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Report to Congressional Requesters

September 2012

MEDICARE SPECIAL NEEDS PLANS

CMS Should Improve Information Available about Dual-Eligible Plans' Performance

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Highlights

Highlights of GAO-12-864, a report to congressional requesters

September 2012

MEDICARE SPECIAL NEEDS PLANS

CMS Should Improve Information Available about Dual-Eligible Plans' Performance

Why GAO Did This Study

About 9 million of Medicare's over 48 million beneficiaries are also eligible for Medicaid because they meet income and other criteria. These dual-eligible beneficiaries have greater health care challenges than other Medicare beneficiaries, increasing their need for care coordination across the two programs. In addition to meeting all the requirements of other MA plans, D-SNPs are required by CMS to provide specialized services targeted to the needs of dual-eligible beneficiaries as well as integrate benefits or coordinate care with Medicaid services. GAO was asked to examine D-SNPs' specialized services to dual-eligible beneficiaries. GAO (1) analyzed the characteristics of dual-eligible beneficiaries in D-SNPs and other MA plans, (2) reviewed differences in specialized services between D-SNPs and other MA plans, and (3) reviewed how D-SNPs work with state Medicaid agencies to enhance benefit integration and care coordination. GAO analyzed CMS enrollment, plan benefit package, projected revenue, and beneficiary health status data; reviewed 15 D-SNP models of care and 2012 contracts with states; and interviewed representatives from 15 D-SNPs and Medicaid agency officials in 5 states.

What GAO Recommends

To increase D-SNPs' accountability, GAO recommends improving D-SNP reporting of services provided to dual-eligible beneficiaries and making this information available to the public. In its comments on a draft of GAO's report, CMS generally agreed with our recommendations.

View GAO-12-864. For more information, contact James C. Cosgrove at (202) 512-7114 or CosgroveJ@gao.gov.

What GAO Found

About 9 percent of the dual-eligible population is enrolled in 322 Medicare dual-eligible special needs plans (D-SNP), a type of Medicare Advantage (MA) plan. All dual-eligible beneficiaries are low income, but those in D-SNPs tended to have somewhat different demographic characteristics relative to those dual-eligible beneficiaries in other MA plans. On the basis of the most current data available (2010-2011), compared to those in other MA plans, dual-eligible beneficiaries in D-SNPs were more frequently under age 65 and disabled, more likely to be eligible for full Medicaid benefits, and more frequently diagnosed with a chronic or disabling mental health condition. In spite of these differences, the health status of D-SNP enrollees as measured by their expected cost to Medicare was similar to the health status of dual-eligible enrollees in other MA plans in 2010.

D-SNPs provide fewer supplemental benefits—benefits not covered by Medicare fee-for-service (FFS)—on average, than other MA plans. Of the 10 supplemental benefits offered by more than half of D-SNPs, 7 were offered more frequently by other MA plans and 3 were offered more frequently by D-SNPs. Yet D-SNPs spent proportionately more of their rebate—additional Medicare payments received by many plans—to fund supplemental benefits compared to other MA plans, and less to reduce Medicare cost-sharing, which is generally covered by Medicaid. The models of care GAO reviewed, of 107 submitted for 2012, described in varying detail how the D-SNP planned to provide specialized services, such as health risk assessments, and meet other requirements, such as measuring performance. However, the Centers for Medicare & Medicaid Services (CMS), which administers Medicare and oversees Medicaid, did not require D-SNPs to use standardized measures in the models of care, which would make it possible to compare the performance of D-SNPs. While D-SNPs are not required to report that information to CMS, such information would be useful for future evaluations of whether D-SNPs met their intended results, as well as for comparing D-SNPs.

CMS stated that contracts between D-SNPs and state Medicaid agencies are an opportunity to increase benefit integration and care coordination. Our review of the contracts indicated only about one-third of the 2012 contracts contained any provisions for benefit integration, and only about one-fifth provided for active care coordination between D-SNPs and Medicaid agencies, which indicates that most care coordination was done exclusively by D-SNPs, without any involvement of state Medicaid agencies. However, some D-SNP contracts with state Medicaid agencies specified that the agencies would pay the D-SNPs to provide all or some Medicaid benefits. Representatives from the D-SNPs and Medicaid officials from the states GAO interviewed expressed concerns about the contracting process, such as limited state resources for developing and overseeing contracts, as well as uncertainty about whether Congress will extend D-SNPs as a type of MA plan after 2013, and the implementation of other initiatives to coordinate Medicare and Medicaid benefits for dual-eligible beneficiaries that could replace D-SNPs.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
C-SNP	chronic condition special needs plan
D-SNP	dual-eligible special needs plan
ESRD	end-stage renal disease
FFS	fee-for-service
FIDESNP	fully integrated dual-eligible special needs plan
HCPP	health care prepayment plan
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
I-SNP	institutional special needs plan
MA	Medicare Advantage
MedPAC	Medicare Payment Advisory Commission
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NCQA	National Committee for Quality Assurance
PACE	Program of All-Inclusive Care for the Elderly
PPACA	Patient Protection and Affordable Care Act
SNP	special needs plan
SSA	Social Security Act

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United States Government Accountability Office
Washington, DC 20548

September 13, 2012

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
House of Representatives

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Pete Stark
Ranking Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

About 9 million of Medicare's over 48 million beneficiaries are also eligible for Medicaid, a joint federal-state program that finances health insurance coverage for certain categories of low-income adults and children.[1] In 2007, these individuals, referred to as dual-eligible beneficiaries, made up 18 percent of all Medicare beneficiaries but accounted for 31 percent of Medicare spending.[2] In the same year, dual-eligible beneficiaries were about 15 percent of Medicaid enrollees but accounted for nearly 40 percent of Medicaid spending.[3] Disproportionate spending for these

[1]Medicare is the federally financed health insurance program for persons 65 years of age or over, certain individuals with disabilities, and individuals with end-stage renal disease (ESRD). Medicare fee-for-service (FFS), also known as original Medicare, includes Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance, which covers hospital outpatient, physician, and other services and requires a monthly premium. Medicare Part B beneficiaries have the option of enrolling in a Medicare Advantage (MA) plan—a private plan alternative to Medicare FFS that operates under Medicare Part C—to receive their Parts A and B benefits. In addition, all Medicare beneficiaries may opt to receive prescription drug coverage under Medicare Part D either through a separate Part D plan or through an MA plan.

[2]Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: June 2011).

[3]Kaiser Family Foundation, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007* (Washington, D.C.: December 2010).

individuals is largely because dual-eligible beneficiaries are more likely than other Medicare beneficiaries to be disabled; report poor health status and limitations in their activities of daily living, such as bathing and toileting; and have cognitive impairments, mental disorders, and certain chronic conditions such as diabetes and pulmonary disease. In addition, dual-eligible beneficiaries' health care services must be coordinated across Medicare and Medicaid, and each program has its own set of covered services, provider networks, regulations, and payment policies.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the creation of a type of Medicare Advantage (MA) plan referred to as a special needs plan (SNP), to address the unique needs of certain Medicare populations.[4] About 1.2 million of the dual-eligible population is enrolled in dual-eligible SNPs (D-SNP),[5] which are SNPs exclusively for dual-eligible beneficiaries. Dual-eligible beneficiaries may also choose to enroll in other types of SNPs for which they are eligible, including institutional SNPs (I-SNP) for individuals residing in nursing facilities or institutions, chronic condition SNPs (C-SNP) for individuals with severe or disabling chronic conditions, or other MA plans, or remain in Medicare fee-for-service (FFS).[6] In addition to meeting all the requirements of other MA plans, all SNPs, including D-SNPs, are required by the Centers for Medicare & Medicaid Services (CMS)—the agency in the Department of Health and Human Services (HHS) that administers Medicare and oversees Medicaid—to provide specialized services targeted to the needs of their beneficiaries, including a health risk assessment and an interdisciplinary care team for each beneficiary enrolled.[7]

[4]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207 (codified at 42 U.S.C. §§ 1395w-21(a)(2)(A) and 1395w-28(b)(6)).

[5]This number includes 233,902 dual-eligible beneficiaries in Puerto Rico.

[6]Throughout this report, "other MA plans" refers to MA plans that are not SNPs. Enrollment in MA plans, including D-SNPs, is voluntary, but dual-eligible beneficiaries are allowed to change plans each month, whereas most other Medicare beneficiaries may change plans only during the annual open enrollment period.

[7]Throughout this report, "specialized services" refers to services CMS requires SNPs to provide, such as health risk assessments, as well as supplemental benefits, which are benefits not provided under Medicare FFS that may be offered by MA plans.

You asked us to examine the extent to which D-SNPs provide unique services for dual-eligible beneficiaries and how D-SNPs and states work together to serve these beneficiaries. In this report, we (1) describe the characteristics and health status of dual-eligible beneficiaries in D-SNPs and how they compare to those of dual-eligible beneficiaries in other MA plans and Medicare FFS, (2) determine the extent to which D-SNPs' specialized services differ from those offered by other MA plans, and (3) describe how D-SNPs work with state Medicaid agencies to enhance benefit integration and care coordination for dual-eligible beneficiaries.

To describe the demographic characteristics of dual-eligible beneficiaries in D-SNPs and how they compare to those of dual-eligible beneficiaries in other MA plans and Medicare FFS, we analyzed July 2011 enrollment data from CMS. To compare the mental health characteristics and health status of dual-eligible beneficiaries in D-SNPs with dual-eligible beneficiaries enrolled in other MA plans and FFS, we analyzed CMS data on 2010 beneficiary risk scores, which measure expected Medicare costs for each beneficiary on the basis of demographic and diagnosis data.[8] Specifically, we calculated the average risk scores for dual-eligible beneficiaries in D-SNPs, other MA plans, and FFS in 2010.[9] In all of these analyses, we used enrollment and plan benefit data to identify the type of plan (D-SNP, other MA plan, or FFS) in which each beneficiary was enrolled.

To determine the extent to which D-SNPs' specialized services differed from services offered by other MA plans, we used CMS's 2012 plan benefit data to compare D-SNPs' supplemental benefits, such as dental and vision coverage, that are outside the original Medicare FFS benefit

[8]Risk scores are a relative measure of projected Medicare costs for each beneficiary—with lower scores indicating lower expected costs—and are expected to be the same for beneficiaries with the same health conditions and demographic characteristics. In this report we use lower risk scores as a proxy for better health status. We report average risk scores in 2010 because 2010 was the year for which the most recent risk score data were available.

