United States Government Accountability Office

Report to Congressional Committees

March 2020

MEDICARE AND MEDICAID

Alignment of Managed Care Plans for Dual-Eligible Beneficiaries

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Alignment of Managed Care Plans for Dual-Eligible Beneficiaries

Why GAO Did This Study

Congress authorized the establishment of D-SNPs in 2003 to address the unique needs of dual-eligible beneficiaries. For example, D-SNPs are required to provide certain specialized services targeted at the needs of dual-eligible beneficiaries, such as health risk assessments. D-SNPs must have approval of state Medicaid agencies to operate, and states can require D-SNPs to coordinate with Medicaid.

Congress included a provision in statute for GAO to review D-SNPs' integration with state Medicaid programs. This report, among other objectives, (1) describes what is known about selected states' experiences with aligned enrollment in D-SNPs, and (2) examines CMS's oversight of aligned enrollment.

GAO reviewed relevant federal guidance and internal control standards. GAO also interviewed Medicaid officials in seven selected states and reviewed available documentation. The states (Arizona, Florida, Kansas, New Jersey, Pennsylvania, Tennessee, and Virginia) were selected, in part, for variation in experiences with aligned enrollment. GAO also interviewed officials from CMS, beneficiary groups, and companies that offered D-SNPs and Medicaid MCOs.

What GAO Recommends

GAO recommends that CMS take steps to obtain quality information on the experiences of dual-eligible beneficiaries who have been default enrolled into D-SNPs. The Department of Health and Human Services concurred with the recommendation.

View GAO-20-319. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Dual-eligible beneficiaries are Medicare beneficiaries who are also enrolled in the Medicaid program in their state. In certain states, they may receive both types of benefits through private managed care plans. As of January 2019, about 386,000 such individuals were enrolled in both a private Medicare plan known as a dual-eligible special needs plan (D-SNP) and a Medicaid managed care organization (MCO) that were offered by the same or related companies. This arrangement, known as aligned enrollment, may create opportunities for better coordination between Medicare's acute care services and Medicaid's long-term services and supports, such as nursing facility care or personal care services.

Example of Aligned Enrollment through Managed Care for a Dual-Eligible Beneficiary
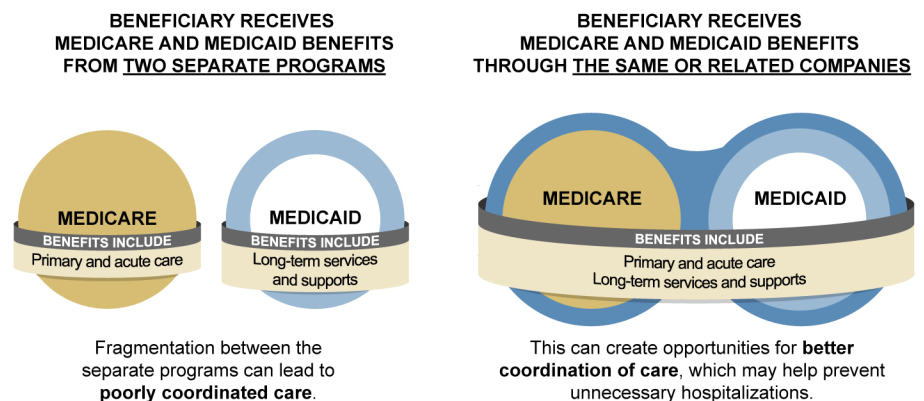
Source: GAO review of federal guidance and literature on aligned enrollment. | GAO-20-319

Medicaid officials in seven selected states described challenges with aligned enrollment. One challenge cited by officials in six of the states was using D-SNP and Medicare data to implement and evaluate aligned enrollment. For example, officials in one state said they cannot separate D-SNP quality data for just their state, because some D-SNPs report data spanning multiple states to the Centers for Medicare & Medicaid Services (CMS). As of December 2019, CMS officials said they are determining the best way for D-SNPs to report these quality data.

CMS has assisted states with aligned enrollment, but lacks quality information on the experiences of dual-eligible beneficiaries who have aligned enrollment through a process known as default enrollment. With default enrollment, states allow automatic assignment of beneficiaries who are enrolled in a Medicaid MCO and are about to become eligible for Medicare to the D-SNP aligned with that MCO. However, CMS's monthly reports on default enrollment do not include information on beneficiaries who choose to disenroll in the first 90 days after being default enrolled, a time frame specified in regulation. According to one beneficiary group, some beneficiaries may disenroll, because they did not realize they were default enrolled and their provider is not in the D-SNP's network. Quality information on the experiences of dual-eligible beneficiaries after default enrollment would allow CMS to better identify the extent to which beneficiaries face challenges and to determine how, if at all, to address the challenges.

_____ **United States Government Accountability Office**

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In 2017, about 12 million of Medicare's over 61 million beneficiaries were also enrolled in Medicaid.[1] These individuals, known as dual-eligible beneficiaries, are often in poorer health and require more care than other Medicare and Medicaid beneficiaries. As such, in 2019, the Centers for Medicare & Medicaid Services (CMS), which administers Medicare and oversees Medicaid, established better care for dual-eligible beneficiaries as one of its 16 strategic initiatives.[2] Dual-eligible beneficiaries can face challenges in dealing with the separate Medicare and Medicaid programs, which have different or overlapping sets of benefits, provider networks,

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[1]Medicare is the federal health insurance program for seniors, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state program and covers medical and health-related services for certain low-income and medically needy individuals, such as children and individuals who are disabled or elderly.

[2]Centers for Medicare & Medicaid Services, *Better Care for Dual Eligibles* (Dec. 6, 2019). At the federal level, CMS, which is part of the Department of Health and Human Services, is responsible for overseeing the design and operation of states' Medicaid programs. States are responsible for the day-to-day operations of their respective Medicaid programs.

and payment policies. For example, the Medicare program is generally responsible for covering dual-eligible beneficiaries' primary and acute care, including hospitalizations and physician services, while state Medicaid programs are generally responsible for covering their long-term services and supports, such as nursing facility care or personal care services. The fragmentation between these separate programs can lead to poorly coordinated care for dual-eligible beneficiaries.

In certain states, dual-eligible beneficiaries may receive Medicare benefits, Medicaid benefits, or both types of benefits through private managed care plans. Like other Medicare beneficiaries, dual-eligible beneficiaries can choose to enroll in Medicare Advantage (MA) plans, which are the private plan alternative to traditional Medicare and generally must cover all traditional Medicare benefits. In particular, as of January 2019, about 2.2 million dual-eligible beneficiaries in 42 states and the District of Columbia had chosen to enroll in dual-eligible special needs plans (D-SNP), which are a type of MA plan. Congress first authorized the establishment of D-SNPs in 2003 to address the unique needs of dual-eligible beneficiaries. D-SNPs are required to provide certain specialized services targeted at the needs of dual-eligible beneficiaries, such as performing health risk assessments and creating individualized care plans. Since January 2013, federal law has required all D-SNPs to have a contract with each state in which it wants to operate.[3] In addition, some states require or allow Medicaid beneficiaries, including dual-eligible beneficiaries, to receive their Medicaid benefits through a Medicaid managed care organization (MCO).

The Bipartisan Budget Act of 2018 directed CMS to assist states that are interested in using D-SNPs as a platform for integration with state Medicaid programs, among other things.[4] Some states have pursued such integration through the use of an arrangement known as aligned enrollment. Aligned enrollment occurs when a dual-eligible beneficiary is enrolled in a D-SNP and Medicaid MCO that are offered by the same or related companies.[5] Some studies suggest that aligned enrollment may

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[3]42 U.S.C. § 1395w-28(f)(3)(D).

[4]Pub. L. No. 115-123, § 50311, 132 Stat. 64, 192. We previously reviewed how D-SNPs work with state Medicaid agencies to enhance benefit integration and care coordination. See GAO, *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance,* GAO-12-864 (Washington, D.C.: Sept. 13, 2012).

[5]See 42 C.F.R. § 422.2 (2019).

create opportunities for the company or companies to better coordinate care and integrate benefits, which may help prevent unnecessary hospitalizations and institutionalizations.[6]

The Bipartisan Budget Act of 2018 includes a provision for us to review the integration between D-SNPs and state Medicaid programs.[7] This report

1. describes what is known about the extent to which states have encouraged aligned enrollment of dual-eligible beneficiaries in D-SNPs,

2. describes what is known about selected states' experiences with aligned enrollment, and

3. examines CMS's role in and oversight of states' use of aligned enrollment.

