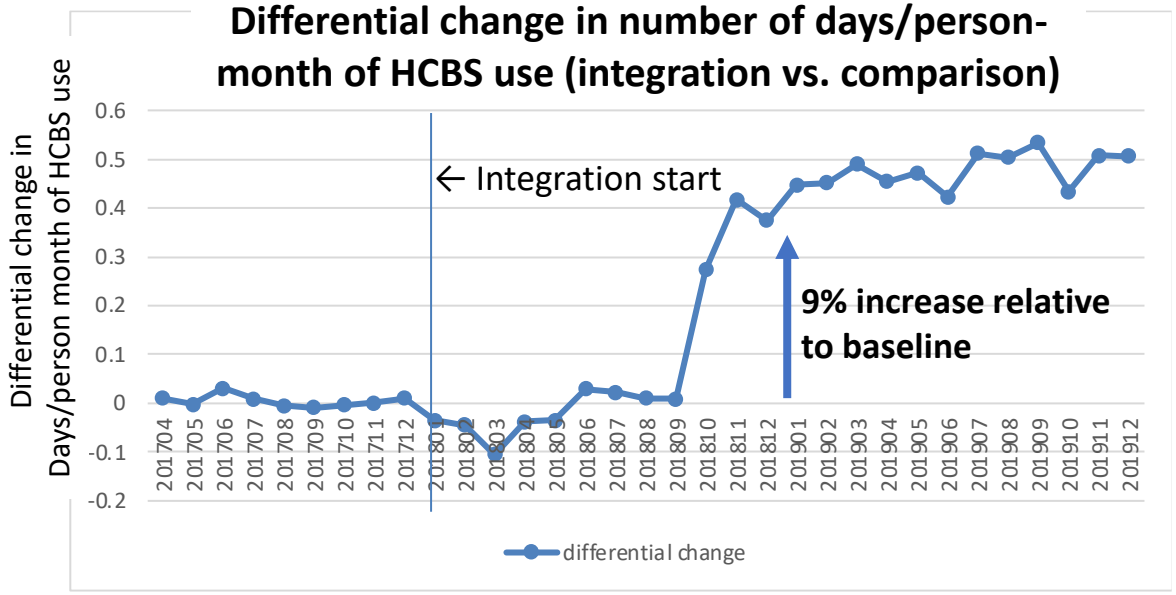
Effects of integration in UPMC FIDE-SNP (Pennsylvania)

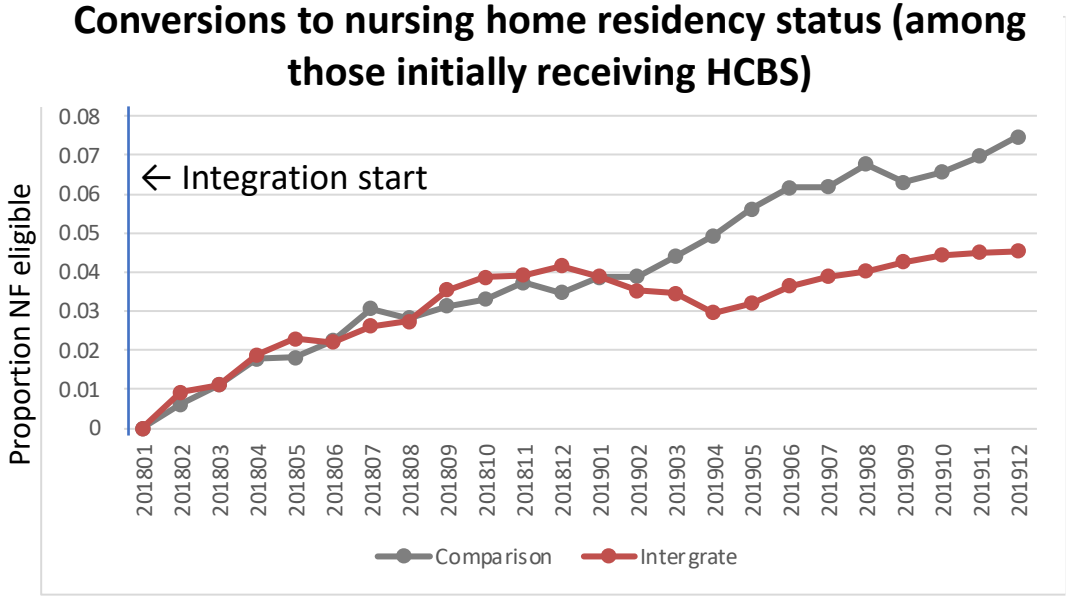
- Established dual eligible enrollees in a UPMC D-SNP joined the insurer's companion Medicaid managed care plan in 2018, resulting in integration of their coverage
- Enrollees in FFS Medicare at baseline retained non-integrated coverage



