OPPORTUNITIES IN DUAL ELIGIBLE SPECIAL NEEDS PLANS (D-SNPS)

Alison Pool, ASA, MAAA
727.259.7469 • alisonp@wakely.com

Brittney Phillips, ASA, MAAA
720.282.4966 • brittneyp@wakely.com

Dual-eligible, Special Needs Medicare Advantage plans (D-SNPs) have been a popular, growing trend in the Medicare Advantage (MA) marketplace over the past several years. Generally, D-SNPs are MA plans that are geared to meet the unique needs of beneficiaries that are dually eligible for both Medicare and Medicaid. Since 2018, the number of D-SNP plans has increased 52% and enrollment in D-SNP plans has grown at an average annual rate of 15.8%.[1] This brief begins a series intended provide insight into some of the key differences between D-SNP and general enrollment plans and to answer the following questions:

What is driving the interest in D-SNPs?

Are Medicare Advantage Organizations (MAOs) able to use D-SNPs as part of a revenue optimization strategy?

Is it advantageous to consider D-SNPS as part of a long-term strategy for future years?

The concept of covering dually eligible individuals has been replicated through D-SNP look-a-like plans: plans that are officially general enrollment plans but target dually eligible members. Under the final rule (42 CFR 422.514), the Centers for Medicare & Medicaid Services (CMS) will no longer enter into a contract with a non-SNP plan that projects 80% or more of its enrollment will be entitled to Medicaid. This rule started for new plans in 2022 and for renewing non-SNP plans in 2023. MA plans that have been active for less than one year and have enrollment of 200 or fewer individuals at the time of such determination are exempt from the rule[2,3]. Further, the limitation to D-SNP look-a-likes only applies in states where there is a D-SNP or any other plan authorized by CMS to exclusively enroll dually eligible individuals, such as Medicare-Medicaid Plans (MMPs). As of 2020, D-SNPs operated in 42 states, the District of Columbia, and Puerto Rico.[4] The discontinuation of D-SNP look-a-like plans in the majority of states may further increase MAOs' interest in offering a true D-SNP.

[1] https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataspecial-needs/snp-comprehensive-report-2021-01

[2] https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf

[3] We note the requirement that a general enrollment plan must enroll at least 300 members by its third year to continue to be renewed by CMS remains and is not impacted by the D-SNP requirements or exceptions. Such general enrollment plans would not be exempt from the 300 member minimum requirement.

[4] https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf

Types of Duals

Eligibility for a D-SNP is defined at both the federal level (Medicare) and state level (Medicaid). Specifics of eligibility vary by state. Medicaid statuses are identified in the Monthly Membership Report (MMR) from CMS and encompass the following categories.

- Qualified Medicare Beneficiary without other Medicaid (QMB Only) – Medicaid Status 01 in MMR;
    - Income:<100% Federal Poverty Line (FPL)
    - Resources<= 3 times Supplemental Security Income (SSI)
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing
- QMB with Full Medicaid (QMB Plus) – Medicaid Status 02 in MMR;
    - Income:<=100% FPL
    - Resources: Determined by State
    - Full Medicaid Coverage
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing
- Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB Only) – Medicaid Status 03 in MMR;
    - Income:>100% FPL but <120% FPL
    - Resources <= 3 times SSI
    - Medicaid pays for Part B premiums
- SLMB Plus – Medicaid Status 04 in MMR;
    - Income>100% FPL but <120% FPL
    - Resources: Determined by State
    - Medicaid pays for Part B premiums
    - Medicaid pays cost sharing
- Qualified Disabled and Working Individual (QDWI) – Medicaid Status 05 in MMR;
    - Income: <200% FPL
    - Resources: <=2 times SSI
    - Part A benefits lost due to return to work but is eligible to enroll and purchase Part A coverage
    - Medicaid pays for Part A premium (if any)

- Qualifying Individual (QI) – Medicaid Status 06 in MMR;
    - Income: >= 120% FPL but <135% FPL
    - Resources: <= 2 times SSI
    - Medicaid pays for Part B premiums
- Qualifying Individuals (2) (QI-2s) – Medicaid Status 07 in MMR;
    - Effective 1/1/1998 – 12/31/2002 only (included for a complete list of Medicaid Statuses)
- Full Medicaid (only) – Medicaid Status 08 in MMR
    - Determined by State
    - Medicaid may pay Part A (if any) and Part B premiums, and Medicare cost sharing

A D-SNP plan may be offered to all or to a subset of the Medicaid categories. It is not unusual for MAOs to offer plans to 'Full Duals' – typically Medicaid statuses 02, 04, and 08 - or 'Partial Duals' – typically Medicaid statuses 01, 03, 05, and 06. This segregation of the Medicaid statuses is consistent with the distinct cost profiles reported in the 'Evaluation of the CMS-HCC Risk Adjustment Model'[5] and adopted for payment year 2017[6] and beyond.