To describe what is known about the extent to which states have encouraged aligned enrollment of dual-eligible beneficiaries in D-SNPs, we reviewed published materials from the Integrated Care Resource Center (a CMS initiative to provide technical assistance, which is operated by contractors) and others. To corroborate this information, we interviewed officials from CMS, the Integrated Care Resource Center, and Medicaid agencies in seven selected states. We selected the seven states (Arizona, Florida, Kansas, New Jersey, Pennsylvania, Tennessee, and Virginia) based on the variation in their experiences with aligned enrollment in D-SNPs, the number of D-SNP enrollees, and their length of time using a managed care delivery system to provide long-term services and supports in Medicaid, also referred to as managed long-term services

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[6]For example, a study in Minnesota compared dual-eligible beneficiaries with aligned enrollment to dual-eligible beneficiaries in a Medicaid MCO and either traditional Medicare or an MA plan. The researchers found the dual-eligible beneficiaries with aligned enrollment received more primary care and less care in hospital settings from 2010 through 2012. However, they could not assess whether more frequent primary care use directly led to lower hospital-based care. Another study compared dual-eligible beneficiaries with aligned enrollment to dual-eligible beneficiaries covered by traditional Medicare and Medicaid in Massachusetts, and it found fewer entries into nursing facilities between 2007 and 2012. See Wayne L. Anderson, Zhanlian Feng, and Sharon K. Long, *Minnesota Managed Care Longitudinal Data Analysis* (Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Mar. 31, 2016); and JEN Associates, Inc., *Massachusetts SCO Evaluation Nursing Facility Residency and Mortality Summary Report* (Cambridge, Mass.: Nov. 23, 2015).

[7]Pub. L. No. 115-123, § 50311(e), 132 Stat. 64, 199.

and supports (MLTSS). We limited our scope to states with MLTSS, in part, because about 80 percent of Medicaid spending on relevant dual-eligible beneficiaries was for long-term services and supports in 2013, the most recent year such data were available.[8] We reviewed the selected states' contracts with D-SNPs and other available documentation to corroborate evidence gathered in these interviews. We also received data on aligned enrollment from five of the seven selected states. We assessed the reliability of the state-reported data by checking for internal consistency and comparing the state-reported data to published information, and we determined the data were sufficiently reliable for the purposes of this report.

To describe what is known about selected states' experiences with aligned enrollment, we interviewed Medicaid officials in each of the seven selected states and CMS officials. In addition, we reviewed available documentation to corroborate officials' statements. To supplement this information, we interviewed seven beneficiary groups, which included nonprofit organizations, State Health Insurance Assistance Programs in two of our seven selected states, and the long-term care ombudsman in one selected state.[9] We also interviewed three companies that offered D-SNPs and Medicaid MCOs, and these companies varied in their number of D-SNP enrollees and number of selected states served. The perspectives of the Medicaid officials and other groups interviewed in the seven selected states are not generalizable, but provided us with valuable insight on states' experiences with aligned enrollment.

To examine CMS's role in and oversight of states' use of aligned enrollment, we reviewed CMS's policies and procedures on D-SNPs and aligned enrollment and assessed them against federal internal control standards related to information and communication.[10] We also

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[8]Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 14, 2019), 427.

[9]Each state has a State Health Insurance Assistance Program, which is a state agency or contractor that provides insurance counseling and assistance to Medicare beneficiaries, their families, and caregivers. In addition, each state has a long-term care ombudsman program that provides assistance for residents of nursing homes, assisted living facilities, and other types of facilities by working to resolve problems raised by residents or their families. A state's long-term care ombudsman program assists Medicaid beneficiaries and individuals not covered by Medicaid.

[10]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

interviewed CMS officials, Medicaid officials in each selected state, beneficiary groups, and companies that offered D-SNPs and Medicaid MCOs, as previously discussed.

We conducted this performance audit from February 2019 to March 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare and Medicaid Coverage for Dual-Eligible Beneficiaries

Dual-eligible beneficiaries qualify for both Medicare and Medicaid, and may enroll in and receive benefits covered by each program. Individuals ages 65 or older can qualify for Medicare based on age, and individuals ages 18 to 64 can qualify for Medicare based on disability.[11] Medicaid eligibility varies by state, but beneficiaries may qualify based on having a low level of income, a need for nursing home care, high medical expenses, or other criteria.

For dual-eligible beneficiaries, Medicare is the primary payer for any benefits covered by both programs. As a result, Medicare is the primary payer for acute and post-acute care, such as physician services, hospitalizations, prescription drugs, and skilled nursing facility care. For many dual-eligible beneficiaries, Medicaid covers benefits not covered by Medicare. This includes long-term services and supports, which may include nursing home care, personal care services, or adult day care. Whether Medicaid covers these benefits varies between the two main categories of dual-eligible beneficiaries. Those in the first category are known as full-benefit, dual-eligible beneficiaries, because they may receive all Medicaid benefits, in addition to Medicare benefits.[12] Medicaid also pays for their Medicare premiums and, in some cases, the cost-sharing for their Medicare benefits. Those in the second category are known as partial-benefit, dual-eligible beneficiaries, because Medicaid assistance is limited to payment of their Medicare premiums and, in some

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[11]Individuals of any age with end-stage renal disease can also qualify for Medicare.

[12]For the remainder of the report, we are referring to full-benefit, dual-eligible beneficiaries when discussing dual-eligible beneficiaries unless otherwise specified.

cases, the cost-sharing for their Medicare benefits. Partial-benefit, dual-eligible beneficiaries have limited income and assets, but their income and assets are not low enough to qualify them for full Medicaid benefits in their state.

For Medicare, dual-eligible beneficiaries can choose to receive their Medicare services from either traditional Medicare or from MA plans.[13] These options differ in key ways. For example, traditional Medicare may have a more extensive provider network than MA plans. However, MA plans may cover additional benefits, such as vision or dental care, which are generally not covered under traditional Medicare. If dual-eligible beneficiaries choose to enroll in MA plans, they may also have the choice between regular MA plans and D-SNPs, which offer certain services targeted at the needs of dual-eligible beneficiaries. For example, D-SNPs are required to perform health risk assessments, create individualized care plans, and provide an interdisciplinary care team for each beneficiary enrolled. They may also cover transportation services, home modifications, or other specialized services that are more likely to be used by dual-eligible beneficiaries.

For Medicaid, states may allow or require Medicaid beneficiaries, including dual-eligible beneficiaries, to receive their Medicaid benefits through an MCO. In this managed care model, Medicaid MCOs are responsible for arranging for and paying providers' claims for a specific set of Medicaid benefits provided to beneficiaries.[14] More recently, some states have created new Medicaid managed care programs or expanded the benefits covered by existing Medicaid managed care programs in order to include additional populations previously covered through Medicaid fee-for-service. The new populations include seniors, persons with disabilities, and those who need long-term services and supports—many of whom may be dually eligible.

Aligned Enrollment in D-SNPs in States with MLTSS

A dual-eligible beneficiary may be able to enroll in a D-SNP and Medicaid MCO that are offered by the same or related companies, an arrangement

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[13]CMS pays MA plans a fixed monthly amount per beneficiary based on (1) the plan's estimated cost for providing the same benefits as traditional Medicare; and (2) CMS's benchmark, which is the maximum amount it will pay MA plans in a given locality.

[14]States pay Medicaid MCOs a fixed periodic payment per beneficiary.

known as aligned enrollment.[15] In states with MLTSS, aligned enrollment means the same or related companies provide a beneficiary's Medicare benefits, such as primary and acute care, through a D-SNP and Medicaid benefits, such as long-term services and supports, through a Medicaid MCO.[16]

State Medicaid agencies enter into contracts with both D-SNPs and Medicaid MCOs, and these contracts may include provisions to facilitate and encourage aligned enrollment. Since January 2013, all D-SNPs have been required to have an executed contract with the Medicaid agency in each state in which it operates.[17] A state can enter into contracts with all, some, or none of the D-SNPs seeking to operate in the state, and any D-SNPs that the state declines to contract with cannot operate in the state. Each year, CMS reviews D-SNPs' contracts with states to ensure that they include eight required elements, including the D-SNP's responsibility for providing or arranging the provision of Medicaid benefits, among other things.[18] According to CMS officials, in these reviews, CMS does not collect information regarding whether states are imposing requirements pertaining to aligned enrollment. States also have contracts with Medicaid

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[15]Aligned enrollment can occur under three scenarios: (1) the same company offers the D-SNP and Medicaid MCO, (2) the companies that offer the D-SNP and Medicaid MCO have the same parent company, and (3) the Medicaid MCO is owned or controlled by the D-SNP's parent company. See 42 C.F.R. § 422.2 (2019). For the purposes of this report, we refer to the companies in the second and third scenarios as "related companies."

