

SNP Alliance Position Paper
March 31, 2006

**ADVANCING MEDICARE AND MEDICAID INTEGRATION:
KEY ISSUES AND DEVELOPMENTAL PRIORITIES
MARCH 2006**

BACKGROUND

Following is a summary of recommendations and steps that CMS can take in 2006 to advance the integration of Medicare and Medicaid under current law. It identifies specific priorities and steps for improving total quality and cost performance through efforts to establish Integrated Special Needs Plans that are fully accountable for the spectrum of Medicare and Medicaid services.

It is based upon work of the SNP Alliance Medicare/Medicaid Integration Work Group and review and discussion among SNP Alliance members and CMS leadership on February 22-23, 2006. Membership of the Medicare/Medicaid Integration Work Group includes State and Plan executive leaders for dual integration demonstrations in Minnesota and Wisconsin and from Evercare and others with advanced skills and expertise in integrated care. SNP Alliance members include the full spectrum of SNP types, with coverage provided in all major regions of the US, and with plan sponsors representing over half of Special Needs Plans serving over 200,000 beneficiaries.

While these recommendations primarily focus on how CMS can most effectively advance the integration of Medicare and Medicaid, many of the recommendations *also pertain to* improving the performance of all SNPs and are supportive of the Alliance's overall mission *to strengthen the long-term business viability of Special Needs Plans*. They also are provided in support of the Alliance's overall 2006 priorities (see below), which include other complementary issues of concern to the SNP Alliance.

1. Establishing *fair and equitable payment* for plans that exclusively or disproportionately serve high-cost/high-risk beneficiaries.
2. Advancing the *integration of Medicare and Medicaid*, with particular regard for improving total quality and cost performance in care of frail elders and adults with disabilities.
3. Advancing *system performance measurement and methods*, with special regard for serving persons with multiple, complex, ongoing and interrelated care needs, as their conditions evolve over time and across care settings.
4. *Demonstrating added value* of pre-paid, integrated, specialized care as the preferred approach to serving high-risk Medicare and Medicaid beneficiaries.

MEDICARE/MEDICAID INTEGRATION FRAMEWORK

In 2005, federal and state governments spent over \$200 billion on persons dually eligible for Medicare and Medicaid. Over 80% of the projected growth in Medicaid expenditures reflects increases in the cost of caring for the aged and disabled. The twenty percent of persons 65 and older who have five or more chronic conditions account for over 68% of Medicare spending. In spite of a significant and growing interdependence between Medicare and Medicaid in serving high-cost, complex care patients, there is increased evidence that the pervasive fragmentation in financing, administration and delivery of care for high-risk beneficiaries actually *causes* significant and unnecessary confusion, administrative duplication, cost shifting, medical complications and increased costs.

To address this concern, the SNP Alliance recommends that CMS pursue an aggressive strategy to:

- *Simplify access* to Medicare and Medicaid benefits by dually eligible beneficiaries.
- *Improve care continuity* among providers who serve the same beneficiaries, either at the same time or in sequence to one another.

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- *Eliminate inappropriate cost shifting* among related care providers, between Medicare and Medicaid, and between State and federal governments.
- *Eliminate regulatory conflicts* for related care providers, between Medicare and Medicaid, and between federal and state administering agencies.
- *Improve total cost and quality performance* through fair and equitable capitated, risk-based payment methods and appropriate, system-oriented performance measures and methods.

The SNP Alliance recommends that CMS pursue these overall objectives by aligning Medicare and Medicaid financing, policy and oversight to support the establishment of Integrated Special Needs Plans (see definition below) as a preferred approach for serving dually eligible beneficiaries.