[9]We excluded enrollees with ESRD, those living outside of the United States, and new enrollees from our calculations of average risk scores for each plan type. We adjusted all average risk scores to account for CMS's normalization factor of 1.041 in 2010; additionally, we adjusted the risk scores for D SNPs and other MA plans downward by 3.41 percent to account for CMS's estimate of the diagnostic coding differences between MA and FFS. (This is likely a conservative estimate. See GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, GAO-12-51 [Washington, D.C.: Jan. 12, 2012].)

package, with the supplemental benefits offered by other MA plans.[10] We also used CMS's 2012 bid pricing tool data, which contain information MA plans submitted to CMS on their projected revenue requirements for providing Medicare-covered services to enrolled beneficiaries, to understand how D-SNPs and other MA plans fund the supplemental benefits they offer. Additionally, we interviewed officials from 15 D-SNPs that had enrolled at least 100 dual-eligible beneficiaries in both 2010 and 2011 to discuss what services are available to dual-eligible beneficiaries in D-SNPs and, when applicable, whether differences exist between the care coordination services they offer in their D-SNPs and their MA organization's other MA plans. We judgmentally selected these D-SNPs to cover a range of geographic regions and plan sizes. We also reviewed the 2012 models of care submitted to CMS by these 15 D-SNPs—representing 14 percent of the 107 models of care we received from CMS.[11] The model of care provides a narrative description of how the D-SNP will address certain clinical and nonclinical elements, such as a health risk assessment and an adequate provider network. We focused in particular on how D-SNPs identified the most-vulnerable subpopulations—beneficiaries that need the most-intensive care—and how they planned to meet these care needs.[12]

To describe how D-SNPs worked with state Medicaid agencies, we analyzed all of the 124 contracts between D-SNPs and state Medicaid agencies that were submitted to CMS for 2012 to determine whether the contracts contained provisions expressly addressing benefit integration and care coordination for dual-eligible beneficiaries between the D-SNP

[10]We focused our analysis on the following types of MA plans: health maintenance organizations, local preferred provider organizations, regional preferred provider organizations, private fee-for-service plans, and provider-sponsored organizations. We excluded one type of MA plan—medical savings accounts—because they are not allowed to offer mandatory supplemental benefits. Mandatory benefits must be provided for every person enrolled in the plan, whereas optional supplemental benefits are available to those enrollees who elect and pay for them. In addition, we excluded plans that only provided Medicare Part B benefits and plans that restricted enrollment to members of an employer group or religious fraternal benefit society.

[11]An individual model of care may cover multiple D-SNPs offered by a single MA organization.

[12]According to CMS, the most-vulnerable beneficiaries include, but are not limited to, those beneficiaries who are frail, disabled, or near the end of life.

and the state Medicaid agency.[13] We supplemented this analysis with interviews of officials from five state Medicaid agencies judgmentally selected to cover a range of geographic areas,[14] and with officials from our sample of D-SNPs.

We assessed the reliability of the data we received from CMS by performing appropriate electronic data checks and by interviewing agency officials who were knowledgeable about the data. This allowed us to determine that the data were suitable for our purposes. We did not independently verify the statements of interview respondents or the statements in documents, such as models of care that were submitted by D-SNPs.

Our analysis has several limitations. We limited our analysis to the 50 states and the District of Columbia.[15] Although most of the analysis is based on 2012, the demographic data are from 2011, and the health status data are from 2010, the most recent years available. The contracts between D-SNPs and state Medicaid agencies we reviewed are limited to contracts submitted to CMS for 2012. Because only 40 percent of all D-SNPs were required to submit contracts in that year, these contracts may not represent the full range of possible D-SNP arrangements with state Medicaid agencies. Additionally, because we judgmentally selected the state Medicaid agencies and D-SNPs for our interviews, we cannot generalize the findings from these interviews to all states and all D-SNPs. We did not assess the quality of care provided by D-SNPs.

[13]For 2012, only new SNPs and those expanding their plan service areas were required to contract with the state Medicaid program. See 42 C.F.R. § 422.107(d) (2011). Our review may not account for relevant terms that may have been incorporated by reference into the contracts. CMS reviewed and approved these contracts for compliance with federal law and CMS regulations.

[14]The states in our sample were Alabama, California, Massachusetts, Minnesota, and Oregon.

[15]We excluded D-SNPs and dual-eligible beneficiaries in Puerto Rico from our analyses because Medicare enrollment, cost, and use in Puerto Rico are different than in the states, including a far greater proportion of Medicare beneficiaries enrolling in MA plans. In addition, the CMS enrollment data we received did not include dual-eligible beneficiaries in Puerto Rico (they were coded as “low-income territory beneficiaries” and were not included in the data extracts).

We conducted this performance audit from September 2011 through September 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our research objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Special Needs Plans

SNPs, including D-SNPs, have been reauthorized several times since their establishment was first authorized in 2003. For example, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Patient Protection and Affordable Care Act (PPACA) both contained provisions reauthorizing and modifying SNPs. See table 1 for a summary of legislation establishing and modifying SNPs.

Table 1: Legislation Establishing and Modifying Authority for Special Needs Plans (SNP) to Operate under the Medicare Advantage (MA) Program

Legislation	Specific provisions
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[a]	Authorized the establishment of MA coordinated care plans that exclusively serve individuals in three classes of special needs: (1) beneficiaries entitled to Medicare and Medicaid (dual-eligible beneficiaries), (2) beneficiaries with severe or disabling chronic conditions, or (3) institutionalized beneficiaries. Authorized HHS to designate other MA plans that disproportionately serve special needs individuals as new SNPs. Authorized SNPs to restrict enrollment to individuals in the classes of special needs through December 31, 2008.
The Medicare, Medicaid and SCHIP Extension Act of 2007[b]	Beginning on January 1, 2008, and extending through December 31, 2009, established a moratorium on the authority of HHS to designate other MA plans disproportionately serving special needs individuals as SNPs and to permit enrollment of individuals in a new or expanding SNP (which was not subsequently extended). Extended authority for SNPs to restrict enrollment to individuals in the classes of special need through December 31, 2009.
The Medicare Improvements for Patients and Providers Act of 2008[c] (MIPPA)	Effective January 1, 2010, requires all D-SNPs to have contracts with state Medicaid agencies to provide—or arrange to provide—benefits to eligible individuals under Medicaid. Made an exception through December 31, 2010, for existing plans not expanding their service areas. Extended the moratorium on the authority of HHS to designate other MA plans that disproportionately serve special needs individuals as SNPs through December 31, 2010, but lifted the moratorium on new SNPs and existing SNPs at the end of 2009. Extended authority for SNPs to restrict enrollment to individuals in the classes of special need through December 31, 2010.
The Patient Protection and Affordable Care Act (2010)[d] (PPACA)	Effective January 1, 2012, and subsequent years, required all SNPs to be approved by the National Committee for Quality Assurance (NCQA) based on standards established by HHS. Extends the exception for existing D-SNPs that do not expand their current service areas to continue operating without contracts with state Medicaid agencies through December 31, 2012. Authorized special payment rules for fully integrated SNPs for dual-eligible beneficiaries. Extended authority for SNPs to restrict enrollment to individuals in the classes of special need through December 31, 2013.

Source: GAO analysis.

[a]Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207.

[b]Pub. L. No. 110-173, § 108, 121 Stat. 2492, 2496. The acronym SCHIP stands for the State Children's Health Insurance Program.

[c]Pub. L. No. 110-275, § 164, 122 Stat. 2494, 2571.

[d]Pub. L. No. 111-148, § 3205, 124 Stat. 119, 457.

In 2012, 322 D-SNPs are operating in 38 states and the District of Columbia.[16] CMS pays D-SNPs the same way that it pays other MA plans; that is, a monthly amount determined by the plan bid—the plan's estimated cost of providing Medicare Part A and Part B benefits—in relation to a benchmark, which is the maximum amount the Medicare program will pay MA plans in a given locality. CMS then adjusts the monthly payments to MA plans on the basis of beneficiaries' risk scores.[17] If an MA plan's bid exceeds the benchmark, the plan must charge each of its beneficiaries an additional premium to make up the difference. If a plan's bid is less than the benchmark, a proportion of the difference is returned to the plan as additional Medicare payments called rebates, which must be used to reduce premiums, reduce cost sharing, or provide mandatory supplemental benefits, such as vision and dental care.[18] Beginning in 2012, CMS has begun to phase in PPACA-mandated modifications in the rebate amount and introduced varied rebate amounts based on CMS's assessments of plan quality.[19] For 2012, rebates ranged from 66.67 percent of the difference between a plan's bid and benchmark

[16]Of these 322 D-SNPs, 17 have been designated by CMS as fully integrated dual-eligible special needs plans (FIDESNP). A FIDESNP is a CMS-approved D-SNP that (1) enrolls special-needs individuals entitled to medical assistance under a Medicaid state plan; (2) provides dual-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization; (3) has a capitated contract with a state Medicaid agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with state policy; (4) coordinates the delivery of covered Medicare and Medicaid health and long-term care services using aligned care management and specialty care network methods for high-risk beneficiaries; and (5) employs policies and procedures approved by CMS and the state to coordinate or integrate member materials, enrollment, communications, grievance and appeals, and quality improvement. 42 C.F.R. § 422.2 (2011). In addition, there are 8 D-SNPs operating in Puerto Rico in 2012.

[17]In 2012, FIDESNPs will be eligible for increased payments when certain requirements, such as having a similar average level of frailty as the Program of All-Inclusive Care for the Elderly (PACE) program, are met.

[18]Under each category of supplemental benefits, plans can provide coverage for a variety of individual services, such as eye exams, eyeglasses, or contact lenses under a vision benefit; however, plans do not have to provide coverage for all individual services under a supplemental benefit category.

[19]CMS assesses plan quality using a five-star rating scale based on measures of clinical quality, patients' reported care experience, and contract performance. Once fully phased in after 2014, the revised rebates will range from 50 percent of the difference between a plan's bid and benchmark for plans with the lowest quality ratings to 70 percent of the difference for plans with the highest quality ratings. See Pub. L. No. 111-148, Title III, Subtitle C, 124 Stat. 442, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040.

for plans with the lowest quality ratings to 73.33 percent of the difference for plans with the highest quality ratings.

D-SNPs must meet the same requirements as other MA plans, such as submitting an application to CMS. And like other MA plans, D-SNPs that meet minimum enrollment requirements are also required to submit data, such as the Health Effectiveness Data and Information Set (HEDIS) quality measures.[20] In addition, they must conduct quality improvement activities, which include the reporting of certain structure and process measures, such as describing how they manage medication reconciliation associated with patient transitions between care settings.[21]

CMS requires D-SNPs to develop a model of care that describes their approach to caring for their target population.[22] The model of care must describe how the plan will address 11 clinical and nonclinical elements established in CMS guidance: (1) describing the specific target population, (2) tracking measurable goals, (3) describing the staff structure and care management goals, (4) providing an interdisciplinary care team, (5) establishing a provider network that has specialized expertise and describing the use of clinical practice guidance and protocols, (6) training plan employees and the provider network on the model of care, (7) performing health risk assessment, (8) creating individualized care plans, (9) establishing a communications network, (10) providing care management for the most vulnerable subpopulations, and (11) measuring plan performance and health outcomes. These models of care are reviewed and approved by NCQA—a private health care quality organization—on the basis of scoring criteria developed with CMS that emphasized the inclusion of in-depth descriptions or case studies. In their MA applications, D-SNPs must also "attest" that they

[20]MedPAC attempted to analyze the quality of SNPs, but found isolating results for SNPs is difficult because of the way organizations that sponsor SNPs report HEDIS quality measures. Most HEDIS data are reported across all of an organization's plans (i.e., both SNPs and other MA plans) rather than reported separately for SNPs. SNPs do report separately on a subset of 12 of 45 HEDIS measures. When comparing these measures, MedPAC found in general that SNP performance was poorer than other MA performance, but there was wide variation across plans. See MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2012), 328-329.

[21]See 42 C.F.R. § 422.152(g)(2)(iii) (2011).

[22]42 C.F.R. § 422.101(f) (2011).

meet a total of 251 subelements related to the 11 elements in their model of care.