[16]For purposes of this report, we specifically reviewed aligned enrollment between D-SNPs and Medicaid MCOs that cover long-term services and supports. However, the definition of aligned enrollment in federal regulation does not require the Medicaid MCO to cover long-term services and supports. See 42 C.F.R. § 422.2 (2019). According to CMS officials, aligned enrollment can include Medicaid MCOs that are responsible for covering benefits like behavioral health, home health, or durable medical equipment. Both Medicare and Medicaid cover these benefits, but eligibility requirements and scope of coverage differ between the two programs. Therefore, aligned enrollment between the D-SNP and Medicaid MCO can improve the coordination of these benefits for dual-eligible beneficiaries.

[17]42 U.S.C. § 1395w-28(f)(3)(D).

[18]These eight elements are specified in regulation. They are (1) the D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits; (2) the categories of eligibility for dual-eligible beneficiaries to be enrolled in the D-SNP; (3) the Medicaid benefits covered under the D-SNP; (4) the cost-sharing protections covered under the D-SNP; (5) the identification and sharing of information about Medicaid provider participation; (6) the verification process of beneficiaries' eligibility for both Medicare and Medicaid; (7) the service area covered by the D-SNP; and (8) the contract period for the D-SNP. See 42 C.F.R. § 422.107(c) (2019).

MCOs, which can include requirements that could facilitate or encourage aligned enrollment.

As shown in table 1, CMS's Integrated Care Resource Center has identified five types of approaches that states can use to encourage aligned enrollment.[19] For example, states can manage which D-SNPs operate in the state, such as only allowing D-SNPs with an aligned Medicaid MCO (that is, a MCO offered by the same company or a related company). This gives dual-eligible beneficiaries greater options for choosing aligned enrollment. As another example, states can allow the automatic assignment of certain dual-eligible beneficiaries to a D-SNP aligned with a Medicaid MCO, a process known as default enrollment. Default enrollment, which requires CMS approval, can directly increase the number of dual-eligible beneficiaries with aligned enrollment.

Table 1: Approaches States Can Use to Encourage Aligned Enrollment

Approach	Description of how a state can implement the approach
Managing which dual-eligible special needs plans (D-SNP) operate in the state	For example, the state contracts only with certain D-SNPs, such as contracting only with D-SNPs that have an aligned Medicaid managed care organization (MCO)—that is, a Medicaid MCO offered by the same or a related company. As another example, the state requires some or all Medicaid MCOs to offer an aligned D-SNP.
	As a result, some or all D-SNPs operating in the state would also have an aligned Medicaid MCO, giving dual-eligible beneficiaries greater options for choosing aligned enrollment.
Limiting D-SNP enrollment to full-benefit, dual-eligible beneficiaries	The state uses its contracts with some or all D-SNPs in the state to limit enrollment to full-benefit, dual-eligible beneficiaries who may receive all Medicaid benefits in addition to Medicare benefits. This would exclude partial-benefit, dual-eligible beneficiaries whose Medicaid assistance is limited to payment of their Medicare premiums and, in some cases, the cost-sharing for their Medicare benefits.
	As a result, the state can deliver a unified Medicare-Medicaid benefit package, because the benefit package does not need to accommodate the differences in Medicaid benefits received by partial- and full-benefit, dual-eligible beneficiaries. A unified Medicare-Medicaid benefit package can be more easily described in D-SNP marketing materials and communications, according to the Integrated Care Resource Center.[a] This may help a beneficiary make a more informed decision around aligned enrollment.

[19]Erin Weir Lakhmani and Alexandra Kruse, *Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment* (Integrated Care Resource Center, Apr. 2018).

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Approach	Description of how a state can implement the approach
Automatically assigning certain beneficiaries to plans with aligned enrollment, including default enrollment	The state allows automatic assignment of full-benefit, dual-eligible beneficiaries to an aligned D-SNP (which is known as default enrollment); the state assigns full-benefit, dual-eligible beneficiaries to an aligned Medicaid MCO; or both. • **Assignment to aligned D-SNPs (default enrollment).** The state allows automatic assignment of beneficiaries who are enrolled in a Medicaid MCO and are about to become eligible for Medicare to a D-SNP aligned with that MCO. With default enrollment, beneficiaries have the ability to opt out of the D-SNP prior to being enrolled or to disenroll within the first 90 days after enrollment. CMS approves D-SNPs' eligibility to receive beneficiaries through the default enrollment process, and CMS processes the enrollment transactions of beneficiaries being default enrolled. • **Assignment to aligned Medicaid MCOs.** The state automatically assigns dual-eligible beneficiaries to the Medicaid MCO aligned with their existing D-SNP, subject to the beneficiaries' ability to opt out or choose a different Medicaid MCO. For example, this can occur with beneficiaries who are already in a D-SNP and about to become eligible for Medicaid long-term services and supports. Either form of automatic assignment can directly increase the number of dual-eligible beneficiaries with aligned enrollment.
Encouraging D-SNP marketing to better support informed beneficiary decision-making	For example, the state, through its contracts with D-SNPs, requires or encourages a D-SNP to target its marketing and outreach to beneficiaries in its aligned Medicaid MCO. As another example, the state reviews D-SNP marketing materials and develops standard marketing messages to make sure the marketing accurately characterizes D-SNPs and services provided. This may minimize beneficiaries' confusion by informing them about aligned enrollment options and the benefits of aligned enrollment.
Enabling counselors to assist beneficiaries with aligned enrollment decisions	The state trains counselors in its State Health Insurance Assistance Program (a state agency or contractor that provides insurance counseling to Medicare beneficiaries) on how to assist dual-eligible beneficiaries with considerations related to aligned enrollment and with enrollment into aligned plans. As a result, the counselors may be better equipped to reduce beneficiaries' confusion and help them make informed decisions about whether to enroll in aligned plans.

Source: GAO analysis of Integrated Care Resource Center information. | GAO-20-319

Notes: We considered aligned enrollment to occur when a dual-eligible beneficiary—a beneficiary who qualifies for Medicare and Medicaid—is enrolled in a D-SNP and Medicaid MCO that are offered by the same or related companies, and the MCO covers long-term services and supports.

[a]The Integrated Care Resource Center is a CMS initiative to provide technical assistance and is operated by contractors.

Coordinated Care for Dual-Eligible Beneficiaries Inside and Outside of D-SNPs

In addition to D-SNPs with aligned enrollment, two other types of Medicare plans—Medicare-Medicaid plans and Program of All-Inclusive Care for the Elderly plans—exclusively or primarily serve dual-eligible beneficiaries and are responsible for both Medicare and Medicaid benefits. These three types of Medicare plans jointly served approximately 818,000 dual-eligible beneficiaries as of January 2019.

- **Aligned enrollment in D-SNPs:** As of January 2019, approximately 386,000 dual-eligible beneficiaries enrolled in D-SNPs had aligned enrollment, according to a report by the Medicare Payment Advisory

Commission.[20] This includes beneficiaries in a subset of D-SNPs that have been designated as fully integrated D-SNPs, which must meet additional specific requirements. For example, they must provide both Medicare and Medicaid benefits through a single managed care plan. In addition, the Medicaid benefits provided by the fully integrated D-SNPs must include long-term services and supports.[21]

- **Medicare-Medicaid plans:** As of January 2019, approximately 388,000 dual-eligible beneficiaries in nine states were enrolled in these types of plans. These plans, which were established through CMS's Financial Alignment Initiative, provide all Medicare benefits and all or almost all Medicaid benefits, and have some administrative processes that have been combined.[22] In April 2019, CMS sent a letter to state Medicaid directors inviting additional states to express interest in the use of Medicare-Medicaid plans.[23]

- **Program of All-Inclusive Care for the Elderly plans:** As of January 2019, approximately 44,000 beneficiaries in 31 states were enrolled in these types of plans. Most, but not all, are full-benefit, dual-eligible beneficiaries, and they are ages 55 or older and need the level of care provided in a nursing home. The plans are provider-sponsored and provide all Medicare and Medicaid benefits. In addition, each plan is required to have a physical site to provide adult day services.

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[20]Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 14, 2019), 436. The report did not indicate the number of states in which this aligned enrollment occurred. This is about 18 percent of the 2.2 million full- and partial-benefit, dual-eligible beneficiaries enrolled in D-SNPs as of January 2019.