An Integrated SNP is defined as any CMS approved Special Needs Plan (dual, institutional, or chronic care SNP) that: a) has federal and state contracts to provide a comprehensive array of Medicare and Medicaid benefits under capitated payment arrangements, b) is actively pursuing integrated financing, administration and care methods, and c) has established methods for improving total quality and cost performance for a high-risk population. Integrated SNPs would be characterized by the following:

1. A dually eligible beneficiary would be able to receive Medicare and Medicaid benefits through a single Special Needs Plan.
2. CMS and state Medicaid agencies would use compatible contracting provisions and methods for the administration of Medicare and Medicaid services.
3. Integrated SNPs would be permitted to use integrated Medicare/Medicaid enrollment forms as part of a coordinated enrollment process.
4. Integrated SNPs would be permitted to use integrated marketing materials and to standardize the enrollee communication process.
5. Integrated SNPs would be at risk for Medicare *and* Medicaid. Payment methods would recognize the higher risk of serving chronically ill or disabled enrollees and Integrated SNPs could pool funding to improve cost and quality outcomes.
6. Grievance and appeals procedures would be standardized to the degree possible under current law, with uniform requirements established wherever possible.
7. Integrated SNPs could use a single quality improvement plan, with compatible quality measures and methods responsive to the multi-dimensional, ongoing and interdependent nature of care for frail elders, adults with disabilities, and persons with do-morbid medical conditions.

2006 MEDICARE/MEDICAID INTEGRATION PRIORITIES

Aligning Medicare and Medicaid financing, regulations and oversight is difficult at best. Ultimately, improving total quality and cost performance for the dually eligible may require establishing a single program, with a single risk-adjusted payment method, one set of regulations, and one oversight structure, using specialized delivery arrangements for persons with severe or disabling chronic conditions.

The SNP Alliance is encouraged by CMS efforts to establish an Integrated Medicare and Medicaid Work Group, organized out of the Administrator's office. In support of this short-term regulatory effort,

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the SNP Alliance recommends that CMS do whatever it can to unify the financing, administration and delivery of care for the dually eligible as soon as possible, with particular regard for improving total cost and quality outcomes for frail elders, persons with co-morbid and/or late-stage medical conditions, and adults with disabilities. It should build upon the goals and the Integrated SNP concept outlined above.

The following six short-term, high-leverage interventions are seen as of priority importance in working toward integrated care, while working within the limits of current law. They are identified in priority order, with priority being defined as a combination of what is seen as doable in the short-term and of priority importance in advancing a preferred approach to integrated care over time. The recommendations are also understood to be complementary to recommendations contained in the SNP Alliance's Blueprint for System Transformation.

The following recommendations are made from the perspective of improving the overall system performance capabilities of SNPs serving persons dually eligible for Medicare and Medicaid, whether they are classified as a dual, institutional, or chronic care SNP. It is important to keep in mind that issues of integrating Medicare and Medicaid are not restricted to dual SNPs, as other SNPs also serve people dually eligible for Medicare and Medicaid. The institutional SNPs are a case in point where most "institutional" beneficiaries are dually eligible.

1. ADVANCE MEDICARE/MEDICAID INTEGRATION THROUGH INTEGRATED SPECIAL NEEDS PLANS.

ISSUE: SNPs were established, in part, to facilitate the integration of Medicare and Medicaid benefits for the dually eligible. The vast majority of SNPs approved by CMS specialize in care for the dually eligible. Moreover, CMS is using the SNP provisions to mainstream existing dually eligible demonstrations when their waiver authority expires. Unfortunately, there are a number of factors that impede the ability of SNPs to improve total quality and cost performance for dual beneficiaries.

First, states with a history of innovation in Medicare/Medicaid integration, via dual demonstrations, are experiencing difficulty in transitioning to mainstream status. In some cases they are being required to uncouple practices central to their overall success. This discourages national leaders from advancing integration methods and discourages other states from pursuing similar integration efforts.

Second, most dual SNPs approved by CMS *only* are accountable for one segment of dual financing—Medicare. While there are sound reasons why this has occurred, dual SNP designation is an important opportunity to eliminate major disparities between Medicare and Medicaid in serving persons receiving benefits from both programs. If specialty plans are *only* responsible for Medicare benefits and expenditures, none of the cost shifting, confusion and complication that exists between Medicare and Medicaid in serving a dual population is likely to be resolved.

Third, most people think about the integration of Medicare and Medicaid in the context of dual SNPs only, even though institutional and chronic SNPs also serve a dual population. In fact, over 70% of Medicaid expenditures for dual beneficiaries are related to the cost of long-term care, the primary *raison d'être* for Institutional SNPs. Moreover, virtually all states, outside of demonstration authority, finance the long-term care segment of a dual beneficiary's care under fee-for-service financing, restricting the ability of SNPs to establish methods for improving *total* quality and cost performance.