New and expanding D-SNPs are required to contract with state Medicaid agencies in 2012, and beginning in 2013, all D-SNPs will be required to have contracts with state Medicaid agencies.[23] According to CMS, the contracts are an opportunity to improve the integration of Medicare and Medicaid benefits, and the agency has implemented this requirement with the goal of "increased integration and coordination" for dual-eligible beneficiaries.[24]

D-SNPs do not cover the same categories of dual-eligible beneficiaries, but their chosen category(ies) must correspond to those under the Medicaid program in the state in which the D-SNP is being offered. Dual-eligible beneficiaries fall into two main categories. One group, termed full-benefit dual-eligible beneficiaries, may receive the entire range of Medicaid benefits, including long-term care. The other group, partial-benefit dual-eligible beneficiaries, does not receive Medicaid-covered health care services, but Medicaid covers Medicare premiums or cost-sharing, or both, for these beneficiaries. Some D-SNPs limit enrollment to full-benefit dual-eligible beneficiaries, while others are open to all dual-eligible beneficiaries. Additionally, some D-SNPs are open only to disabled beneficiaries under age 65, whereas others are open only to those aged 65 and over.

[23]Social Security Act (SSA), § 1859(f) (requirement for contract); Pub. L. No.110-275, § 164(c)(2), 122 Stat. 2573 (temporary exemption for certain SNPs) as amended by Pub. L. No. 111-148, § 3205(d), 124 Stat. 458 (extending temporary exemption through 2012). CMS regulations require that contracts between D-SNPs and states include documentation of (1) the MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits; (2) the category(ies) of eligibility for dual-eligible beneficiaries to be enrolled; (3) the Medicaid benefits covered; (4) the cost-sharing protections covered; (5) the identification and sharing of information on Medicaid provider participation; (6) the verification of enrollees' eligibility for both Medicare and Medicaid; (7) the service area covered; and (8) the contract period. 42 C.F.R. § 422.107(c) (2011). Although such contracts will be required for D-SNPs to operate within a state, there is no requirement that a state enter into such a contract.

[24]CMS, *Common Contracting Issues and Discussion* (Baltimore, Md.: revised September 2011).

Other Initiatives for Care Coordination for Dual-Eligible Beneficiaries

Recently, the federal government, states, researchers, and advocates have focused increased attention on care coordination for dual-eligible beneficiaries. PPACA required HHS to establish the Federal Coordinated Health Care Office (generally known as the Medicare-Medicaid Coordination Office) within CMS to more-effectively integrate Medicare and Medicaid benefits and to improve federal-state coordination for dual-eligible beneficiaries to ensure that they receive full access to the items and services to which they are entitled.[25] Experts believe that, in addition to benefiting dual-eligible beneficiaries, more-effective benefit integration and care coordination can generate significant savings by, for example, lowering emergency room use.

The Medicare-Medicaid Coordination Office, working with the Center for Medicare & Medicaid Innovation (called the Innovation Center), is beginning a financial alignment initiative that is expected to enroll up to 2 million beneficiaries in 26 states and is intended to align Medicare and Medicaid services and funding so as to reduce costs while improving beneficiaries' care.[26] Through these demonstrations, the federal and state governments expect to realize savings from aligning the payments and integrating care. Under existing coordination efforts, integrating benefits requires an investment of resources from states to work with D-SNPs, or other stakeholders, but according to experts most of the financial savings accrue to Medicare, because most savings result from services that are largely paid for by Medicare, such as reductions in the number or length of hospital stays. Under the financial alignment initiative, savings will be shared by Medicare and Medicaid without reference to whether the savings are achieved in Medicare or Medicaid services, although the allocation of these savings between Medicare and Medicaid has not yet been finalized. Two models will be tested: a managed FFS model, under which payments are adjusted retrospectively, and a capitated model under which one payment is made to an MA plan under a three-way contract among Medicare, the state Medicaid agency, and the plan.

[25]Pub. L. No. 111-148, § 2602, 124 Stat. 315.

[26]In 2011, the Medicare-Medicaid Coordination Office, in partnership with the Innovation Center, entered into contracts with 15 states for up to $1 million each to design state demonstrations. Furthermore, in July 2011 CMS issued a letter calling for additional state Medicaid agencies to submit letters of intent to participate in the demonstrations to better align Medicare and Medicaid funding.

The initiative is being conducted under the demonstration authority of the Innovation Center, under which the Secretary of HHS may conduct evaluations that analyze both quality of care and changes in spending.[27] For purposes of testing models under this authority, budget neutrality—which would require that no more be spent under the demonstration than is currently being spent on care for dual-eligible beneficiaries—does not apply. The Secretary can expand the demonstrations nationwide if the demonstrations are determined to reduce spending without reducing the quality of care or improve the quality of care without increasing spending.[28]

The state demonstrations under the financial alignment initiative do not necessarily include D-SNPs, and in some cases may replace D-SNPs. As of June 2012, all 26 states had submitted their proposals for the demonstrations. Decisions about implementation of these designs had not been announced as of July 2012 yet implementation of these models is expected to begin by January 2013 and continue into 2014.

Dual-Eligible Beneficiaries in D-SNPs Had Similar Health Status to Other Dual-Eligible Beneficiaries

The demographic and mental health characteristics of dual-eligible beneficiaries enrolled in D-SNPs in 2011 differed from those of dual-eligible beneficiaries in other MA plans and, to a lesser extent, from those of dual-eligible beneficiaries in FFS.[29] Despite these differences, dual-eligible beneficiaries in D-SNPs and dual-eligible beneficiaries in FFS and other MA plans had very similar health status in 2010, the year for which the most recent data were available, as measured by Medicare risk scores.

[27]SSA, § 1115A.

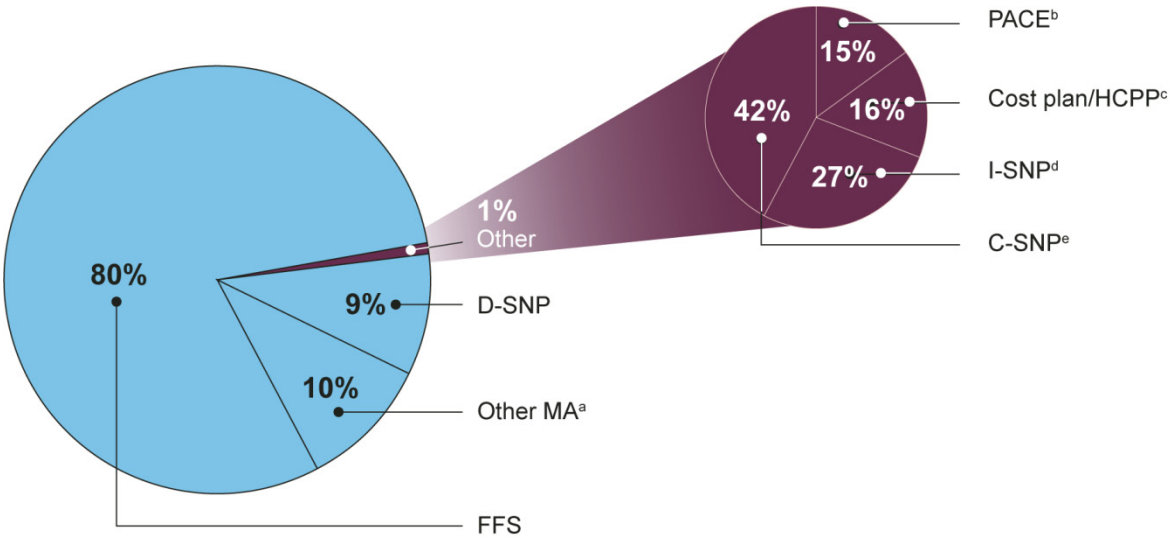
[28]The demonstration may be expanded through rulemaking if (1) the Secretary determines that the expansion would reduce spending without reducing the quality of care or improve the quality of care without increasing spending; (2) the CMS Chief Actuary certifies that the expansion would reduce or not increase net program spending; and (3) the Secretary determines that the expansion would not deny or limit the coverage or the provision of benefits for applicable individuals. SSA, § 1115A(c).

[29]Data on mental health characteristics are based on the 2010 risk score data.

Dual-Eligible Beneficiaries in D-SNPs Had Characteristics That Were Generally Similar to Their FFS Counterparts but Differed in Key Respects from Such Beneficiaries in Other MA Plans

Dual-eligible beneficiaries in D-SNPs (9 percent of all dual-eligible beneficiaries in 2011, as shown in fig. 1) were most similar to dual-eligible beneficiaries in FFS, but differed substantially from dual-eligible beneficiaries in other MA plans on certain demographic and mental health measures.[30]

Figure 1: Enrollment of Dual-Eligible Beneficiaries by Plan Type, 2011



Source: GAO analysis of CMS data.

Notes: Percentages are based on 9,188,828 dual-eligible beneficiaries in Medicare and Medicaid as of July 2011. Data sources include CMS's 2011 enrollment data, 2011 plan benefit package data, and 2010 risk score data (used only to determine residence). Data exclude dual-eligible beneficiaries in Puerto Rico and those living outside of the 50 states and the District of Columbia in 2010.

[a]Other MA plans include non-SNP health maintenance organizations (including point of service options), local and regional preferred provider organizations, provider-sponsored organizations, private fee-for-service plans, and medical savings account plans.

[b]Program of All-Inclusive Care for the Elderly (PACE), which provides a range of integrated preventative, acute care, and long-term care services for the frail elderly.

[30]Demographic data refer to dual-eligible beneficiaries in July 2011. Mental health data refer to dual-eligible beneficiaries in July 2010 and are based on 2009 diagnosis data. Both sources exclude beneficiaries in Puerto Rico and those living outside of the 50 states and the District of Columbia in 2010.

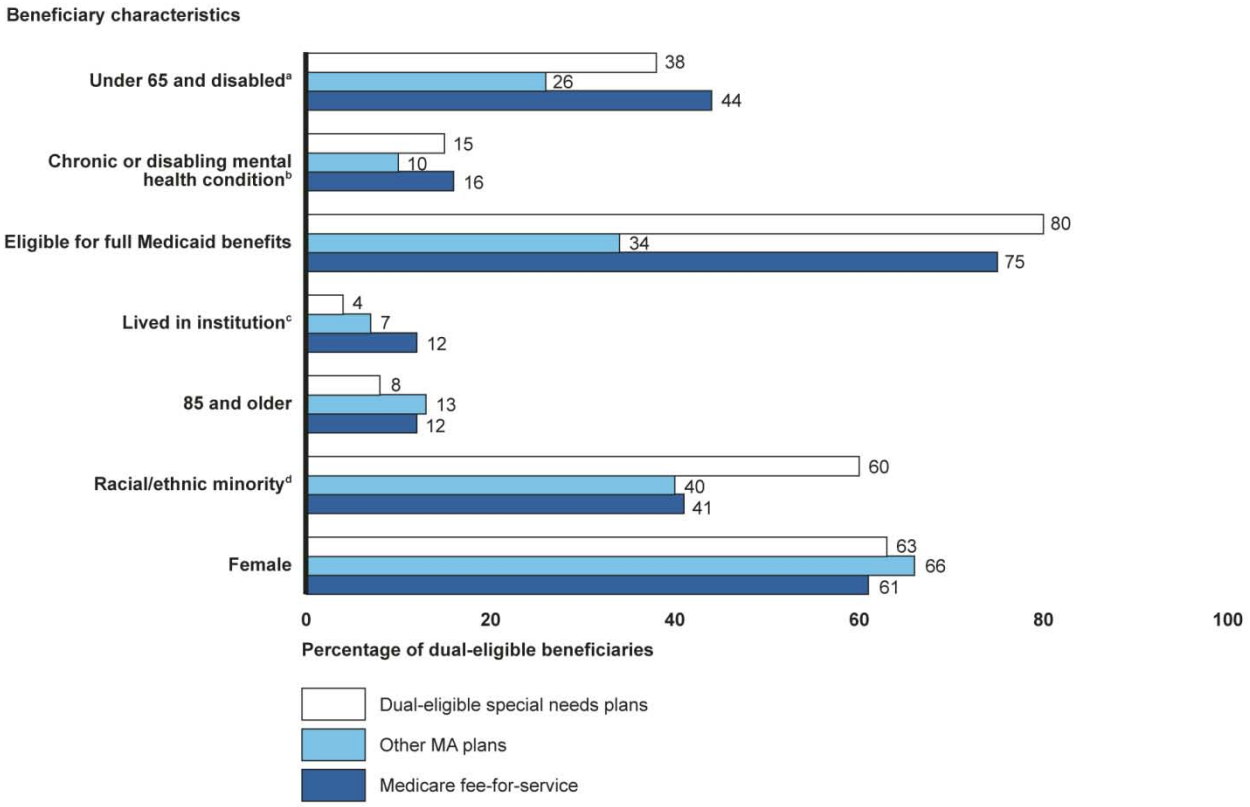
[c]Cost plans provide original Medicare services, but enrollees can receive covered services outside of the health maintenance organization or competitive medical plan network. Health care prepayment plans (HCPP) are union- or employer-sponsored plans that provide or arrange for some or all of Part B Medicare benefits on a prepayment basis, while payments for Part A services are made on a FFS basis.