Effects of integration in UPMC FIDE-SNP (Pennsylvania)

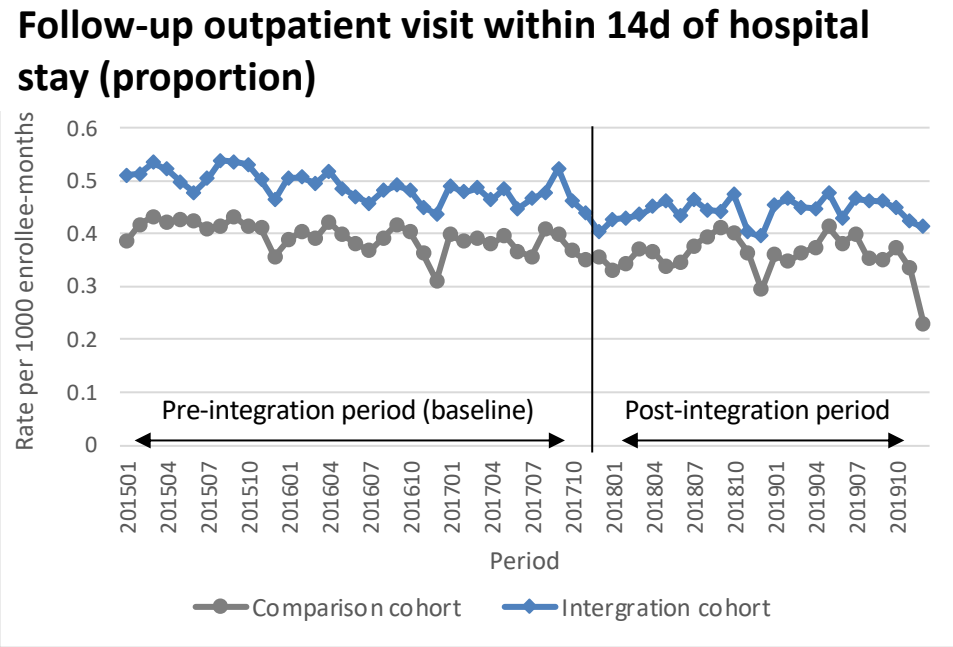
- Integration in UPMC FIDE-SNP associated with greater increases in HCBS use after 2018, and slower conversion to nursing home residency status

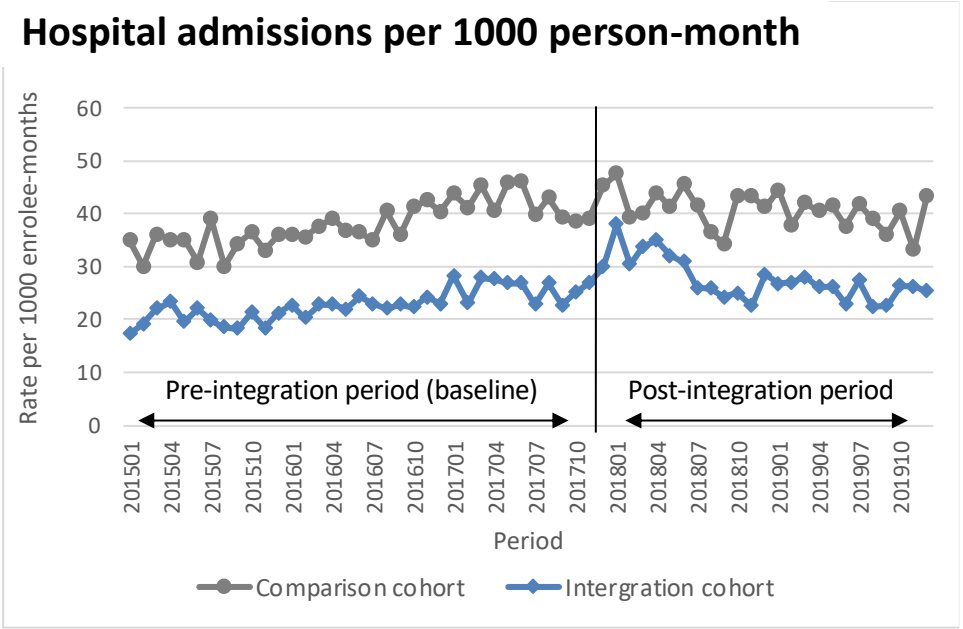




Effects of integration in UPMC FIDE-SNP (Pennsylvania)