[21]Starting in 2021, "highly integrated D-SNPs" will be a new designation for D-SNPs that provide long-term services and supports, behavioral health services, or both, consistent with state policy—including when provided through an aligned Medicaid MCO. Also starting in 2021, D-SNPs that do not qualify for the fully integrated D-SNP or highly integrated D-SNP designations will face new requirements for notifying state Medicaid agencies about hospital and skilled nursing facility admissions for certain dual-eligible beneficiaries.

[22]In a previous report on the Financial Alignment Initiative, we made two recommendations designed to help CMS strengthen its oversight of the provision of care coordination services for dual-eligible beneficiaries enrolled in the initiative; CMS took action to address these recommendations. See GAO, *Medicare and Medicaid: Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries*, GAO-16-31 (Washington, D.C.: Dec. 18, 2015).

[23]Centers for Medicare & Medicaid Services, State Medicaid Director Letter #19-002, *Re: Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare* (Baltimore, Md.: Apr. 24, 2019).
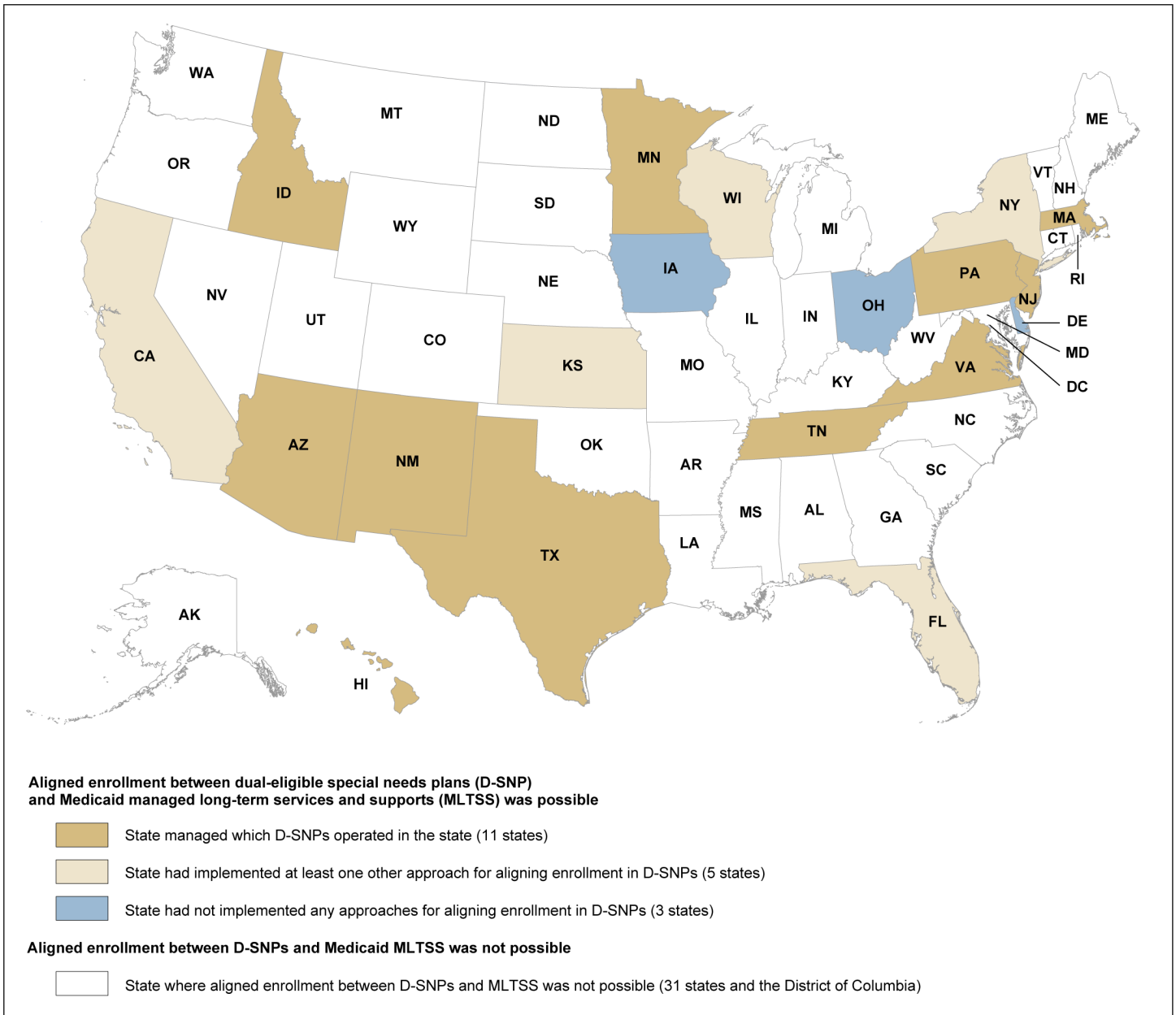
Most States that Can Encourage Aligned Enrollment Have Begun to Do So

As of July 2019, of the 19 states with MLTSS and where aligned enrollment of dual-eligible beneficiaries in D-SNPs is possible, 16 have implemented at least one of the five approaches to encourage aligned enrollment identified by CMS's Integrated Care Resource Center.[24] (See fig. 1.) Of those 16 states, 11 managed which D-SNPs operate in the state, which is the foundation for promoting aligned enrollment, according to officials from the Integrated Care Resource Center.

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[24]According to the Medicaid and CHIP Payment and Access Commission, 24 states had MLTSS programs as of June 2019. (See Medicaid and CHIP Payment and Access Commission, *Managed Long-Term Services and Supports*, accessed December 17, 2019, https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/). We determined that aligned enrollment in D-SNPs is not possible in five of the 24 states with MLTSS. As of July 2019, one state did not have D-SNPs, two states administered MLTSS programs via quasi-governmental entities, and two states did not have MLTSS programs separate from the Financial Alignment Initiative.

Figure 1: States' Use of Approaches to Encourage Aligned Enrollment in D-SNPs for Dual-Eligible Beneficiaries, July 2019

**Aligned enrollment between dual-eligible special needs plans (D-SNP)
and Medicaid managed long-term services and supports (MLTSS) was possible**

State managed which D-SNPs operated in the state (11 states)

State had implemented at least one other approach for aligning enrollment in D-SNPs (5 states)

State had not implemented any approaches for aligning enrollment in D-SNPs (3 states)

Aligned enrollment between D-SNPs and Medicaid MLTSS was not possible

State where aligned enrollment between D-SNPs and MLTSS was not possible (31 states and the District of Columbia)

Source: GAO analysis of published materials from the Integrated Care Resource Center and others; Map Resources (Map). | GAO-20-319

Note: We considered aligned enrollment to occur when a dual-eligible beneficiary—a beneficiary who qualifies for Medicare and Medicaid—is enrolled in a D-SNP and Medicaid managed care organization (MCO) that are offered by the same or related companies, and the MCO covers long-term services and supports. This map reflects the status of states' implementation of approaches to encourage aligned enrollment as of July 2019. Medicaid officials in some states told us they plan to

start or end the use of some approaches in 2020. Dual-eligible beneficiaries who are enrolled in Medicare-Medicaid plans or in Program of All-Inclusive Care for the Elderly plans in other states have a form of integrated care that is similar to, but different from, aligned enrollment in D-SNPs. In particular, as of July 2019, dual-eligible beneficiaries in nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas) are enrolled in Medicare-Medicaid plans.

The "State where aligned enrollment between D-SNPs and MLTSS was not possible" category includes five states with MLTSS. Of those, one state did not have D-SNPs, two states administered MLTSS programs via quasi-governmental entities, and two states did not have MLTSS programs separate from the Financial Alignment Initiative. The other 26 states and the District of Columbia did not have MLTSS.

Of our seven selected states, all of them had implemented at least one of the five approaches to encourage aligned enrollment in 2019. The three most common approaches among our selected states were (1) managing which D-SNPs operate in the state; (2) limiting D-SNP enrollment to full-benefit, dual-eligible beneficiaries; and (3) encouraging D-SNP marketing to better support informed beneficiary decision-making. The details of the approaches implemented in each state varied widely.

Managing which D-SNPs operate in the state. Five of the seven selected states (Arizona, New Jersey, Pennsylvania, Tennessee, and Virginia) managed which D-SNPs operated in 2019, but they varied in how they implemented this approach. For example, when Virginia established its Medicaid MLTSS program in 2017, only one D-SNP operated in the state, and Virginia required the companies with Medicaid MLTSS contracts to also start offering D-SNPs within 3 years. In contrast, when Pennsylvania and Tennessee implemented this approach, multiple D-SNPs already operated in each state. Pennsylvania and Tennessee required new D-SNPs to have aligned Medicaid MCOs, but allowed existing D-SNPs to continue operating. As a result, beneficiaries had the choice between D-SNPs that had aligned Medicaid MCOs and D-SNPs that did not have aligned Medicaid MCOs. Medicaid officials in these two states told us they chose not to cancel existing D-SNPs that did not have aligned Medicaid MCOs, as doing so could have disrupted beneficiary-provider relationships.