[d]Institutional special needs plan (I-SNP).

[e]Chronic condition special needs plan (C-SNP).

A larger proportion of dual-eligible beneficiaries in D-SNPs, as well as dual-eligible beneficiaries in FFS, were under age 65 and disabled in 2011 compared with those in other MA plans (see fig. 2). Additionally, similar proportions of dual-eligible beneficiaries in D-SNPs and dual-eligible beneficiaries in FFS (15 and 16 percent, respectively) were diagnosed with a chronic or disabling mental health condition such as major depressive disorder or schizophrenia, compared with just 10 percent of dual-eligible beneficiaries in other MA plans. Among the characteristics in our analysis, the largest difference between D-SNPs and other MA plans was the proportion of full-benefit beneficiaries in each plan type: 80 percent of dual-eligible beneficiaries in D-SNPs and 75 percent of dual-eligible beneficiaries in FFS were eligible for full Medicaid benefits, compared with just 34 percent of dual-eligible beneficiaries in other MA plans.

Figure 2: Characteristics of Dual-Eligible Beneficiaries in D-SNPs Compared with Dual-Eligible Beneficiaries in Other MA Plans and FFS



Source: GAO analysis of CMS data.

Notes: Sources include CMS's 2011 enrollment data, 2011 plan benefit package data, and 2010 risk score data. Percentages for demographic data are based on about 851,000 dual-eligible beneficiaries in D-SNPs, 882,000 in other MA, and 7.3 million in FFS as of July 2011. Percentages for chronic or disabling mental health conditions are based on about 755,000 dual-eligible beneficiaries in D-SNPs, 757,000 in other MA, and 7.1 million in FFS for whom risk score data were available as of July 2010, the most recent year available, and are based on 2009 diagnosis data. Actual totals vary for each characteristic due to missing data. Data exclude beneficiaries in Puerto Rico and those living outside of the 50 states and the District of Columbia in 2010.

[a]Under 65 and disabled does not include beneficiaries with ESRD.

[b]A chronic and disabling mental health condition is defined as a diagnosis of schizophrenia; schizoaffective disorder; or major depressive, bipolar, or paranoid disorders.

[c]Refers to beneficiaries who lived in an institution during July 2011.

[d]Racial or ethnic minorities include Black, Hispanic, Asian, and North American Native beneficiaries, and beneficiaries who reported "Other" race; however, CMS's enrollment data have limitations in accurately identifying beneficiary race and ethnicity, resulting in an underreporting of Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives.

While dual-eligible beneficiaries in D-SNPs were generally similar to those in FFS, there were several demographic measures on which dual-eligible beneficiaries in D-SNPs differed from both those in FFS and other MA plans. A smaller proportion of dual-eligible beneficiaries in D-SNPs lived in institutions (e.g., nursing facilities, intermediate care facilities, or inpatient psychiatric hospitals) in July 2011 compared with dual-eligible beneficiaries in FFS, and, to a lesser extent, other MA plans. D-SNPs also enrolled a smaller proportion of dual-eligible beneficiaries who were 85 or older compared with the other plan types, as well as a larger proportion of beneficiaries who were racial or ethnic minorities.[31]

Health Status of Dual-Eligible Beneficiaries in D-SNPs Was Similar to That of Dual-Eligible Beneficiaries in FFS and Other MA Plans

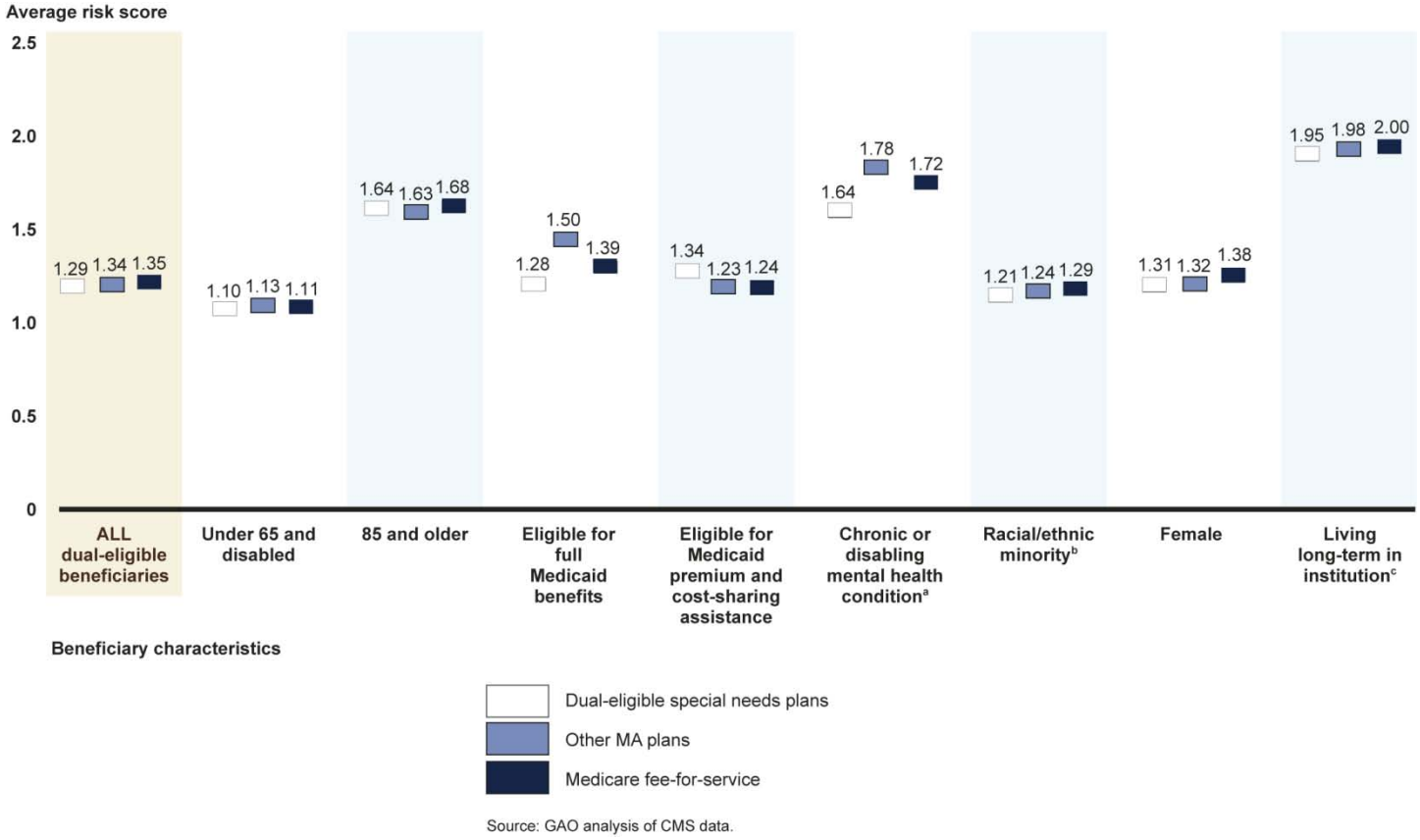
Dual-eligible beneficiaries in D-SNPs had very similar health status as measured by their 2010 risk scores, the year for which the most recent data were available, when compared with dual-eligible beneficiaries in FFS and other MA plans.[32] As shown in figure 3, the average risk score—which predicts Medicare costs—of dual-eligible beneficiaries in D-SNPs (1.29) was similar to the average scores for dual-eligible beneficiaries in FFS (1.35) and other MA plans (1.34).[33] Just under 20 percent of dual-eligible beneficiaries in D-SNPs and dual-eligible beneficiaries in FFS and other MA plans were expected to cost Medicare at least twice as much as the average Medicare FFS beneficiary, and less than 10 percent in each plan type were expected to cost at least three times the average.

[31]Racial or ethnic minorities include Black, Hispanic, Asian, and North American Native beneficiaries, and beneficiaries who reported “Other” race. CMS’s enrollment data have limitations in accurately identifying beneficiary race and ethnicity, resulting in an underreporting of Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives.

[32]We report data on health status based on dual-eligible beneficiaries enrolled in Medicare and Medicaid as of July 2010. These data are not linked to beneficiaries’ demographic characteristics in 2011.

[33]Average risk scores for D-SNP enrollees and dual-eligible beneficiaries in other MA plans and FFS were even-more similar when comparing only the risk scores for beneficiaries who lived in the community in July 2010 (D-SNP=1.27, other MA=1.29, FFS=1.28). This is true in part because a larger proportion of dual-eligible beneficiaries who were considered to be long-term institutional (i.e., those who resided in an institution for at least 3 months) enrolled in FFS than in D-SNPs in 2010. CMS calculates the risk scores of these institutional beneficiaries using a different model than it does for community beneficiaries, and the resulting risk scores for the two groups are different. Institutionalized dual-eligible beneficiaries in D-SNPs, other MA plans, and FFS had similar risk scores in 2010 (D-SNP=1.95, other MA=1.98, FFS=2.00).

Figure 3: Average Risk Scores of Dual-Eligible Beneficiaries by Characteristic and Plan Type, 2010



Source: GAO analysis of CMS data.

Notes: Sources include CMS's 2010 enrollment data, plan benefit package data, and risk score data. Data exclude new enrollees, beneficiaries with ESRD, and those living in Puerto Rico and outside of the 50 states and the District of Columbia. We adjusted all average risk scores to account for CMS's normalization factor of 1.041 in 2010; additionally, we adjusted average risk scores of D-SNPs and other MA plans downward by 3.41 percent to account for diagnostic coding differences between MA plans and FFS.

[a]A chronic or disabling mental health condition is defined as a diagnosis of schizophrenia; schizoaffective disorder; or major depressive, bipolar, or paranoid disorders.