Predictive ratios for Community Population, 2014 Model[6]

FFS population	1.000
Non-dual	1.015
Full benefit duals	0.914
Partial benefit duals	1.092
Source: RTI International analysis of 2010-2011 Medicare 100% data	

Note that the predictive ratios from the table above are the ratio of predicted cost to actual cost for the applicable subgroup. In other words, the table indicates that Full benefit duals, or Full duals, tend to have higher actual costs than costs predicted from a risk adjustment model that combined all dual types and non-duals (a predictive ratio < 1.000), and Partial benefit duals, or Partial duals, tend to have lower actual costs than those predicted (a predictive ratio > 1.000).

The new payment model implemented for payment year 2017 represents six community subgroups with distinct cost profiles[7], meaning that the risk score model is adjusted to more accurately reflect the difference in each subgroup or population. For instance, the full duals had a predicted ratio <1.000 showing that risk score model had been under predicting actual costs. The new payment model reflects

[5] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf

[6] Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017

[7] The six community models are Full benefit dual aged, Full benefit dual disabled, Partial benefit dual aged, Partial benefit dual disabled, Non-dual aged, and Non-dual disabled.

the higher costs associated with the Full dual population. Since each member identified as Full dual would be on the risk model reflecting higher predicted costs associated with the population, aggregating a cohort of members who qualify as Full benefit dual will impact (increase) revenue and allow for richer benefits.

The predictive ratio for the Partial benefit dual is >1.000 or lower cost than predicted so the risk score model will reflect the lower expected costs. For an MAO developing D-SNP plans, understanding the risk model associated with the population being targeted and striking a balance between the dual types is a key to managing benefits and profitability.

Application Process

Determining the strategic move for the organization is clearly the first step however the application process should not be neglected. For MAOs with existing D-SNP look-a-like plans, MAOs wanting to start a D-SNP plan, or for MAOs beginning in 2023 that are planning to include D-SNP plans in their offering, the preparation and application for a D-SNP is similar.

As noted, the application process does include submissions with CMS as well as contracts with the state Medicaid agency. The requirements and data for Medicaid will vary by state and need to be considered on a state-by-state basis. The CMS requirements do vary somewhat year-to-year but have demonstrated some consistency with respect to the documents and timing.

Following is the calendar for CY 2022. Note that these deadlines apply for all MA and Part D plans, and not just SNPs:

APPLICATION AND BID REVIEW PROCESS (CY 2023)[8]

Date	Milestone
November 30, 2021	Recommended date by which applicants should submit their Notice of Intent to Apply Form to CMS to ensure access to Health Plan Management System (HPMS) by the date applications are released.
November 30, 2021	CMS User ID form due to CMS
January 12, 2022	Final Applications Posted by CMS
January 21, 2022	Deadline for Notice of Intent to Apply (NOIA) form submission to CMS
February 16, 2022	Completed Applications due to CMS
February 16, 2022	Special Needs Plans (SNPs) Annual Renewal ubmitede updated Modesl of Care (MOCs)
April 2022	Plan Creation module, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) available on HPMS.
Early May 2022	PBP/BPT Upload Module available in HPMS
Mid May 2022	Release of CY 2023 Formulary Submission Module.
June 6, 2022	Bids due to CMS.
Late August 2022	CMS completes review and approval of bid data.

[8] Contract Year 2022 Application (cms.gov)

Date	Milestone
September 2022	CMS executes MA and MA-PD contracts with organizations whose bids are approved and who otherwise meet CMS requirements.
Mid October 2022	Annual Coordinated Election Period begins for CY 2022 plans

For new plans, initiating the HPMS application as well as the notice to CMS should be completed mid-November. For established plans, strategic planning through November and December ensure being ready to submit a NOIA prior to mid-January.

The SNP application is separate from the new MA and Prescription Drug Benefit applications and separate from service area expansion applications. SNPs are required to follow existing MA and Prescription Drug Benefit program rules.

- SNPs requiring approval or re-approval under the NCQA SNP Approval process should submit their **Model of Care** (MOC) written narrative and **MOC Matrix** Upload Document in the HPMS MOC Module.
- Dual Eligible SNPs will need to submit a signed and executed **State Medicaid Agency Contract** (SMAC). The SMAC is submitted to CMS through HPMS by July 1 every year.[9]
- Existing MAOs must be qualified in all counties of the SNP service area. If not, a service area expansion application is required.
- An initial applicant seeking to offer a SNP must submit an MA and Part D application in conjunction with the SNP Application.

This brief begins a series intended to answer questions and provide insight into some of the key differences between D-SNP and general enrollment plans. Subsequent papers will include more information including:

- Requirements for D-SNPs, such as Model of Care requirements.
- Market dynamics such as competitiveness by geographic market, common benefit offerings, industry trends, potential profitability, and administrative expense benchmarks.
- STAR rating considerations.
- Strategic and actuarial bidding considerations.

Please contact Alison Pool at alisonp@wakely.com or Brittney Phillips at brittneyp@wakely.com with any questions or to follow up on any of the concepts presented here.

[9] See: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf

OUR STORY

Wakely's Expertise

We move fast to keep our clients ahead of the healthcare curve.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Deep data delivery. Because of Wakely's unique access to various data sources, we can provide insights that may not be available from other actuarial firms.

We are thought leaders. We go beyond the numbers.

Learn more about Wakely Consulting Group at www.wakely.com