Fourth, while there now is general agreement that risk-adjusted financing is critical to the financial viability of specialized managed care, most Medicaid managed care contracts are not risk-adjusted; and where risk adjustment is used, there are significant disparities in payment methods across states. Moreover, while some states have initiated new efforts to integrate Medicare and Medicaid, in their zeal

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to contain costs, some have established sufficiently low capitation rates so that neither plans nor consumers have any incentives to establish or join an integrated plan.

And finally, while we applaud the efforts of Congress and CMS to allow plans to specialize in care of high-risk beneficiaries, simple designation of specialized MA plans will not resolve the core problems of fragmented care. The vast majority of cost shifting, confusion, administrative complication and waste in care of the dually eligible are rooted in a misalignment of Medicare and Medicaid financial methods and incentives, plan and provider policy, and oversight structures that fail to recognize the multidimensional, ongoing and interdependent nature of complex chronic care. While the MMA-SNP provisions are a major step forward in seeking to improve total quality and cost performance for high-risk beneficiaries, SNPs will not reach their full potential without strong, proactive, focused national leadership, with sufficient resources to transform a pot pours of antiquated policies and procedures that are deeply rooted in the infrastructure of program operations and embraced by a long history of culture and tradition.

SOLUTION: CMS should build upon the SNP provisions contained in the MMA law, using the objectives and definition previously outlined as a guide for decision-making, and provide aggressive leadership in aligning Medicare and Medicaid financing, policy and oversight. CMS should:

- 1.1 Increase the amount of resources focused on resolving disparities in Medicare and Medicaid financing, policy and oversight. CMS has taken a major step forward in establishing a Medicare and Medicaid Integration Work Group, comprised of Medicare *and* Medicaid leadership and working out of the Administrator's office. However, most of the staffs involved in this work group have other major responsibilities. The problems they are being asked to resolve are rooted in long history of tradition and entrenched policies and operating systems. Additional staff and resources are necessary to resolve the many impediments to integration in a timely manner.
- 1.2 Work toward establishing a permanent office focused on care for the dually eligible that is of equal stature to other offices that are exclusively focused on Medicare or Medicaid. Approximately a third of all expenditures for Medicare and Medicaid (over \$200 billion in 2005) are spent each year in care of dually eligible persons. Most costs are for persons with multiple, complex and ongoing care needs with total quality and cost performance dependent upon a unified approach to healthcare financing and administration. Optimum system performance requires dedicated staff focused on the interdependence between Medicare and Medicaid and the unique needs of those with severe or disabling chronic conditions.
- 1.3 Encourage States to move toward full integration of Medicare and Medicaid through Integrated SNPs as soon as possible. Publish information regarding SNPs that are fully and/or partially at-risk for Medicare *and* Medicaid services and identify benefits and related risk arrangements that are being utilized. CMS needs a complementary state-based work effort to succeed.
- 1.4 Maintain all existing dual demonstration waivers and advance learning to other states. Educate CMS regional offices about the agreements CMS central office has negotiated with states, such as Minnesota's memorandum of understanding, so that states and plans are not held accountable for different rules established by CMS central and regional offices. Where CMS does not have the authority to allow certain aspects of dual integrated programs to be maintained once demonstration authority is expired, and the state plan amendment process does not provide this capacity, CMS should support legislation to make permanent dual demonstration waivers for Minnesota, Wisconsin, and Massachusetts.
- 1.5 Allow states to establish Medicare and Medicaid integration methods through state plan amendment and minimize the need for waivers and variances. Make integrated care easy.
- 1.6 Notify the State of any Integrated SNP applicant and consult with them as part of their review and approval process to ensure a coordinated response.
- 1.7 Review Integrated SNP applications through a national Medicare/Medicaid Integration team, including representation from CMS's Medicare and Medicaid components, with a goal of promoting uniform policies and procedures wherever possible.