[b]Racial or ethnic minorities include Black, Hispanic, Asian, and North American Native beneficiaries, and beneficiaries who reported "Other" race; however, CMS's enrollment data have limitations in accurately identifying beneficiary race and ethnicity, resulting in an underreporting of Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives.

[c]Refers to beneficiaries who were considered to be "long-term institutional" (i.e., living in an institution for at least 3 months) as of July 2010.

The average risk scores of dual-eligible beneficiaries in each plan type also generally were similar across demographic groups. However, there were some differences between plan types. Dual-eligible beneficiaries in

D-SNPs who were eligible for full Medicaid benefits had lower average risk scores than those of similar beneficiaries in other MA plans and FFS.[34] Dual-eligible beneficiaries in D-SNPs with a chronic or disabling mental health condition also had lower average risk scores than those in other MA plans. Additionally, partial-benefit dual-eligible beneficiaries in D-SNPs had higher average risk scores than their counterparts in other MA plans and FFS.

D-SNPs Typically Offer Fewer Supplemental Benefits Than Other MA Plans, and Information on Planned Services Is Not Comparable

Dual-eligible beneficiaries in D-SNPs do not necessarily get more benefits than those in other MA plans, although D-SNP representatives told us their care coordination services are more comprehensive than other MA plans. D-SNPs and other MA plans varied in how frequently they offered supplemental benefits—benefits not covered by FFS—and MA plans offered more of these supplemental benefits than D-SNPs. While the models of care we reviewed described in varying detail how the D-SNPs plan to provide other services, such as health risk assessments, to beneficiaries, most D-SNPs did not provide—and are not required to provide—estimates of the number of dual-eligible beneficiaries that would receive the services.

D-SNPs Offered Fewer of Their 10 Most-Common Supplemental Benefits Than Other MA Plans

D-SNPs provide fewer supplemental benefits, on average, than other MA plans. Of the 10 supplemental benefits offered by more than half of D-SNPs, 7 were offered more frequently by other MA plans and 3 were offered more frequently by D-SNPs.[35] (See fig. 4.) These 3 supplemental benefits were offered much more frequently by D-SNPs compared to other MA plans: they offered dental benefits one-and-a-half times more

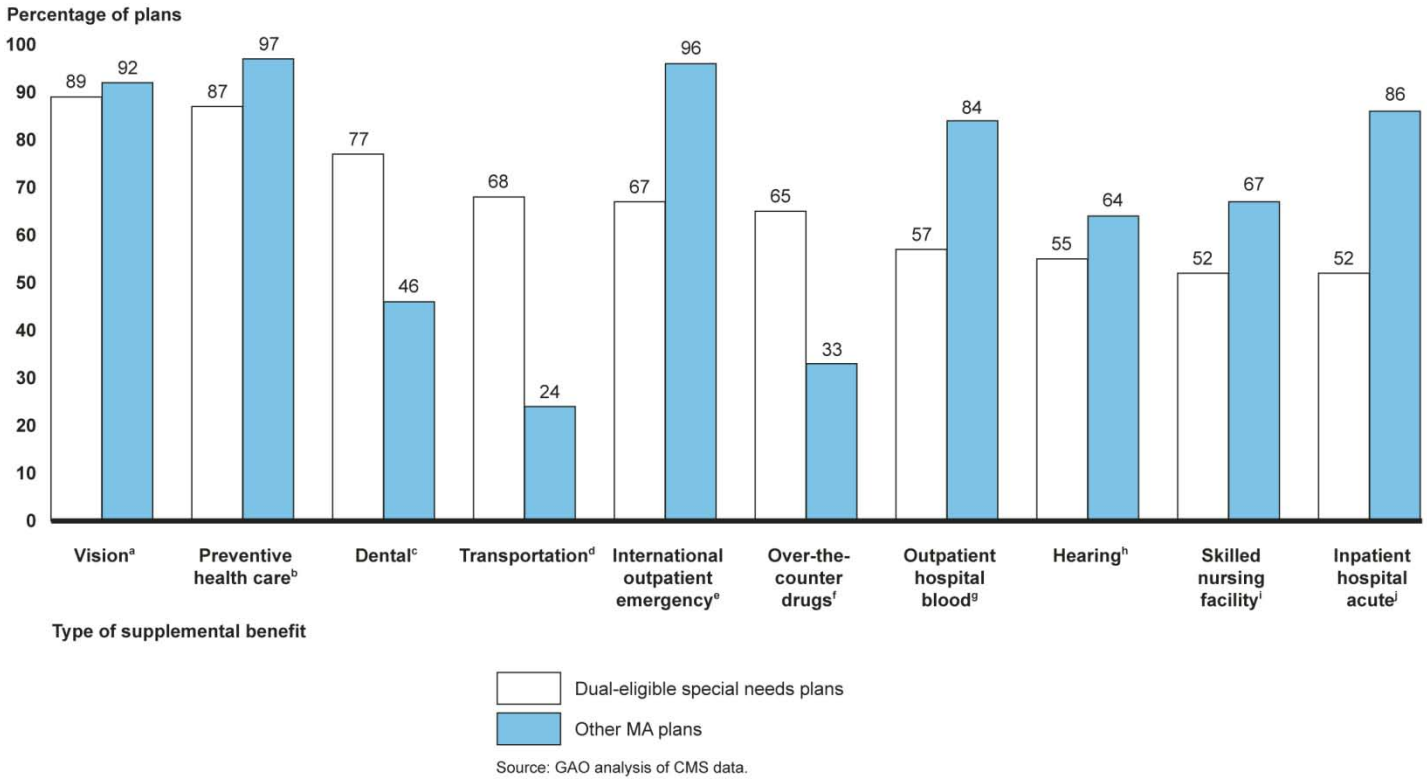
[34]However, when taking into consideration the large proportion of FFS beneficiaries who lived in institutions compared to D-SNP beneficiaries, full-benefit dual-eligible beneficiaries in D-SNPs and FFS had similar average risk scores (1.25 and 1.29, respectively).

[35]We examined a total of 20 supplemental benefits offered by D-SNPs and other MA plans. In addition to the categories listed in fig. 4, we also examined the following 10 supplemental benefits categories offered by fewer than half of D-SNPs: (1) podiatry, (2) meal benefits, (3) chiropractic, (4) acupuncture, (5) point-of-service or out-of-network option, (6) home infusion, (7) inpatient psychiatric hospital/facility, (8) U.S. Visitor/Travel program, (9) cardiac/pulmonary rehabilitation, and (10) outpatient drug benefit. Of these additional 10 benefits, 5 were offered less frequently by D-SNPs compared to other MA plans. We limited our analysis to plans with no premium because 99 percent of D-SNPs have no Part C premium, and in our interviews with D-SNPs, representatives emphasized the importance of zero-premium plans for the dual-eligible population.

often, over-the-counter drugs nearly twice as often, and transportation benefits almost three times more often. However, a smaller proportion of D-SNPs compared to other MA plans offered hearing benefits, as well as benefits for certain inpatient settings and outpatient services. For some of the services D-SNPs offered less frequently, dual-eligible beneficiaries may receive some coverage through Medicaid. In addition, according to CMS, some of the benefits offered more frequently by other MA plans (e.g. international outpatient emergency) are not necessarily as useful a benefit for D-SNPs.[36]

[36]For 2013, CMS will allow certain D-SNPs that meet integration and performance standards to offer additional supplemental benefits beyond those CMS currently allows all MA plans to offer, where CMS finds that the offering of such benefits could better integrate care for dual-eligible beneficiaries. Such benefits are subject to CMS approval, but may include nonskilled nursing services, personal care services, and other long-term care services and supports designed to enable beneficiaries to remain in the community. D-SNPs must offer these additional supplemental benefits at no additional cost to the beneficiary.

Figure 4: Supplemental Benefits Offered by More Than Half of Dual-Eligible Special Needs Plans (D-SNP) Compared with Other Medicare Advantage (MA) Plans, 2012



Source: GAO analysis of CMS data.

Notes: Source data are for the 2012 contract year. The following types of MA plans are included: health maintenance organizations, local preferred provider organizations, regional preferred provider organizations, private fee-for-service plans, and provider-sponsored organizations. We excluded plans that charged a Part C premium.

[a]Vision benefits can include coverage for routine eye exams, contact lenses, or eyeglasses (lenses and frames).

[b]Preventive health care benefits can include screenings and immunizations beyond what Medicare fee-for-service (FFS) covers, as well as health education and fitness club membership.

[c]Dental benefits can include oral exams, teeth cleanings, fluoride treatments, dental X-rays, or emergency dental services.

[d]Transportation benefits can include travel from a beneficiary's home to medical appointments.

[e]International outpatient emergency benefits can include additional services beyond what Medicare FFS covers.

[f]Over-the-counter drug coverage can include nonprescription medicines not covered under Medicare Part D.

[g]Outpatient blood benefits can include units of blood received as an outpatient or as part of a Part B–covered service for the first three units not covered by Medicare FFS.

[h]Hearing benefits can include coverage for hearing tests, hearing aid fittings, and hearing aid evaluations.

[i]Skilled nursing facility benefits can include waiving the 3-day inpatient hospital stay requirement in Medicare FFS.

[j]Inpatient hospital acute benefits can include additional days beyond what Medicare FFS covers.

For the three most-common D-SNP supplemental benefits—vision, prevention, and dental—we analyzed the individual services covered under these benefits and found that D-SNPs' vision and dental benefits were generally more comprehensive than those offered by other MA plans. For example, in their vision benefit, a larger proportion of D-SNPs compared to other MA plans covered contact lenses and eyeglasses. In addition, a larger proportion of D-SNPs compared to other MA plans included in their dental benefit coverage of oral surgery, extractions, and restorative services. However, D-SNPs were less likely than other MA plans to include membership in health clubs as part of their preventive health care benefits.

Despite offering these supplemental benefits somewhat less often than other MA plans, D-SNPs allocated a larger percentage of their rebates to supplemental benefits than other MA plans. (See table 2.) They were able to do so largely because they allocated a smaller percentage of rebates to reducing cost-sharing. Most dual-eligible beneficiaries will have their cost-sharing covered by Medicaid, so D-SNPs have less need than other MA plans to cover cost-sharing. We also found that D-SNPs tended to receive smaller rebates than other MA plans ($70 per member per month on average compared to $108).

Table 2: Percentage of Rebate Allocated to Supplemental Benefits, Reducing Cost Sharing, and Premium Reduction, 2012

Percent		
	D-SNPs	**Other MA**
Supplemental benefits[a]	51	14
Reduce A/B cost share[b]	19	53
Part B premium buy down[c]	1	6
Part D basic premium buy down[d]	19	11
Part D supplemental premium buy down[e]	10	15

Source: GAO analysis of CMS data.

Notes: Data are from CMS's 2012 bid pricing tool. The following types of MA plans are included: health maintenance organizations, local preferred provider organizations, regional preferred provider organizations, private fee-for-service plans, and provider-sponsored organizations. We excluded plans that charged a Part C premium. Numbers may not add up to 100 percent due to rounding.

[a]MA plans may use their rebates to offer supplemental benefits, which are benefits beyond the Medicare FFS package.

[b]MA plans may use their rebates to reduce cost-sharing for Parts A and B.

[c]Beneficiaries in MA plans continue to pay the Part B premium; however, MA plans may use their rebates to reduce beneficiaries' Part B premiums.

[d]MA plans may use their rebates to reduce the premium for the basic Part D drug benefit.

[e]MA plans may use their rebates to reduce supplemental premiums for drug benefits beyond the basic Part D package.

