September 2012

MEDICARE SPECIAL NEEDS PLANS

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

GAO Highlights

Accountability * Integrity * Reliability

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

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.