- However, no clear effects of integrated coverage on other dimensions of health care use or coordination





Research gaps

Research gaps

1) D-SNP-based integrated models continue to evolve with regulatory reforms, but we know little about associated changes in quality or spending
2) Dual eligible population is heterogeneous (Table), but most evaluations only examined aggregate effects for an 'average' enrollee

Heterogeneity among dual eligibles

Characteristic	% with Characteristic
Eligible for Medicare due to disability	41%
Depression or other serious mental illness	43%
Intellectual or developmental disability	17%
Difficulty performing ≥3 Activities of Daily Living	25%
Resides in a nursing facility	12%

Research gaps

3) Are we measuring the right domains of quality, access, and patient experience for dual eligibles?
   - Measures in CAHPS, MCBS capture generic constructs of quality, access, and patient experience, but these may not be sufficiently tailored to evaluate care for dual eligibles
   - Need to re-evaluate what measures of quality we are measuring for key subpopulations for dual eligibles
4) What types of D-SNP models improve equity of care for dual eligibles?
   - MACPAC and other organizations have called for reforms to incorporate an explicit focus on equity, but evidence to guide policy is incomplete

Research gaps

5) What are effective ways of increasing enrollment in integrated D-SNP-based models, and where do integrated models improve care?
   - Opportunities to learn from default enrollment

6) What factors are detracting from enrollment in integrated coverage models?