As a result of the selected states' differing approaches to managing which D-SNPs operated, the proportion of aligned to unaligned D-SNPs in each state varied. (See fig. 2.)

Figure 2: Extent of Aligned D-SNPs in Selected States, 2019

State	D-SNP with aligned Medicaid MCO	D-SNP without aligned Medicaid MCO	Total
Arizona	●●●●●●		6
New Jersey	●●●●		4
Pennsylvania	●●●	○○○○○○○	10
Tennessee	●●●	○○○	6
Virginia	●●●●●		5
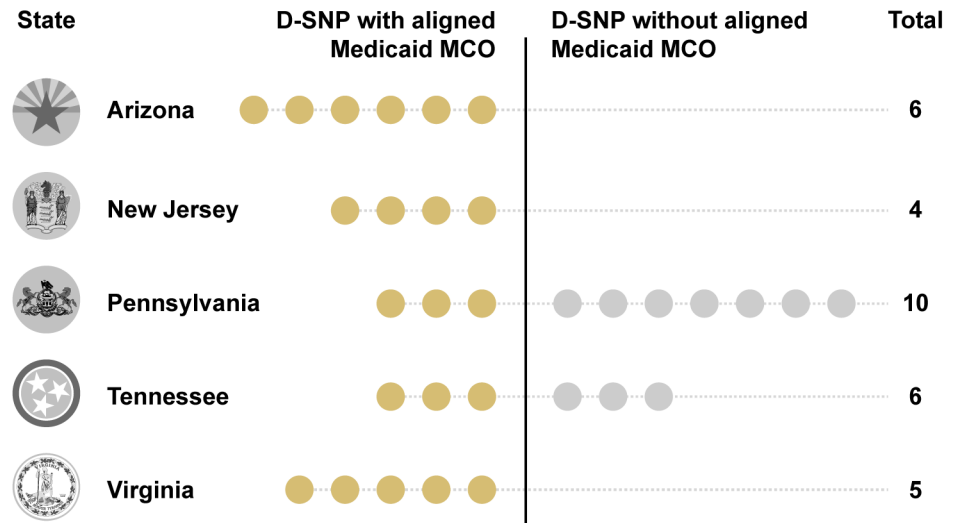
Source: GAO analysis of state-reported information. | GAO-20-319

Note: We considered aligned enrollment to occur when a dual-eligible beneficiary—a beneficiary who qualifies for Medicare and Medicaid—is enrolled in dual-eligible special needs plan (D-SNP) and Medicaid managed care organization (MCO) that are offered by the same or related companies, and the MCO covers long-term services and supports. However, depending on the state, not all dual-eligible beneficiaries in aligned D-SNPs have aligned enrollment.

The states shown managed which D-SNPs operated, generally contracting only with D-SNPs with aligned Medicaid MCOs. Pennsylvania and Tennessee required new D-SNPs to have aligned Medicaid MCOs, but allowed existing D-SNPs to continue operating.

Limiting D-SNP enrollment to full-benefit, dual-eligible beneficiaries. Five of the selected states (Arizona, Kansas, New Jersey, Pennsylvania, and Virginia) limited D-SNP enrollment in some or all of their D-SNPs to full-benefit, dual-eligible beneficiaries in 2019.[25] In particular, Arizona and New Jersey Medicaid officials said that limiting D-SNP enrollment to full-benefit, dual-eligible beneficiaries allowed D-SNPs to provide a more straightforward benefit package. In turn, this can be more easily described in D-SNP materials and communications, which may help

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[25]Kansas had three D-SNPs, and the state limited enrollment in two D-SNPs to full-benefit, dual-eligible beneficiaries in 2019, according to Kansas Medicaid officials. The other D-SNP could enroll partial-benefit, dual-eligible beneficiaries. Kansas Medicaid officials also told us that all D-SNPs in the state will be able to enroll partial-benefit, dual-eligible beneficiaries in 2020. Pennsylvania had 10 D-SNPs, and the state limited enrollment in the state's three aligned D-SNPs to full-benefit, dual-eligible beneficiaries in 2019. The state's other seven non-aligned D-SNPs could enroll partial-benefit, dual-eligible beneficiaries.

beneficiaries to make more informed decisions around aligned enrollment.

Encouraging D-SNP marketing to better support informed beneficiary decision-making. Five of the selected states (Arizona, New Jersey, Pennsylvania, Tennessee, and Virginia) took steps to encourage D-SNP marketing to support informed beneficiary decision-making in 2019. For example, Arizona and Pennsylvania encouraged D-SNPs to directly market themselves to beneficiaries in the D-SNP's aligned Medicaid MCO, in order to promote aligned enrollment. In addition, New Jersey Medicaid officials told us they review D-SNP marketing and work directly with D-SNPs to develop standard marketing language. In particular, the officials said some D-SNPs had marketed themselves as offering certain extra benefits, but those benefits were already a standard part of the state's Medicaid package. The officials said they worked with the D-SNPs to correct the marketing, and they also developed standard language for marketing in the state. This can help reduce beneficiary confusion when making enrollment decisions.

Automatically assigning certain beneficiaries to plans with aligned enrollment. Four selected states (Arizona, Florida, Pennsylvania, and Tennessee) allowed automatic assignment of certain beneficiaries to plans with aligned enrollment in 2019. For example, Arizona, Pennsylvania, and Tennessee allowed default enrollment by which certain Medicaid beneficiaries were automatically assigned to aligned D-SNPs.[26] Under federal rules, beneficiaries have the opportunity to opt out prior to being default enrolled and select a different source of Medicare coverage; they also have the opportunity to disenroll within the first 90 days after default enrollment and select a different source of Medicare coverage.

In addition, Florida and Pennsylvania automatically assigned certain dual-eligible beneficiaries to aligned Medicaid MCOs. For example, Florida law requires the state Medicaid agency to automatically assign certain D-SNP enrollees to aligned MLTSS plans when beneficiaries become eligible for

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[26]Virginia Medicaid officials told us the state will allow D-SNPs that receive CMS approval to start using default enrollment in 2020. In addition, CMS officials told us other states are considering using default enrollment in the future.

long-term services and supports and have not voluntarily chosen an MLTSS plan.[27]

Engaging counselors to assist beneficiaries with aligned enrollment decisions. Two of the seven selected states (Arizona and Pennsylvania) engaged enrollment counselors to encourage aligned enrollment in 2019. For example, Arizona's state Medicaid office works with the state's Aging and Disability Resource Center and State Health Insurance Assistance Program counselors to increase beneficiary understanding of aligned enrollment and options to enroll in aligned plans. In 2019, Pennsylvania's contracts with D-SNPs required collaboration between the D-SNPs and the state's independent enrollment broker that assists beneficiaries with Medicaid enrollment.[28]

In addition to there being variation in the selected states' use of approaches to encourage aligned enrollment, the proportion of D-SNP enrollees with aligned enrollment varied from 20 percent in Pennsylvania to 100 percent in New Jersey among the selected states that were able to provide data for 2019. (See fig. 3.) There can be multiple reasons for the varied levels of aligned enrollment between D-SNPs and MLTSS. For example, Arizona recently entered into new Medicaid MCO contracts, and this resulted in changes to the parts of the state served by each Medicaid MCO. According to state Medicaid officials, these new contracts somewhat reduced the extent of aligned enrollment.
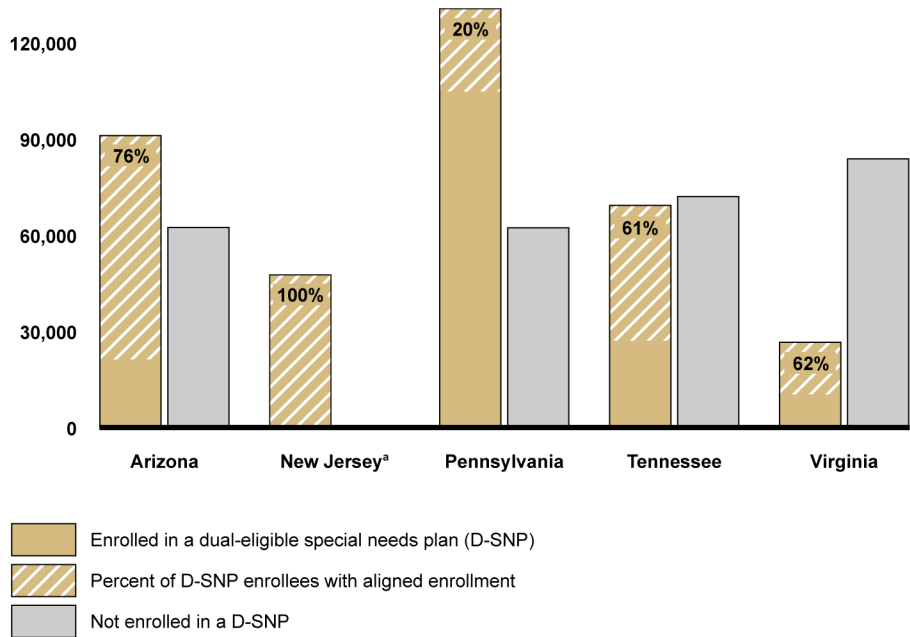
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[27]Fla. Stat. Ann. § 409.984 (2019).

