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RESEARCH ARTICLE

Effects of Early Dual-Eligible Special Needs Plans on Health Expenditure

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Objective. To examine the effects of the penetration of dual-eligible special needs plans (D-SNPs) on health care spending.

Data Sources/Study Setting. Secondary state-level panel data from Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) public use file and Special Needs Plan Comprehensive Reports, Area Health Resource Files, and Medicaid Managed Care Enrollment Report between 2007 and 2011.

Study Design. A difference-in-difference strategy that adjusts for dual-eligibles' demographic and socioeconomic characteristics, state health resources, beneficiaries' health risk factors, Medicare/Medicaid enrollment, and state- and year-fixed effects.

Data Collection/Extraction Methods. Data from MMLEADS were summarized from Centers for Medicare and Medicaid Services (CMS)'s Chronic Conditions Data Warehouse, which contains 100 percent of Medicare enrollment data, claims for beneficiaries who are enrolled in the fee-for-service (FFS) program, and Medicaid Analytic Extract files. The MMLEADS public use file also includes payment information for managed care. Data in Special Needs Plan Comprehensive Reports were from CMS's Health Plan Management System.

Principal Findings. Results indicate that D-SNPs penetration was associated with reduced Medicare spending per dual-eligible beneficiary. Specifically, a 1 percent increase in D-SNPs penetration was associated with 0.2 percent reduction in Medicare spending per beneficiary. We found no association between D-SNPs penetration and Medicaid or total spending.

Conclusion. Involving Medicaid services in D-SNPs may be crucial to improve coordination between Medicare and Medicaid programs and control Medicaid spending among dual-eligible beneficiaries. Starting from 2013, D-SNPs were mandated to have contracts with state Medicaid agencies. This change may introduce new effects of D-SNPs on health care spending. More research is needed to examine the impact of D-SNPs on dual-eligible spending.

Key Words. Dual-eligible, special needs plan, health care spending, care coordination

Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid benefits. These individuals have low incomes and are either elderly or have long-term disabilities. Due to their complex needs, dual-eligible individuals require a mix of acute care, long-term care, behavioral health, and social services (Gold, Jacobson, and Garfield 2012; Medicare Payment Advisory Commission 2012). Studies have found that dual-eligibles are among the highest-cost enrollees in both programs. While accounting for about 18 percent of Medicare fee-for-service (FFS) enrollment, they represented about 31 percent of total Medicare FFS spending in 2010 (Medicare Payment Advisory Commission 2012). In addition, they accounted for about 15 percent of Medicaid enrollment but about 40 percent of Medicaid spending (Kaiser Family Foundation 2011). Studies have indicated that the lack of coordination between Medicare and Medicaid programs is a significant cause for the disproportionate costs among this population (Grabowski 2007; Ng, Harrington, and Kitchener 2010; Gold, Jacobson, and Garfield 2012; Medicare Payment Advisory Commission 2012).

Medicare and Medicaid typically pay for different services dual-eligible individuals need. Specifically, most primary and acute care services, such as physician, hospital, prescription drug, and other related services, are covered through Medicare. Most long-term services and supports, including community-based services, nursing facility services, and personal care assistance, are paid by Medicaid (Komisar, Feder, and Kasper 2005; Verdier et al. 2015). This fragmented payment structure creates conflicting incentives as both programs have intentions to limit their own payment and shift costs to another program (Grabowski 2007, 2009). For example, health services delivered by nursing homes are less expensive than those by hospitals, and appropriate interventions implemented in nursing homes could reduce avoidable hospitalizations (Kane et al. 2004; Loeb et al. 2006; Graverholt, Forsetlund, and Jamtvedt 2014). Therefore, coordinating health care delivery between nursing homes and hospitals could generate cost savings. However, utilizing more nursing home services and less hospital services means more payment by Medicaid and costs savings for Medicare. Thus, Medicaid programs have little incentive to encourage nursing home utilization and

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