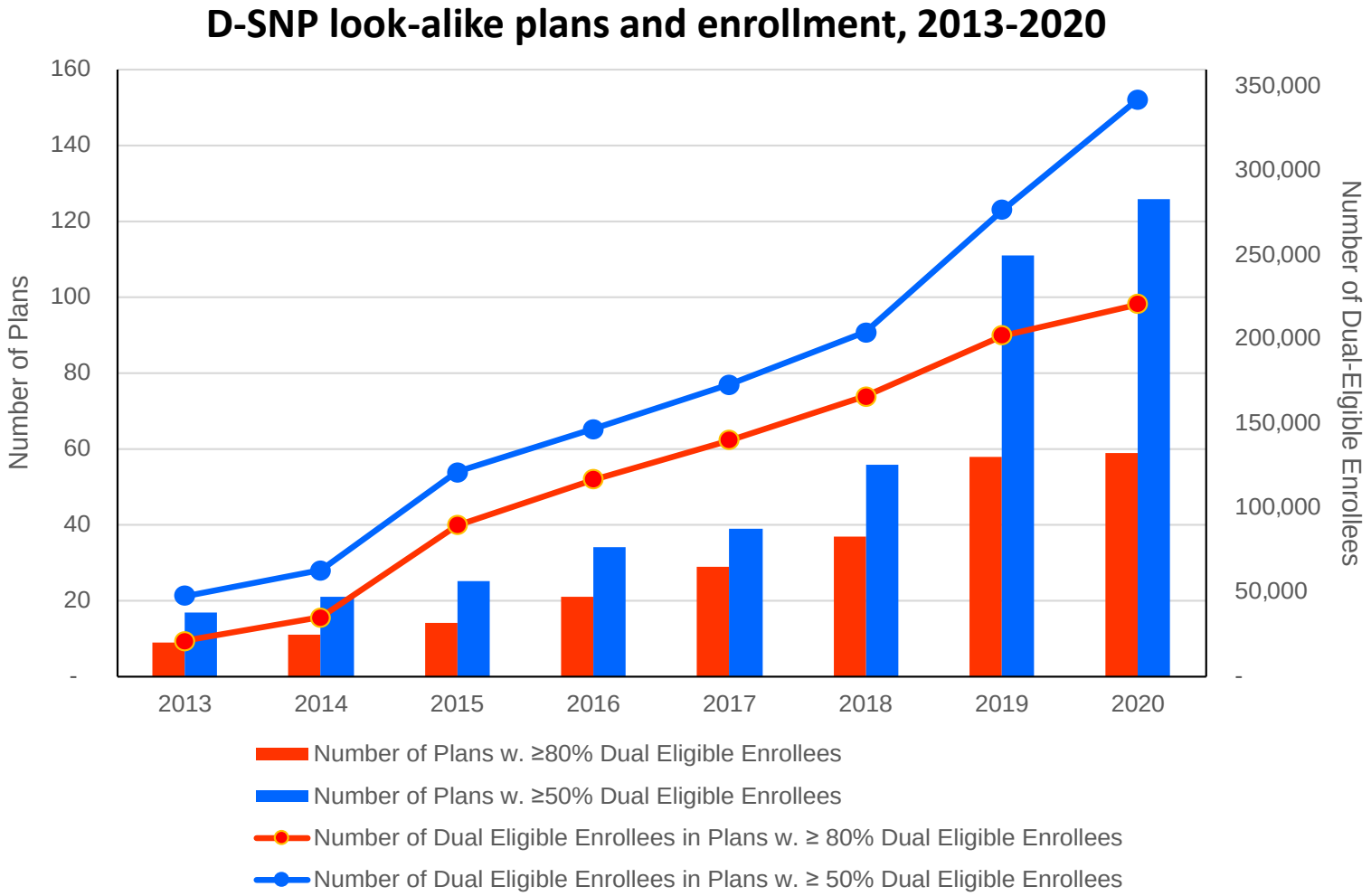
Threats to integrated coverage

D-SNP look-alike plans have emerged as a threat to more integrated coverage models

- Look-alike plans are Medicare Advantage plans that serve a high proportion of dual eligibles, but are not classified as D-SNPs
- Look alike plans are not held to the regulatory standards of D-SNPs and provide no opportunity for financial integration with Medicaid
- Enrollment in look-alike plans is growing rapidly, particularly among Hispanic dual eligibles and duals in highly socioeconomically disadvantaged communities
  - Some growth has come at the expense of integrated D-SNPs
- Prompted CMS regulations to restrict growth of look-alikes

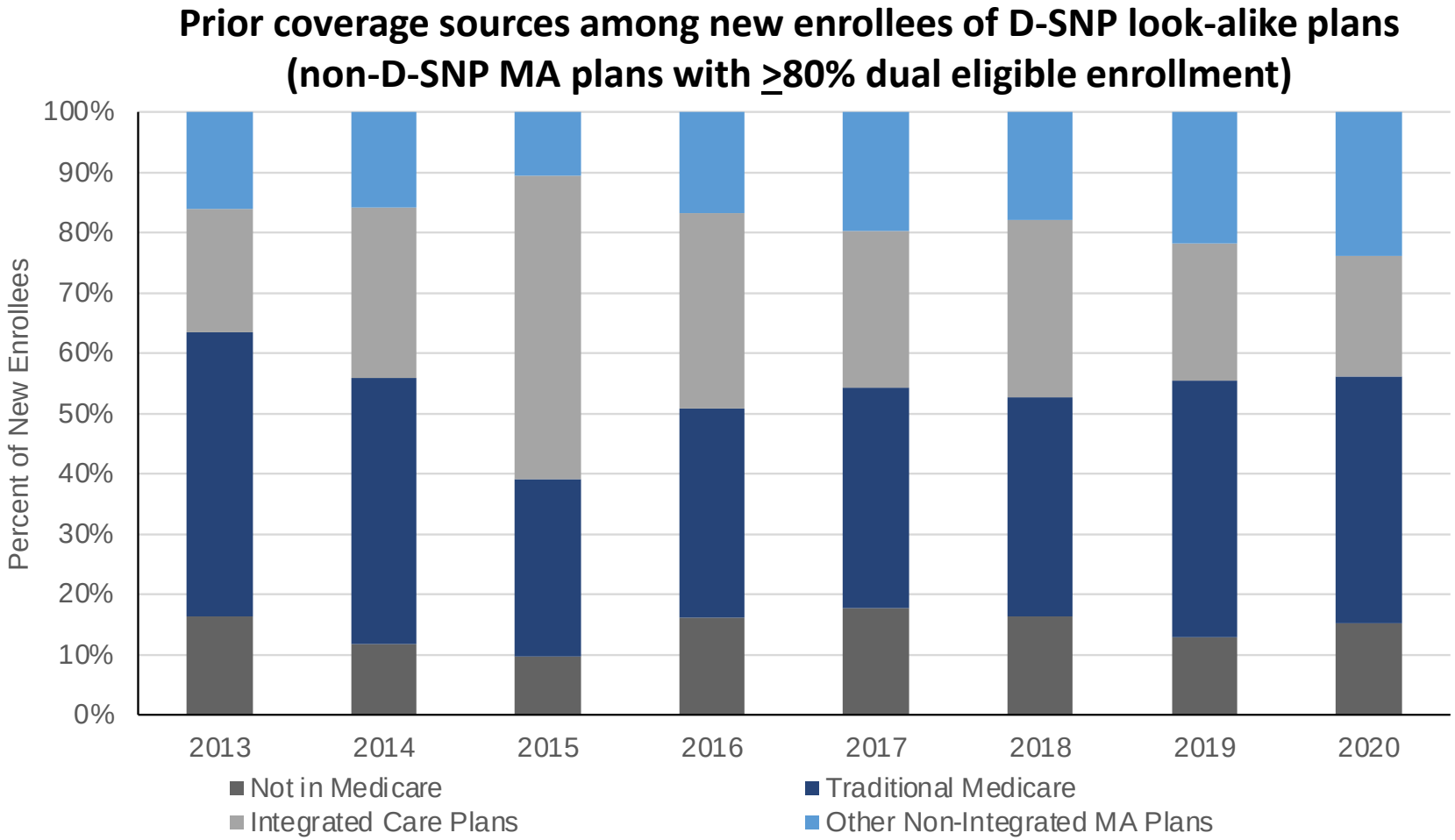
D-SNP look-alike enrollment grew 10x from 2013-20