[28]According to Pennsylvania Medicaid officials, the state relied on its State Health Insurance Assistance Program to educate beneficiaries about Medicare coverage. The state's contract also required the independent enrollment broker to be familiar with the State Health Insurance Assistance Program and provide the program's contact information when appropriate.

Figure 3: Dual-Eligible Beneficiaries in Medicaid Managed Care in Selected States, by Enrollment, 2019

Full-benefit, dual-eligible beneficiaries

Legend:
- Enrolled in a dual-eligible special needs plan (D-SNP)
- Percent of D-SNP enrollees with aligned enrollment
- Not enrolled in a D-SNP

Source: GAO analysis of state-reported data. | GAO-20-319

Note: We considered aligned enrollment to occur when a dual-eligible beneficiary—a beneficiary who qualifies for Medicare and Medicaid—is enrolled in a D-SNP and Medicaid managed care organization (MCO) that are offered by the same or related companies, and the MCO covers long-term services and supports. For Arizona, the figure also includes the number of dual-eligible beneficiaries with aligned enrollment between D-SNPs and Medicaid MCOs that cover certain behavioral health services, in addition to Medicaid MCOs that cover long-term services and supports.

Pennsylvania and Virginia data are from July 2019, Tennessee and New Jersey data are from August 2019, and Arizona data are from September 2019. Kansas and Florida could not provide data.

[a]New Jersey limits enrollment in D-SNPs to beneficiaries who choose aligned Medicaid MCOs, but could not provide data on the number of dual-eligible beneficiaries not enrolled in D-SNPs.

Medicaid Officials in Selected States Described Challenges with Aligned Enrollment

Medicaid officials in the seven selected states described various challenges with aligned enrollment. The most common challenge mentioned was difficulty using D-SNP data to implement and evaluate aligned enrollment policies. Medicaid officials in the selected states told us many of these challenges require ongoing monitoring and collaboration with CMS and the companies offering D-SNPs.

Difficulty using data to implement and evaluate aligned enrollment. Medicaid officials in six of the selected states (Florida, Kansas, New

Jersey, Pennsylvania, Tennessee, and Virginia) told us that using D-SNP and Medicare data to implement and evaluate aligned enrollment policies can be difficult. For example, Tennessee Medicaid officials told us that getting the data from CMS needed for default enrollment was a challenge. In particular, they said that, when the state was first starting to implement default enrollment, they had challenges with getting data from CMS in a timely fashion to identify which Medicaid beneficiaries were about to become dually eligible for Medicare, particularly those with eligibility due to disability.[29] This meant that the state could not provide D-SNPs with the information needed by the D-SNPs to send notices to those beneficiaries in the required time frame.[30] CMS officials also acknowledged that its data do not always identify individuals becoming eligible for Medicare early enough for D-SNPs to send notices in the required time frame. Tennessee Medicaid officials told us that CMS has worked with the state on this issue and it has now become easier for the state to receive the needed data. Furthermore, CMS and its Integrated Care Resource Center have also developed materials and, according to CMS officials, provided ongoing technical assistance for states on accessing data for default enrollment and other aspects of implementation of aligned enrollment.[31]

Medicaid officials in Virginia and New Jersey described related challenges with using D-SNP data to determine whether their policies work. Virginia Medicaid officials told us that it can be difficult to evaluate the health benefits of aligned enrollment, because data on quality

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[29]States must provide the information necessary for D-SNPs to identify individuals who are in their initial coverage election period and, therefore, may be default enrolled into the plan. See 42 C.F.R. § 422.66(c)(2)(i)(B) (2019).

[30]D-SNPs must send notices to individuals qualifying for default enrollment at least 60 days prior to enrollment. The notice is required to include information on the beneficiary's ability to opt out of the D-SNP, among other information. See 42 C.F.R. § 422.66(c)(2)(iv) (2019).

[31]For example, see CMS, *Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment* (July 2018); Integrated Care Resource Center, *CMS Files that Provide Data to States on Upcoming Medicare Eligibility* (Integrated Care Resource Center, July 2018); and Danielle Chelminsky, *How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources* (Integrated Care Resource Center, Nov. 2018).

measures can span multiple states.[32] Specifically, one of the state's D-SNPs operates in multiple states and therefore reports health outcome data to CMS for its entire service area.[33] Virginia Medicaid officials told us they are not able to separate data for Virginia residents from those of other states. As a result, they said they currently cannot determine the effect of their aligned enrollment policies, and they plan to require the D-SNP to report Virginia-specific quality data in the future. New Jersey Medicaid officials described a challenge with receiving the relevant data to evaluate health outcomes for dual-eligible beneficiaries with aligned enrollment. The state has CMS approval to receive Medicare data directly from CMS. However, as of November 2019, the state's data vendor was not in compliance with federal Medicare data security requirements for storing certain data, which meant that the state could not accept the Medicare data.

The Bipartisan Budget Act of 2018 encourages CMS to require reporting of MA quality measures, including D-SNP quality measures, at the plan level.[34] However, CMS has identified several challenges to developing such a requirement. One challenge CMS has identified is that about two-thirds to three-quarters of D-SNPs would not have reliable ratings, for

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[32]The data on quality measures come from two data sets. The first data set is the Healthcare Effectiveness Data and Information Set, which measures plan performance on clinical processes and intermediate clinical outcomes. For example, it measures the percentage of beneficiaries who have discussed the risk of falling with their health care provider and who have received certain cancer screenings, among other things. The second data set is the Consumer Assessment of Healthcare Providers and Systems. The surveys provide information on respondents' personal experiences interacting with their health plan and health care providers.

[33]All MA organizations, including D-SNPs, have contracts with CMS, and a single contract can pertain to more than one MA plan. For example, a single contract between an MA organization and CMS can pertain to both special needs plans and non-special needs plans, or a single contract can pertain to plans in multiple states. CMS generally requires a MA organization to report quality data for each contract and not for the separate plans, if any, under each contract. The Healthcare Effectiveness Data and Information Set includes certain measures that are collected at the plan level for D-SNPs and other special needs plans only, and these plan-level data are publicly available. These measures include advanced care planning, functional status assessment, medication review, and pain assessment, and they are aggregated to the contract level with weighting based on the enrollment of each special needs plan.

[34]Pub. L. No. 115-123, § 50311(d), 132 Stat. 64, 198 (codified as amended at 42 U.S.C. §§ 1395w-23(o)(6), (7)).

example, because those plans had too few participants in the survey.[35] Another challenge CMS has identified is the additional complexity and administrative burden for plans completing this reporting. As of December 2019, CMS officials told us they are continuing to work to determine the best reporting level for each quality measure. They also plan to collect additional feedback from stakeholders and a technical expert panel.

Difficulties with information dual-eligible beneficiaries receive about Medicare enrollment choices. Medicaid officials in five of the selected states (Kansas, New Jersey, Pennsylvania, Tennessee, and Virginia) told us they have experienced challenges in ensuring that beneficiaries receive quality information about their Medicare enrollment choices. For example, in 2019, Pennsylvania's contracts with D-SNPs required collaboration between the D-SNPs and the state's independent enrollment broker that assists beneficiaries with Medicaid enrollment. However, Pennsylvania Medicaid officials told us the state's independent enrollment broker did not have the capacity to provide this type of assistance in addition to its primary responsibility of assisting beneficiaries with Medicaid enrollment.