Models of Care Describe How D-SNPs Plan to Provide Specialized Health Care Services, but CMS Lacks Standard Measures Needed for Evaluation

Although the 15 models of care we reviewed described the types of services D-SNPs intended to provide, D-SNPs generally did not state in their models of care how many of their enrolled beneficiaries were expected to receive these services. The criteria D-SNPs are evaluated on in the approval process emphasize the inclusion of in-depth descriptions and case studies rather than details about how many beneficiaries would likely receive these services, for example, the number of beneficiaries that will use additional services targeted to the most vulnerable. CMS does not require D-SNPs to report that information in the models of care, although such information could be useful for future evaluations of whether D-SNPs met their intended goals,[37] as well as for comparisons

[37]CMS officials told us they plan to conduct a review of how 150 SNP models of care have been implemented in 2012. CMS also asks plans to collect information on certain measures related to the model of care as a part of their quality improvement program; however, this information is only required to be made available upon request and is not systematically reported to CMS or the public. CMS officials also told us about several SNP quality initiatives that are in operation or in planning stages; however, these activities were not equivalent to a full evaluation of the SNP program.

among D-SNPs.[38] Three D-SNPs we interviewed told us that a lack of specificity in the model-of-care scoring criteria confused some D-SNPs; having more specific scoring criteria may also eliminate some uncertainty in the approval process.

Knowing the extent of the special services D-SNPs expect to provide would assist future evaluations of whether they met their goals, but most models of care did not include this information. For example, all 15 D-SNPs stated in their models of care that they planned to conduct health risk assessments for beneficiaries within 90 days of enrollment and an annual reassessment, as they are required to do by CMS. However, only 4 provided information on how many members had actually completed a health risk assessment or reassessment in prior years, with cited completion rates for 2010 ranging from 52 to 98 percent. In addition, none of the D-SNPs we reviewed indicated in their models of care how many beneficiaries were expected to receive add-on services such as social support services that were intended for the most-vulnerable beneficiaries. The models of care we reviewed did include, as required in the model-of-care scoring criteria, information about how the D-SNP identifies the most vulnerable beneficiaries in the plan and the add-on services and benefits that would be delivered to these beneficiaries. D-SNPs' models of care described a variety of methods used to identify these beneficiaries: health risk assessments (10 D-SNPs); provider referrals (9); and hospital admissions or discharges (7). However, the models of care generally did not indicate how many or what proportion of beneficiaries were expected to be among the most vulnerable, although one D-SNP's model of care stated that complex-care patients constituted over one-third of its membership. Furthermore, it was sometimes unclear whether the services described as targeted to these beneficiaries were in addition to those available to all dual-eligible beneficiaries in the D-SNP. D-SNPs also described the services that they plan to offer to the most-vulnerable beneficiaries, the most frequent being complex/intensive case management (6 D-SNPs). Other services D-SNPs planned to offer the most-vulnerable beneficiaries included 24-hour hotlines, social support services, and supplemental benefits beyond what was planned to be offered to all dual-eligible beneficiaries in the D-SNP.

[38]Improved collection of information allows an agency to meet its goals for accountability for effective and efficient use of resources, and is consistent with standards for internal control. GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

CMS guidance also requires D-SNPs to describe how they intend to evaluate their performance and measure outcomes in achieving goals identified in their models of care, but CMS does not stipulate the use of standard outcome or performance measures in the model of care, such as measures of patient health status and cognitive functioning. As a result, it would be difficult for CMS to use any data it might collect on these measures to compare D-SNPs' effectiveness or evaluate how well they have done in meeting their goals. Furthermore, without standard measures, it would not be possible for CMS to fully evaluate the relative performance of D-SNP models of care. While it is not required, an evaluation of D-SNPs could both help to improve the D-SNP program and inform other initiatives to better coordinate care for dual-eligible beneficiaries. The models of care we reviewed had little uniformity in the measures plans selected. Four D-SNPs discussed their approach to performance and health outcome measurement largely in general terms, such as describing which datasets they would use or the categories of outcomes that would be measured. The other 11 D-SNPs provided specific measurements, which included measuring items such as readmissions, emergency room utilization, and receipt of follow-up calls after inpatient stays. Were CMS to move to a standard set of performance and outcome measures, it could be less burdensome and no more costly than what some D-SNPs currently collect. Using standard measures could also streamline the models-of-care review process.

D-SNPs Reported More-Comprehensive Care Coordination Services and Greater Beneficiary Interaction Than Other MA Plans

Of the 15 D-SNPs we interviewed, 9 were in organizations that offered both D-SNPs and other MA plans, and representatives from 7 of those D-SNPs told us that their care coordination services are different from those in their organization's other MA plan offerings. For example, a representative from one D-SNP told us that while care coordination and case management were available in both types of plans offered by that organization, dual-eligible beneficiaries in the D-SNP are continuously enrolled in case management, whereas dual-eligible beneficiaries in other MA plans who need these services receive them for only a limited time. A representative from another D-SNP said that the plan provides care coordination services similar to those of other MA plans offered by its organization but that dual-eligible beneficiaries in the D-SNP who need these services are identified faster than are dual-eligible beneficiaries in the other MA plans. A representative of a third D-SNP said it has a community resource unit that is not available in other MA plans offered by its organization, which works with local agencies such as long-term care providers and adult protective services.

Multiple representatives of the 15 D-SNPs we interviewed described their care coordination services as being "high touch"—meaning that the plans, particularly the case managers, have frequent interaction with dual-eligible beneficiaries in the D-SNP. For example, representatives from one D-SNP told us that its plan includes in-person meetings with case managers. Representatives from another D-SNP described several specific examples of care coordination successes, such as when a case manager followed up on a beneficiary's Medicaid reenrollment application to ensure that the beneficiary did not lose eligibility, and another situation in which a case manager worked with the complex social and housing needs of a beneficiary who had both physical and mental health issues. Representatives from a third D-SNP noted that they have providers who conduct home visits to help prevent hospitalization.

Although Some D-SNP Contracts with State Medicaid Agencies Expressly Provide for Benefit Integration or Care Coordination, Most Do Not

CMS stated that contracts between D-SNPs and state Medicaid agencies are an opportunity to increase benefit integration and care coordination.[39] However, only about one-third of the 2012 contracts we reviewed contained any provisions expressly providing for D-SNPs to deliver Medicaid benefits, thereby achieving benefit integration. Only about one-fifth of the contracts expressly provided for active care coordination between D-SNPs and Medicaid agencies, which indicates that most care coordination was done exclusively by D-SNPs, without any involvement of state Medicaid agencies. Further, D-SNP representatives and state Medicaid officials expressed concerns about resources needed to contract with D-SNPs, and uncertainty about the future of D-SNPs.

[39]The contracts were not required to address these goals. However, the contracts must document the Medicaid benefits, if any, to be provided by the D-SNPs. See, 42 C.F.R. § 422.107(c) (2011).

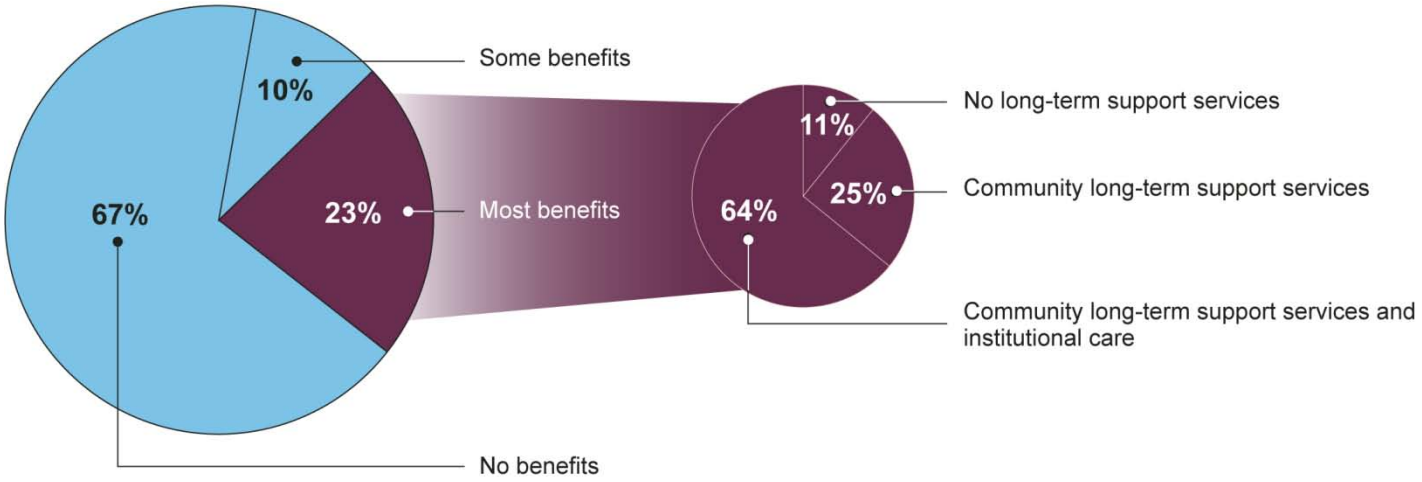
Some Contracts Include Provisions to Address the Integration of Benefits or Meaningful Coordination of Services between D-SNPs and Medicaid Agencies, but Most Do Not

Benefit Integration

The 2012 D-SNP contracts with state Medicaid agencies we reviewed varied considerably in their provisions for integration of benefits and state payments to D-SNPs for covering specific services. According to CMS, "[t]his variability is to be expected, as States and MA organizations can develop agreements for [D-SNPs] to assume responsibility for providing or arranging for a wide range of Medicaid services based on each State's ability and interest in integrating its Medicaid program with Medicare via a SNP."[40] Thirty-three percent of the 124 D-SNP contracts with state Medicaid agencies for 2012 that we reviewed expressly provided for the delivery of at least some portion of Medicaid benefits, thereby integrating Medicare and Medicaid benefits. The contracts varied in the extent of the Medicaid benefits for which a plan was responsible. About 10 percent provided a limited number of Medicaid services, such as dental or vision benefits. In contracts where there was some integration of Medicare and Medicaid benefits, states contracted for the different services, making comparisons among the contracts difficult. Of the 23 percent that integrated most or all Medicaid benefits, 64 percent of D-SNPs provided all Medicaid benefits, including long-term care support services in community settings and institutional care; 25 percent provided most Medicaid benefits, including long-term support services in community settings but not institutional care; and 11 percent provided most Medicaid benefits but did not provide any long-term support services or institutional care. (See fig. 5.)

[40]CMS, *State Resource Center: State Options for Designing Dual SNP Contracts with Medicare Advantage Organizations that Adhere to MIPPA Requirement* (Baltimore, Md.: 2009), 5.

Figure 5: Dual-Eligible Special Needs Plans (D-SNP) Integration of Medicaid Benefits, 2012



Source: GAO analysis of D-SNP/state contracts.

Note: Percentages are based on 124 D-SNP/state Medicaid agency contracts for 2012 that were reviewed by GAO.