Look-alikes offered in 17 states as of 2020



Source: Ma, Frakt, Roberts, et al. "Enrollment Growth of Dual-Eligible Beneficiaries in Medicare Advantage D-SNP 'Look-Alike' Plans," (Under review, 2023).

Over one-quarter of new D-SNP look-alike enrollees come from more integrated plans



Source: Ma, Frakt, Roberts, et al. "Enrollment Growth of Dual-Eligible Beneficiaries in Medicare Advantage D-SNP 'Look-Alike' Plans," (Under review, 2023).

Look-alike plans likely to enroll duals of Hispanic ethnicity and in socially vulnerable communities

Look-alike plans: non-D-SNP MA plans with ≥80% dual eligible enrollment

Enrollee Characteristics	D-SNPs	Look-Alike Plans
Age		
<55	14%	7%
55-64	15%	9%
65+	71%	84%
Race/Ethnicity		
Non-Hispanic White	29%	15%
Non-Hispanic Black	24%	9%
Hispanic	38%	56%
Other	9%	20%

Enrollee Characteristics	D-SNPs	Look-Alike Plans
Dual Eligibility Status		
Full Dual Eligible	67%	87%
Partial Dual Eligible	33%	13%
Social Vulnerability Index		
1st Quartile	3%	1%
2nd Quartile	9%	13%
3rd Quartile	44%	16%
4th Quartile	44%	69%

Source: Ma, Frakt, Roberts, et al. "Enrollment Growth of Dual-Eligible Beneficiaries in Medicare Advantage D-SNP 'Look-Alike' Plans," (Under review, 2023).

Consequences of the growth of look-alike plans

- Look alike plans contribute to the erosion of integrated coverage models among dual eligibles
- CMS will no longer renew contracts of non-D-SNP MA plans where ≥80% of enrollees are dual eligibles, but this will not restrict growth of plans just below this threshold
- Consequences of look-alike plans on care and health care disparities not well understood, but important to characterize for guiding future regulatory reforms

Thank you

Please reach out!

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Appendix

Characteristics of duals in D-SNPs vs. other Medicare plan types

Characteristic	D-SNPs	Non-D-SNP MA	Traditional Medicare
Age, years	66.2	67.6	60.9
Female	66%	61%	60%
Race and ethnicity:			
White, non-Hispanic	32%	40%	47%
Black, non-Hispanic	26%	17%	20%
Hispanic	34%	32%	19%
Asian or Pacific Islander	4%	7%	7%
Multiracial or other	4%	3%	6%
Education:			
Less than high school	45%	41%	39%
High school/vocational	31%	35%	37%
College or higher	22%	23%	23%

Characteristic	D-SNPs	Non-D-SNP MA	Traditional Medicare
Married	21%	26%	21%
Difficulty with ADLs, count of 0-6	1.26	1.42	1.40
Chronic conditions (self-reported):			
Diabetes	47%	44%	38%
Hypertension	70%	69%	63%
Myocardial infarction	14%	14%	12%
Hyperlipidemia	66%	62%	59%
Cancer	15%	10%	14%
Depression	46%	44%	47%
Asthma or COPD	31%	28%	31%
Rheumatoid Arthritis	34%	32%	27%

Source: 2016-2020 Medicare Current Beneficiary Surveys