As another example, Virginia Medicaid officials told us they have faced challenges using state D-SNP contracts to regulate D-SNP marketing. They told us that certain provisions in the state's contracts with D-SNPs were intended to regulate the extent of D-SNP marketing in 2019. In particular, each D-SNP was supposed to only market to beneficiaries enrolled in that D-SNP's aligned Medicaid MCO, which was intended to increase the extent of aligned enrollment in the state. However, state Medicaid officials told us that D-SNPs had different interpretations of the contract provisions, and one D-SNP had billboards and television advertisements available to the general public. Due to the difficulty of enforcement, among other reasons, Virginia Medicaid officials told us they chose to not include these provisions in the D-SNP contracts for 2020.

Through the Integrated Care Resource Center, CMS has developed materials describing how states can regulate D-SNP marketing in their contracts with D-SNPs, and the agency reviews and may disapprove D-

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[35]For example, there must be at least 11 respondents, among other criteria, for reliable scoring of measures from the Consumer Assessment of Healthcare Providers and Systems. According to CMS's analyses, which it summarized in the preamble to the final rule for 2019, this threshold meant that measures could not be reported at the plan level for two-thirds of D-SNPs. 83 Fed. Reg. 16,440, 16,526 (April 16, 2018).

SNP marketing materials that do not follow federal requirements. CMS officials also told us they make themselves available to states to explain how to include marketing restrictions in the contracts that states have with D-SNPs.

Limits of staff knowledge. Medicaid officials in four of the selected states (Florida, Kansas, New Jersey, and Pennsylvania) told us that limited staff knowledge of Medicare presents a challenge. For example, Medicaid officials in Kansas told us only one or two staff in the state's Medicaid agency are knowledgeable about Medicare and would have the knowledge to implement aligned enrollment approaches. Similarly, Medicaid officials in Florida said they only recently learned about one of the approaches for encouraging aligned enrollment, which is that the state can decline to contract with certain D-SNPs. In addition, New Jersey and Pennsylvania Medicaid officials told us staff knowledge of Medicare is limited and that they would like to increase their level of knowledge as they continue to foster aligned enrollment.

Competition from look-alike MA plans targeted to dual-eligible beneficiaries. Medicaid officials in four of our selected states (Arizona, Pennsylvania, Tennessee, and Virginia) identified certain MA plans that are so-called "look-alike" plans to the D-SNPs, which create a potential challenge to fostering aligned enrollment.[36] According to CMS, look-alike plans are MA plans that are designed for and marketed exclusively to dual-eligible beneficiaries, but that are not D-SNPs. Therefore, look-alike plans do not need a contract with the state to operate and do not have to comply with state approaches that foster aligned enrollment.

Medicaid officials from our selected states and the Medicare Payment Advisory Commission gave examples of the impact of look-alike plans. For example, Tennessee Medicaid officials told us that dual-eligible beneficiaries in look-alike plans do not receive care coordination between Medicare and Medicaid, in contrast with dual-eligible beneficiaries in D-SNPs, which are required to provide such coordination. In addition, Arizona Medicaid officials told us that look-alike plans have affected

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[36]There is no single definition of what constitutes a look-alike plan. The Medicare Payment Advisory Commission has defined a look-alike plan as a traditional MA plan that had drug coverage and that had dual-eligible beneficiaries as the majority of its enrollees. It found that the number of plans meeting this definition grew from 44 in 2017 to 95 in 2019. Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 14, 2019), 441-443.

levels of aligned enrollment in the state. Similarly, according to the Medicare Payment Advisory Commission, look-alike plans can undermine states' efforts to develop D-SNPs that integrate Medicare and Medicaid by encouraging dual-eligible beneficiaries to instead enroll in look-alike plans.[37]

CMS has also identified look-alike plans as a challenge and is considering some steps in response. In 2018, CMS revised its marketing guidelines to prohibit look-alike plans from marketing themselves as designed for dual-eligible beneficiaries and as having a relationship with the state Medicaid agency. In its April 2019 policy update for MA plans, CMS said that look-alike plans enable companies to offer plans that circumvent state and federal requirements for D-SNPs, which undermines efforts to improve the quality of care.[38] In February 2020, CMS published a proposed rule that, if finalized, would prohibit the offering of MA plans whose enrollment of dual-eligible beneficiaries exceeds specific projected or actual enrollment thresholds in states with a D-SNP. According to CMS, this would prevent look-alikes from undermining the statutory and regulatory framework for D-SNPs.[39]

Extent of overlapping provider networks. Medicaid officials in two of our selected states (Pennsylvania and Tennessee) reported challenges with aligned D-SNPs and Medicaid MCOs that do not have completely overlapping networks of relevant providers.[40] That is, even though the D-SNP and Medicaid MCO are offered by the same or related companies, certain providers may be in only the D-SNP network or only the Medicaid MCO network—but not both. For example, representatives from a beneficiary group in Pennsylvania told us that a dual-eligible beneficiary's provider may be in the Medicaid MCO network, but not the D-SNP network. This can disrupt that beneficiary's continuity of care if he or she is default enrolled into the D-SNP. There are no requirements for the

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[37]Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 14, 2019), 441.

[38]Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* (Apr. 1, 2019).

[39]In the preamble to the proposed rule, CMS proposed a threshold of 80 percent and sought comment on other enrollment thresholds. See 85 Fed. Reg. 9,002, 9,021-23 (proposed Feb. 18, 2020).

[40]A third state (New Jersey) told us they have received a few complaints about this issue, but that it is not a common issue.

state or D-SNP to ensure that a beneficiary's primary care provider is in the D-SNP into which he or she is default enrolled. CMS's model for the notice sent to beneficiaries identified for default enrollment suggests (but does not require) that the D-SNP include information on whether or not the beneficiary's primary care provider is in the D-SNP's network.

CMS officials said they did not know of any complaints the agency has received on the issue. They also said they have not analyzed how the provider network of a D-SNP compares to the provider network of its aligned Medicaid MCO. Furthermore, in the preamble to the default enrollment final rule issued in April 2018, CMS said that it did not include any criteria related to provider networks, but that network adequacy requirements would apply and states can use their contracts with D-SNPs to create requirements for continuity of care. One state that does this is Tennessee, which specifically requires D-SNPs to develop provider networks that have substantial overlap with the provider network of their aligned Medicaid MCOs. The state also requires D-SNPs to ensure continuity of care for beneficiaries who have been default enrolled. For example, Tennessee Medicaid officials said that if a beneficiary who has been default enrolled has a long-standing primary care provider with the D-SNP's aligned Medicaid MCO, the state requires the D-SNP to continue covering services by that provider for at least 30 days and to attempt to contract with the provider.

CMS Has Assisted States with Aligned Enrollment, but Lacks Quality Information on the Experience of Beneficiaries Whose Aligned Enrollment Was Due to Default Enrollment

CMS has assisted states with aligned enrollment. In particular, CMS has provided technical assistance to states on implementing the various approaches that encourage aligned enrollment. One way that CMS has done this is through its Integrated Care Resource Center, which has developed materials on how states can use their contracts with D-SNPs to align enrollment and promote integration.[41] The Integrated Care Resource Center has also facilitated peer-to-peer assistance between states. For example, Integrated Care Resource Center officials said they facilitated conversations and assistance between state Medicaid officials in New Jersey and Pennsylvania on D-SNP marketing. Medicaid officials in six of our selected states said they had utilized CMS's technical assistance, and they had overall positive views of CMS's assistance.

CMS reviews some aspects of the contracts between states and D-SNPs, including checking that the contracts include the eight required elements.

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[41]For example, see James Verdier, et al., *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options* (Integrated Care Resource Center, November 2016).

According to CMS officials, in these reviews, CMS does not collect information regarding whether states are imposing requirements pertaining to aligned enrollment. CMS's program audits of MA plans similarly do not include reviews of such state requirements pertaining to aligned enrollment.[42]

CMS has a direct role with one aspect of aligned enrollment: default enrollment. In particular, CMS approves D-SNPs to receive beneficiaries through default enrollment, and it processes the enrollment transactions of beneficiaries being default enrolled.

- **D-SNPs' approval for default enrollment:** Before a D-SNP can receive beneficiaries through default enrollment, it must submit a proposal to CMS for approval. CMS reviews the D-SNP's proposal and checks that the D-SNP meets an established list of requirements outlined in regulation. Among other requirements, the D-SNP must demonstrate it has the state's support for default enrollment and that the required elements have been included in its template for the notice that is sent to beneficiaries identified for default enrollment. CMS also checks that the D-SNP is not facing any CMS enrollment sanctions and that the D-SNP has a quality rating of three or more stars.[43] CMS grants approval for up to 5 years if it determines the D-SNP meets these requirements.