Sixty-seven percent of contracts between D-SNPs and state Medicaid agencies did not expressly provide for D-SNPs to cover Medicaid benefits. To carry out MIPPA's requirement that each D-SNP contract provide or arrange for Medicaid benefits to be provided, CMS guidance has required that contracts list the Medicaid benefits that dual-eligible beneficiaries could receive directly from the state Medicaid agency or the state's Medicaid managed care contractor(s).[41]

For D-SNPs contracting with state Medicaid agencies to provide all or some Medicaid benefits, the capitated payment reflected variation in coverage and conditions. One state that contracts for all Medicaid benefits except a limited number of services including long-term care services paid the D-SNP at a rate of $423 per member per month. Another state, which contracted for a limited number of benefits, including Medicare-excluded drugs, expanded dental coverage, and case-management services, paid the D-SNP $132 per member per month. This state's Medicaid agency retained responsibility for inpatient hospital

[41]CMS stated in its state contract training materials for 2013 D-SNP–state Medicaid agency contracting that contracts for 2013 must specify how Medicare and Medicaid benefits are integrated and coordinated.

services and long-term care coverage. Some contracts, rather than stating a single capitation rate, gave payment rates for different categories, including risk or acuity level, beneficiary age, and service location, as well as whether the beneficiary was designated as nursing home eligible and whether services for these beneficiaries were provided in the community or facility setting. Within one state, payment rates ranged from just under $170 per month for dual-eligible beneficiaries who were neither nursing home eligible nor had a chronic mental health condition and were living in the community to over $8,600 per month for dual-eligible beneficiaries residing in a nursing facility and requiring the highest level of care.

Some of the 2012 contracts providing for payments from state Medicaid agencies to D-SNPs did not address the direct provision of benefits, often providing for payments to the D-SNP for assuming the state's responsibility for paying dual-eligible beneficiaries' Medicare copayments, coinsurance, and deductibles. These payments ranged from $10 to $60 per member per month.

Coordination of Services

While all contracts between D-SNPs and state Medicaid agencies for 2012 provided for some level of care coordination to beneficiaries, approximately 19 percent expressly provided for active coordination of beneficiary services between the D-SNP and the state Medicaid agency.[42] Most active coordination occurs when dual-eligible beneficiaries transition between care settings or between Medicare and Medicaid. Thirteen percent of all contracts contained provisions requiring D-SNPs and the state Medicaid agency to coordinate the transition of beneficiaries between care settings (such as hospital to nursing home) within a given time frame. For example, one state's D-SNP contracts directed the plans to notify the Medicaid service coordinators or agency caseworker, as applicable, no later than 5 business days after a dual-eligible beneficiary had been admitted to a nursing facility. The other 6 percent of contracts included provisions for providing different coordination activities such as requiring the plan to work with Medicaid staff to coordinate delivery of wrap-around Medicaid benefits.

[42]For D-SNPs that provided all Medicaid benefits as part of their plan, coordination with the state Medicaid agency was likely not needed as the plan provided all benefits.

The remaining 81 percent of all contracts did not specifically address D-SNPs' coordination with state Medicaid staff, such as case managers. Rather, these contracts indicated that the D-SNP would coordinate Medicaid and Medicare services but did not specify the role of the state Medicaid agency in coordinating those services. Because D-SNPs are required by Medicare to provide care coordination services to dual-eligible beneficiaries, these services are often provided without reimbursement or payment from the state Medicaid agency.

D-SNP and State Officials Expressed Some Concerns about Contracting

Concerns about Resource Investment

D-SNP representatives and state Medicaid officials we spoke with reported that contract development and submission to CMS are resource-intensive. State officials reported that because they had limited resources, they needed to balance the benefits of the contract with the time and resources needed to develop and oversee it. As one state Medicaid official said, the state "bandwidth"—resources—was a challenge, and she was concerned about contracting with the large number of D-SNPs in her state. This official added that the state did not want to be in the position of making contractual commitments that could not be honored because of limited funds or other resources. In contrast, the plan representatives we interviewed expressed interest in continuing to operate D-SNPs and were therefore eager to contract with states despite any challenges that might exist. Beginning in 2013, D-SNPs will not be permitted to operate without state contracts.

Representatives from 12 of the 15 plans and officials from 3 of the 5 state Medicaid agencies we spoke with pointed out that establishing a contract between Medicaid and a Medicare plan highlights conflicts between federal and state requirements. A representative from one D-SNP told us that it was challenging for plans and state Medicaid agencies to agree about the characterization of dual-eligible beneficiaries because Medicare and some states have different definitions. Officials from one state Medicaid agency and D-SNP representatives reported difficulty reconciling the difference between the Medicare contracting cycle, which is based on the calendar year, and the fiscal year contracting cycle for their states. They reported that, if a contract would not cover the entire calendar year, CMS would not approve it. In one case, a state Medicaid official reported that CMS's deadline of July 1, 2012, for 2013 contracts would occur before the state signed contracts for 2013. Sometimes non-

Medicaid structures conflict with CMS's contracting requirements for D-SNPs. A representative of one D-SNP told us that Medicaid benefits for individuals with developmental disabilities were managed through a contract with the state's family services agency, not the state Medicaid agency. Therefore, to provide services to this population, the D-SNP had to become a subcontractor to the family services agency. The official said that the D-SNP and the state need to work with CMS to develop a subcontracting relationship that is acceptable.[43] State Medicaid officials and D-SNP representatives reported that they did not always have the resources or the administrative ability to resolve these types of issues before entering into a contract.

Beginning in 2013, D-SNPs must secure a contract with the state Medicaid agency in each state in their service area. To do this, D-SNPs may need to establish new relationships with state officials who, according to the D-SNP representatives we interviewed, sometimes have very limited knowledge of Medicare and its requirements. However, some states have experience with Medicaid managed care and in some cases, D-SNP representatives had previously worked with the state on Medicaid contracts, thereby somewhat easing the transition to working with D-SNPs.

Uncertainty about D-SNPs and Other Initiatives for Dual-Eligible Beneficiaries

Plan representatives and state Medicaid officials told us that uncertainty about the future made them cautious in contracting. Authority for SNPs to restrict enrollment to special needs populations (such as dual-eligible beneficiaries) currently expires at the end of 2013; SNPs may not continue as a unique type of MA plan if Congress does not extend this authority. Were this to occur, states would lose any advantages they might have gained from investing their resources to work with D-SNPs to integrate benefits and coordinate care. Furthermore, uncertainty regarding the future of D-SNPs creates uncertainty for the states about how to continue to serve dual-eligible beneficiaries currently enrolled in D-SNPs.

Uncertainty about the implementation of state demonstrations under the CMS initiative to align Medicare and Medicaid services—financial alignment initiative—has made some states hesitant to enter into

[43]For 2013, CMS issued guidance specifying criteria under which D-SNPs and states may enter into such subcontracting arrangements.

contracts with D-SNPs. As of June 2012, all proposals had been made available for public comment but CMS had not finalized agreements with the states. Medicaid officials from two states told us that if their proposed financial alignment demonstrations were implemented, D-SNPs in their states would cease to exist.[44] Some states were moving forward with D-SNP contracts while concurrently preparing to shift D-SNPs to a different type of managed care plan if their demonstration proposal is implemented. However, officials from one state told us that they did not have sufficient clarity about the direction of the state Medicaid program in relation to its proposed demonstration to enter into contracts. Even in those states where demonstrations would not eliminate D-SNPs, contracting challenges as well as potential financial incentives associated with the demonstrations from the financial alignment initiatives create disincentives for states to work with D-SNPs outside of the financial alignment initiatives and, therefore, leaves the future of D-SNPs in question in these states as well.

Conclusions

D-SNPs have the potential to help beneficiaries who are eligible for both Medicare and Medicaid navigate these two different systems and receive the health services that meet their individual needs. However, CMS has not required D-SNPs to report information that is critical to better holding plans accountable and determining whether they have realized their potential. Although the models of care D-SNPs must submit to CMS generally state what these plans intend to do, they do not all report the number of services they intend to provide. For example, plans are not required to report the number of enrollees they expect to designate as most vulnerable, or how many and which additional services they will provide to these enrollees. Although D-SNPs are required to collect performance and outcome measures, they are not required to use standard measures such as existing measures of hospital readmission or patient health status and cognitive functioning. Further they are not required to report these measures to CMS, and, lacking standard measures, it would in any case be difficult to compare D-SNPs' effectiveness. Standardizing these measures should have a minimal

[44]As of July 2012, one additional state from our sample had proposed as part of its Financial Alignment Initiative proposals shifting D-SNPs into demonstration plans and, therefore, end D-SNPs in their state. An additional five states not included in our sample propose shifting D-SNPs into demonstration plans or otherwise ending D-SNPs in their states.

effect on D-SNPs' administrative efforts, because additional measures could replace some or all of the measures currently used as well as much of the narrative in models of care. Standardizing measures could also reduce CMS's administrative efforts by streamlining review of D-SNPs. Additional standardized information would allow CMS to meet its goals for accountability for effective and efficient use of resources.

Further, CMS has neither evaluated the sufficiency and appropriateness of the care that D-SNPs provide nor assessed their effectiveness in integrating benefits and coordinating care for dual-eligible beneficiaries. Nonetheless, CMS is embarking on a new demonstration in up to 26 states with as many as 2 million beneficiaries to financially realign Medicare and Medicaid services so as to serve dual-eligible beneficiaries more effectively. If CMS systematically evaluates D-SNP performance, it can use information from the evaluation to inform the implementation and reporting requirements of this major new initiative.

Recommendations for Executive Action

To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should take the following four actions:

- require D-SNPs to state explicitly in their models of care the extent of services they expect to provide, to increase accountability and to facilitate evaluation;
- require D-SNPs to collect and report to CMS standard performance and outcome measures to be outlined in their models of care that are relevant to the population they serve, including measures of beneficiary health risk, beneficiary vulnerability, and plan performance;
- systematically analyze these data and make the results routinely available to the public; and
- conduct an evaluation of the extent to which D-SNPs have provided sufficient and appropriate care to the population they serve, and report the results in a timely manner.

Agency and Other External Comments and Our Evaluation

We obtained comments on a draft of this report from HHS and the SNP Alliance, which represents 32 companies that offer more than 200 SNPs. CMS provided written comments, which are reprinted in appendix I, and technical comments that we incorporated where appropriate. Representatives from the SNP Alliance provided us with oral comments.

HHS Comments

HHS concurred with our recommendation that CMS should require plans to explicitly state in their models of care the extent of services they expect to provide, and agrees that information about the extent to which D-SNPs provide certain services would increase accountability and facilitate evaluation. HHS also stated that CMS recently began to collect information on the completion of health risk assessments, but has not made it public because the information is relatively new. HHS did question the usefulness of quantifying the number of members expected to receive services described in the documents, stating that the model of care is a framework for indicating how the SNP proposes to coordinate the care of SNP enrollees. However, as we noted in the draft report, we believe such information could be useful in later evaluating whether D-SNPs met their intended goals.

HHS also concurred with our recommendation that CMS should require D-SNPs to collect and report standard measures relevant to the populations they serve, and stated that CMS is working to create new measures that will be relevant to dual-eligible beneficiaries in D-SNPs. HHS also stated that CMS currently collects a broad range of standard quality measures, including HEDIS, as well as structure and process measures. HHS included in its response a recent Health Plan System Management memorandum that CMS sent to MA organizations, including D-SNPs, which outlined updated reporting requirements for 2013. HHS also noted that in addition to the data it currently collects, CMS requires D-SNPs to conduct both a Quality Improvement Project and a Chronic Care Improvement Project, and asked GAO to note this in the final report. We did not include these because, as we noted in the draft report, quality and quality measures were not in the scope of our work.

HHS also concurred with our other two recommendations.

