SNP Alliance Proposal
Remove Barriers to Integrating Medicare and Medicaid Services for Dual Eligibles
November 2015

Background
Individuals eligible for both Medicare (federal) and Medicaid (states) benefits make up 20% of the Medicare population and account for about 34% of spending for each program. Dual eligibles have low-income, less education, and higher rates of Alzheimer’s and dementia, severe disabilities and multiple chronic conditions than typical Medicare beneficiaries. The lack of coordination between Medicare and Medicaid programs for dual eligibles results in fragmented care, beneficiary confusion, administrative duplication and cost inefficiencies for patients, providers and program administrators. Dual eligibles typically must use three separate enrollment cards (Medicare Parts A/B, Medicare Part D and Medicaid) to access all benefits. They receive member materials, letters, and communications from three separate entities and are often confused by which entity covers each benefit.

Rapid growth in the number of dual eligible beneficiaries is projected to put severe pressure on Medicare and Medicaid budgets in coming decades. Today, our nation spends over $350 billion per year to care for 10.2 million dual eligibles with benefits under both Medicare and Medicaid.

Congressional Action to Date
Experience in a number of states indicates that health care delivery can be improved for dual eligibles by integrating both Medicare and Medicaid services under a single health plan. In 2003, Congress created Dual Eligible Special Needs Plans (D-SNPs) under Medicare Advantage for this purpose. D-SNPs enroll only dual eligibles and must meet care delivery and coordination requirements tailored to their needs. In 2008, Congress required D-SNPs to have contracts with state Medicaid agencies to offer Medicaid benefits along with Medicare. D-SNPs now serve 1.7 million dual eligibles in 40 states, with nearly 115,000 enrolled in Fully Integrated Dual Eligible SNPs (FIDESNPs) that provide Medicare and most Medicaid services, including long-term services and supports and/or behavioral health.

Congress also created the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) to improve alignment of Medicare and Medicaid Program policy for dual eligibles. The MMCO initiated the Financial Alignment Initiative (FAI) in which 10 states are integrating Medicare and Medicaid health services through Medicare-Medicaid Plans (MMPs) under fully capitated payment arrangements. Today, over 380,000 dual eligibles are enrolled. CMS/MMCO also approved an administrative alignment demonstration with the State of Minnesota based on the FIDESNP model. A number of other State Medicaid agencies continue to seek dual integration efforts outside the FAI, building on the D-SNP platform.

While major progress has been made, states are not required to contract with D-SNPs. Many states would like to integrate their Medicaid programs for duals with Medicare but view the FAI, and D-SNP and FIDESNP processes as complicated and unstable.

Next Steps for Medicare-Medicaid Integration
Stabilize Integration Platforms through Permanent Extension of D-SNPs and Clarifying FAI MMPs’ Future
D-SNPs operate under temporary authority and have been subject to a series of short extensions. Authority expires again December 2018. Permanent authority for D-SNPs is key to further integration efforts. MMPs approved under the FAI are approved for three-year periods, making the future of MMPs unclear although the MMCO is working on extensions. Further alignment is needed in both programs to optimize program performance. States and plans are reluctant to make important investments in next-stage efforts without assurance of a stable integration platform and additional time to integrate.

Expand MMCO Authority and Amend Medicare Statutes to Facilitate D-SNP Integration
Integration is technical and complex, requiring operational coordination between CMS, states, and plans. Congress should enhance CMS/MMCO authority for advancing dual integration, including for states and plans operating outside of demonstration authority. Medicare statutes should be amended to allow the MMCO to assume primary responsibility for working with States on dual integration issues and for aligning regulatory and operational policies within CMS related to D-SNP and FIDESNP state contracting; for integrating benefits and services; for aligning program oversight, including for enrollment processes, use of a single enrollment card, joint review and simplification of member materials, coordination of member communications and plan contracting schedules; and for integration of model of care, performance measures, data collection and reporting, consumer protections, and grievances and appeals.