- **Default enrollment transactions:** CMS processes the enrollment transactions of dual-eligible beneficiaries being default enrolled, and it tracks these transactions in a monthly report. The monthly report lists the total number of beneficiaries identified for default enrollment for each applicable D-SNP, and the report lists numbers for certain subsets of beneficiaries who were ultimately not default enrolled. These subsets include beneficiaries who opted out prior to being default enrolled and beneficiaries whose default enrollment was not allowed by CMS for various reasons.

Despite its direct role in default enrollment, CMS lacks quality information on the experiences of dual-eligible beneficiaries after they are default enrolled. This is inconsistent with federal internal control standards on information and communication, which state that management should use

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[42]According to CMS officials, the agency does not collect information related to aligned enrollment in its oversight of state Medicaid managed care programs.

[43]CMS has a 5-star quality rating system—with 5 stars indicating the highest quality—for MA plans as a tool to help beneficiaries make enrollment decisions.

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quality information to achieve the agency's objectives.[44] In particular, the monthly reports on enrollment transactions do not include data on the extent to which dual-eligible beneficiaries choose to disenroll after being default enrolled. Although the reports include data on the number of beneficiaries who opt out prior to being default enrolled (which CMS officials said was low), they do not include data on beneficiaries who choose to disenroll in the first 90 days after being default enrolled.[45] This 90-day time frame for disenrollment is specified by federal regulation, and beneficiaries may choose to disenroll for various reasons.[46] For example, one reason for disenrollment given by one beneficiary group we interviewed is that some beneficiaries may not realize they have been default enrolled into a D-SNP until they next see their provider, and that provider may not be in the D-SNP's provider network. They said that beneficiaries may not have seen the notice or other information about being default enrolled, or they may not have understood the information. In addition, CMS cannot systematically review beneficiary complaints for trends or concerns related to default enrollment. Dual-eligible beneficiaries, like other Medicare beneficiaries, can submit complaints to CMS. These complaints are entered in the agency's complaint tracking module, and D-SNP account managers, like other MA plan account managers, are responsible for monitoring complaints.[47] CMS officials said that the D-SNP account managers have not identified any trends or concerns about default enrollment. However, CMS officials said default enrollment is not tracked as a distinct category in the complaint tracking module, and the guidance on monitoring complaints that is provided to the D-SNP account managers does not direct them to look for issues explicitly related to default enrollment. Quality information on the experiences of dual-eligible beneficiaries after they are default enrolled would allow CMS to better identify the extent to which these beneficiaries

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[44]See GAO-14-704G.

[45]According to CMS officials, approximately 6,300 beneficiaries were identified for default enrollment from January 1 through August 1, 2019, and approximately 300 of those beneficiaries opted out prior to being default enrolled through September 30, 2019. These numbers include data on default enrollment for D-SNPs in six states and Puerto Rico.

[46]Two selected states (Arizona and Tennessee) require D-SNPs to report the number of beneficiaries who disenroll during the first 90 days after being default enrolled.

[47]Account managers are the CMS officials responsible for overseeing the contracts between the MA organization and CMS. A single contract can contain more than one MA plan or D-SNP.

face challenges as a result of default enrollment and to determine how, if at all, to address the challenges.

Future studies may provide CMS with additional information on beneficiaries in D-SNPs with aligned enrollment, but that information will not be available until 2022 or later. In particular, federal law directs the Medicare Payment Advisory Commission, in consultation with the Medicaid and CHIP Payment and Access Commission, to compare the quality of the different types of D-SNPs, including those with aligned enrollment, as well as comparing them to other types of plans.[48] The commission is to develop an initial report by 2022 with subsequent reports afterward.

Conclusions

Better care for dual-eligible beneficiaries is one of CMS's strategic initiatives, and the agency has supported states' decisions to encourage aligned enrollment in order to encourage better coordination of care. However, CMS lacks quality information on the experiences of beneficiaries who have aligned enrollment as the result of the use of default enrollment. For example, CMS's monthly reports on default enrollment do not include data on beneficiaries who choose to disenroll after being default enrolled. CMS lacks this information even though selected states and others have reported challenges that could affect the care received by those beneficiaries. Quality information on the experiences of these dual-eligible beneficiaries would allow CMS to better identify the extent to which beneficiaries are facing challenges as a result of default enrollment and to determine how, if at all, to address those challenges.

Recommendation for Executive Action

We are making the following recommendation to CMS:

The Administrator of CMS should take steps to obtain quality information on the experiences of dual-eligible beneficiaries who have been default enrolled into D-SNPs, such as by obtaining information about the extent to which and reasons that beneficiaries disenroll from a D-SNP after being default enrolled. (Recommendation 1)

Agency Comments

We provided a draft of this report to the Department of Health and Human Services (HHS) for comment. In its comments, reproduced in appendix I, HHS concurred with our recommendation. HHS stated that it is committed to increasing the number of dual-eligible beneficiaries in integrated care

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[48]42 U.S.C. § 1395w-28(f)(8)(E).

and that it supports states with these efforts, such as the use of aligned enrollment. HHS also said that it has not identified any trends or areas of concern in its monitoring of beneficiaries who opted out prior to being default enrolled. In response to our recommendation, HHS stated it will evaluate opportunities to obtain more information on dual-eligible beneficiaries who disenroll from a D-SNP after being default enrolled. HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is 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 key contributions to this report are listed in appendix II.

James Cosgrove
Director, Health Care

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

FEB 1 9 2020

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 AND MEDICAID: Alignment of Managed Care Plans for Dual-Eligible Beneficiaries*" (GAO-20-319).

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

Sincerely,

Sarah Arbes
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — "MEDICARE AND MEDICAID: ALIGNMENT OF MANAGED CARE PLANS FOR DUAL-ELIGIBLE BENEFICIARIES" (GAO-20-319)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. Improving quality, reducing costs, and improving the customer experience for people eligible for both Medicare and Medicaid is one of HHS's strategic initiatives aimed at improving the nation's health and quality of life.

Beneficiaries who are dually eligible for both Medicare and Medicaid can face significant challenges in navigating the two programs, which include separate or overlapping benefits and administrative processes. Fragmentation between the two programs can result in poor outcomes, such as avoidable hospitalizations and suboptimal beneficiary experiences.

HHS is addressing such fragmentation through policies and programs that integrate care for dually eligible individuals. For example, new Medicare Advantage rules require Dual Eligible Special Needs Plans (D-SNPs) to more seamlessly integrate benefits across the two programs to promote coordination, and, for certain integrated D-SNPs, unify the appeals processes across Medicare and Medicaid to make it easier for enrollees in these plans to navigate their coverage.

Additionally, HHS is committed to increasing the number of dually eligible beneficiaries in integrated care. Through HHS's Integrated Care Resource Center, HHS provides technical assistance to help states align enrollment and promote integration. As GAO noted, the Integrated Care Resource Center has specifically identified five types of approaches that states can use to encourage aligned enrollment. For example, one identified approach is to maximize integration through auto-assignment, also known as default enrollment. To ensure that this process is working as it is intended, HHS monitors the number of beneficiaries who were default enrolled that opt out of their plan before their effective date. HHS has not identified any trends or areas of concerns.

Recommendation 1
The Administrator of CMS should take steps to obtain quality information on the experiences of dual-eligible beneficiaries who have been default enrolled into D-SNPs, such as by obtaining information about the extent to which and reasons that beneficiaries disenroll from a D-SNP after being default enrolled.

HHS Response
HHS concurs with GAO's recommendation. HHS will evaluate opportunities to obtain more information on dually eligible beneficiaries who disenroll from a D-SNP after default enrollment.

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact	James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov
Staff Acknowledgments	In addition to the contact named above, Martin T. Gahart (Assistant Director), Corissa Kiyan-Fukumoto (Analyst-in-Charge), Jason Coates, Kelly Krinn, Virginia Lefever, Drew Long, Jennifer Rudisill, and Ethiene Salgado-Rodriguez made key contributions to this report.

Related GAO Products

Medicare and Medicaid: Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries. GAO-16-31. Washington, D.C.: December 18, 2015.

Disabled Dual-Eligible Beneficiaries: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings. GAO-14-523. Washington, D.C.: August 29, 2014.

Medicare and Medicaid: Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems, and States. GAO-13-100. Washington, D.C.: December 5, 2012.

Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance. GAO-12-864. Washington, D.C.: September 13, 2012.

Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging. GAO/HEHS-00-94. Washington, D.C.: August 18, 2000.