SNP Alliance Comments

First, SNP Alliance representatives stated that the benefits D-SNPs provide most frequently are more meaningful to dual-eligible beneficiaries than some of the supplemental benefits provided more frequently by other MA plans. We note in the report that some of the supplemental benefits offered at lower rates by D-SNPs may be covered by Medicaid, thereby reducing the need for them to be covered by D-SNPs. Second, SNP Alliance representatives were concerned with our definition of FIDESNPs. They explained that CMS's definition, which we used, limits FIDESNPs to those that integrate all Medicare and Medicaid benefits without any limits, such as the number of nursing home days covered. They contended that some D-SNPs may be considered fully integrated even though they do not include all benefits, such as nursing home care, and may have some limits. However, in reporting on CMS activities we have no basis for using different definitions than those formally applied by the agency. Third, SNP Alliance representatives stated that the ability of their D-SNP members to fully integrate benefits through contracting is limited by the capacity and interest of state Medicaid agencies. We note in the report that state Medicaid agencies we interviewed acknowledged limitations in their capacity for contracting. Fourth, SNP Alliance representatives had some concern with our emphasis on estimating how many beneficiaries are expected to receive the services described in the model of care, stating that all dual-eligible beneficiaries would have access to the services described based on need. However, as we stated in the draft report, information is not generally available on the number of beneficiaries that use these benefits. Finally, SNP Alliance representatives were supportive of the state demonstrations under the financial alignment initiative. They noted that D-SNPs are being used as a platform for half of the state demonstrations, with the remainder being based on a Medicaid model. They considered the adoption of the D-SNP model by many of the state demonstrations as evidence of D-SNPs' success.

SNP Alliance representatives generally agreed with our recommendations. They said that they support better aligning reporting requirements with the models of care, and stated that D-SNPs need a set of core measures that are most relevant to the dual-eligible population they serve.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of HHS and to interested congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or CosgroveJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

James C. Cosgrove
Director, Health Care

Appendix I: Comments from the Department of Health & Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 27 2012

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICARE SPECIAL NEEDS PLANS: CMS Should Improve Information Available about Dual-Eligible Plans' Performance" (GAO-12-864).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE SPECIAL NEEDS PLANS: CMS SHOULD IMPROVE INFORMATION AVAILABLE ABOUT DUAL ELIGIBLE PLANS' PERFORMANCE" (GAO-12-864)

The Department appreciates the opportunity to review comment on this draft report.

GAO was asked to analyze the characteristics of dual eligible beneficiaries in Special Needs Plans that serve dual eligibles (D-SNPs) and other Medicare Advantage (MA) plans, review the differences in specialized services between D-SNPs and other MA plans, and review how D-SNPs work with state Medicaid agencies to enhance benefit integration and care coordination. GAO found that, in order to increase D-SNP accountability, the Centers for Medicare & Medicaid Services (CMS) should improve D-SNP reporting of services provided to dual eligible beneficiaries and make this information available to the public.

HHS concurs with GAO's recommendations, and the agency is either implementing or currently taking steps toward implementing three of the four recommended actions, as described further below. We respectfully request that the report be revised to include the information summarized below, so as to provide a more complete and accurate picture of CMS's oversight of D-SNPs and the agency's efforts to evaluate the extent to which these plans have provided appropriate care to dual eligibles.

GAO Recommendation

CMS should require D-SNPs to state explicitly in their models of care the extent of services they expect to provide to increase accountability and to facilitate evaluation.

HHS Response

HHS concurs with GAO's recommendation and agrees that information about the extent to which D-SNPs provide certain services would increase accountability and facilitate evaluation. Currently, CMS collects some of the information referenced in the report. For example, the draft report states (on page 21) that, in its review of the models of care (MOCs) of 15 D-SNPs, GAO found that the D-SNPs generally did not state how many of their enrolled beneficiaries were expected to receive certain services. As an example, while all of the 15 D-SNPs stated that they planned to conduct health risk assessments (HRAs) within 90 days of enrollment, and an annual reassessment, the D-SNPs were not required, and thus, in most cases, did not report information on how many of their members had actually completed an HRA or reassessment in prior years. However, CMS requires D-SNPs to report this information separately, via the annual Part C reporting process. As this data collection is relatively new, CMS has not yet made information regarding SNPs' HRA completion rates public, but we have reviewed this data to identify areas of improvement. To that end, CMS has engaged a contractor to develop a standardized HRA tool (HRAT) and is testing the feasibility of using this tool once it has been tested and validated. CMS will also identify approaches for ensuring that D-SNPs have acceptable HRAT completion rates. HHS suggests that the report be revised to include this information, so as to provide a more complete picture of CMS's requirements.

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE SPECIAL NEEDS PLANS: CMS SHOULD IMPROVE INFORMATION AVAILABLE ABOUT DUAL ELIGIBLE PLANS' PERFORMANCE" (GAO-12-864)

In addition, CMS requires that each SNP describe its target population, and characteristics of that population in its MOC. D-SNPs are expected to target plan benefits and services to their specific population of dual eligibles. The report recommends that D-SNPs also be required to quantify the number of members who would receive such services, but it is not clear what purpose that information would serve, as the purpose of the MOC is to provide a framework for appropriately coordinating the care of SNP enrollees. CMS is willing to consider modifications to the MOCs, but would appreciate further clarification from GAO as to what information would be useful (beyond the example described above).

GAO Recommendation

CMS should require D-SNPs to collect and report to CMS standard measures relevant to the population they serve, including measures of beneficiary health risk, beneficiary vulnerability, and plan performance.

HHS Response

HHS concurs with GAO's recommendation. CMS currently requires D-SNPs to report a set of standardized measures and is developing additional standardized measures. CMS collects a broad variety of measures through the Health Plan Employer Data and Information Set (HEDIS®), Health Outcomes Survey (HOS), and Consumer Assessment of Health Plans Survey (CAHPS®) and via CMS contractors or administrative avenues. These measures, including readmission rates and other state-of-the-art outcome measures, are used in evaluating the quality and performance of contracts that include D-SNPs. In evaluating these MA plans, CMS relies on consensus building organizations, such as the National Committee on Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA), to identify and specify the appropriate measures for these and other special populations. Thus, CMS already requires a standard set of measures for reporting. As additional measures become available through these organizations, CMS will implement them as appropriate for these plans. Further, CMS is in the process of determining, as part of Medicare's star rating system, which measures are appropriately collected at the plan level (e.g., for a given SNP) versus at the broader contract level (e.g., across all plans within a contract). These determinations will need to consider the effect of small sample sizes (a particularly critical issue for SNPs), as well as the substantially higher cost for achieving appropriate sample sizes for a large number of SNPs.

We have attached our recent Health Plan Management System (HPMS) memorandum, dated August 3, 2012, which outlines updated requirements for reporting calendar year (CY) 2013 HEDIS®, HOS, and CAHPS® measures. (See Table 2 of the attached memo, which lists required SNP-specific HEDIS measures, including plan all cause readmissions. In addition, public use files containing SNP-specific HEDIS measures, from 2008-2012, are available on the CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/SNP-HEDIS-Public-Use-Files.html.) GAO acknowledges (footnote 19) that D-SNPs are required to submit a subset of the HEDIS measures

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE SPECIAL NEEDS PLANS: CMS SHOULD IMPROVE INFORMATION AVAILABLE ABOUT DUAL ELIGIBLE PLANS' PERFORMANCE" (GAO-12-864)

but, given that the title of the report and its recommendations focus on CMS's publication of a standard set of quality measures for D-SNPs, HHS recommends that the report properly reflect CMS's efforts in these areas.

The report also fails to mention that all Special Needs Plans (SNPs), including D-SNPs, are required to submit both a Quality Improvement Project (QIP) and a Chronic Condition Improvement Project (CCIP), which are unique quality improvement initiatives that must be conducted as part of the plan's Quality Improvement Program Plan in accordance with regulations at 42 CFR §422.152. For CY 2012, we are aligning the requirements of these initiatives with broadly-focused Department of Health and Human Services (HHS) activities. As such, all plans, including D-SNPs, must conduct a 3-year QIP that is focused on reducing all-cause hospital readmissions, in accordance with the Partnership for Patients initiative, an HHS-wide initiative that includes a variety of initiatives focused on improving care and reducing costs. Plans must also conduct a CCIP that is focused on reducing risks for cardiovascular disease, in support of the national "Million Hearts" campaign. Plans are currently submitting their "plan" section of the "Plan, Do, Study, Act" cycle, and CMS staff, with contractor support, will review and score this section of the QIP and provide feedback and technical assistance to plans over the next several months.

In addition to the SNP-specific HEDIS measures described above, D-SNPs are required to report their scores on six specific structure and process measures to NCQA, which then prepares summary reports for CMS. While these reports are not yet publicly available, CMS is willing to discuss these results with GAO, and is considering when and how to make them publicly available. We would also note that CMS continues its efforts to develop standardized outcome measures to assess healthcare quality for all Medicare Advantage Organizations (MAO) products, including SNPs, through a contract with RAND. These outcome measures are expected to be grounded in evidence-based practices and feasible to apply at the plan level. A number of potentially-viable outcomes measures have been identified as a result of a recently-completed pilot study, and RAND is currently preparing for the implementation of a validation study. Once standardized measurements are developed and tested, CMS expects to incorporate the measures within the MA program.

Finally, we also note that HHS engaged the Measure Applications Partnership (MAP), a multi-stakeholder group of public and private-sector organizations and experts convened by the National Quality Forum (NQF) in May 2011. The MAP's latest report, "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population," released in June 2012, recognizes the fragmented and episodic nature of the care the dual eligible population receives and stated that measurement can set expectations and provide powerful incentives for change. (The full text of the report is available at: http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx). The report highlights a recommended starter set of specific measures for immediate use that are sensitive to the unique needs of dual eligible beneficiaries, including measures of patient/caregiver experience, hospital readmissions, care transitions, detecting and treating

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE SPECIAL NEEDS PLANS: CMS SHOULD IMPROVE INFORMATION AVAILABLE ABOUT DUAL ELIGIBLE PLANS' PERFORMANCE" (GAO-12-864)

depression, and screening older adults for fall risk. In addition, the report also highlighted measures that the workgroup felt should be expanded or broadened and provided guidance for further measurement development work as well as measure gaps for dual eligible populations. HHS intends to move forward in assessing the suggestions within the report, including the modification of these measures as appropriate for application at the plan level.

GAO Recommendation

The CMS should systematically analyze these data and make the results routinely available to the public.

HHS Response

HHS concurs with the GAO's recommendation, as CMS currently makes certain D-SNP performance data publicly available. Please refer to HHS's response to GAO's second recommendation above for more information.

GAO Recommendation

CMS should conduct an evaluation of the extent to which D-SNPs have provided sufficient and appropriate care to the population they serve and report the results in a timely manner.

HHS Response

HHS concurs with GAO's recommendation and intends to continue to evaluate the information described above to examine D-SNPs' overall performance. HHS is contemplating a more formal, comprehensive evaluation, but such a review is likely dependent on the program's continued operation, as the SNP authority currently expires at the end of 2013.

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or CosgroveJ@gao.gov

Staff Acknowledgments

In addition to the contact named above, Phyllis Thorburn, Assistant Director; Ramsey Asaly; George Bogart; Melanie Anne Egorin; Linda Galib; Giselle Hicks; Corissa Kiyan; Elizabeth T. Morrison; and Kristal Vardaman made key contributions to this report.

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