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2. ALIGN MEDICARE AND MEDICAID PAYMENT INCENTIVES

ISSUE: Medicare has advanced risk-adjusted payment methods to eliminate some of the adverse incentives for specializing in care of high-risk beneficiaries. Most states continue to finance the long-term care segment of care for frail and disabled dual beneficiaries through fee-for-service financing. It is not clear the degree to which state-based risk-adjustment for Medicaid financing is compatible with the CMS-HCC payment method used for Medicare financing. The disparities in payment methods across states and between Medicare and Medicaid *cause* hospitals and nursing homes and state and federal agencies to routinely shift costs between one another without regard for their cumulative effects. While physicians and care managers are charged with prescribing and managing care to optimize *total* quality and cost performance, they are incented to use some services more than others, even when they know some care alternatives would be more cost effective. Under standard MA policies and procedures, Integrated SNPs must uncouple and separately account for costs, and live within separately defined Medicare and Medicaid costs limits and rigid accounting rules that impede their ability to improve total quality and cost performance through care management, substitution of services, etc.

SOLUTION: CMS and States should align Medicare and Medicaid payment to optimize total quality and cost performance for persons who are dually eligible for both programs. To this end, CMS should:

- 2.1 Establish an integrated bidding process for Integrated SNPs, where both Medicare and Medicaid costs are identified in the same bid and differentiate the desk review process so that CMS staff can recognize basic differences between Integrated SNPs and Medicare only SNPs or MA plans.
- 2.2 Convene a group of auditors and SNPs to identify options for modifying audit requirements so Integrated SNPs and related physicians and care managers can make decisions about what combination of services are most efficient and effective for optimizing *total* quality and cost performance.
- 2.3 Allow States to share in some of the “savings” that are to be accrued to Medicare from Integrated SNP bids to encourage states to promote Integrated SNPs, compensate states for Medicaid expenditures that contribute to Medicare cost savings or allow Integrated SNPs to use some of the savings for such purposes.
- 2.4 Assess the compatibility of financial incentives in serving high-risk duals by analyzing existing fee-for-service and state-defined risk-adjusted Medicaid payment methods in relation to the Medicare CMS-HCC payment method.
- 2.5 Establish methods to document and monitor *total* Medicare and Medicaid quality and cost performance for duals, with a special focus on persons with serious or disabling chronic conditions.

**3. ALLOW INTEGRATED SNPs TO SPECIALIZE IN CARE OF FRAIL
ELDERS OR ADULTS WITH DISABILITIES.**

ISSUE: SNPs were established to allow MA plans to specialize in care of persons with severe or disabling chronic conditions. Under current provisions, a wide variety of specialization is allowed. Dual SNPs can specialize in care for persons with different financial needs, e.g. full duals vs. QMBs and SLMBs. Chronic care SNPs can specialize in specific diseases, ESRD and AIDS, or certain combination of diseases, e.g. complex diabetes, CHF, and COPD. Institutional SNPs can specialize in care for people living a specific set of facilities or persons living in their own home. However, under current CMS guidance, SNPs cannot specialize in care for frail elders or for adults with disabilities or any subset of disability. For example, while we understand that dual SNPs are permitted to specialize in care for adults with disabilities, it is not clear whether institutional SNPs also would be permitted to limit enrollment to one or more categories of disability (e.g. physically disabled OR developmentally disabled OR mentally impaired). Merging care for these special needs individuals under the same “specialty” program is like requiring ESRD and AIDS programs to function under the same SNP; you can do it but it dilutes the

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SNPs efforts to address the unique clinical, cultural and cost issues that are operative or requires the SNP to establish two specialized efforts under a single administrative structure.

Frail elders and adults with disabilities are the two largest, highest-cost and fastest growing care segment of the dual population. Their unique care needs are well documented. The two primary methods for gaining Medicare eligibility are age and disability based. The report language for establishing Special Needs Plans indicate that the provisions “provide the Secretary the authority to designate other chronically ill or disabled beneficiaries as special needs beneficiaries to allow plans to serve additional high risk groups who would benefit from enrollment in plans that offer *targeted geriatric approaches* and innovations in chronic illness care”. The report language also suggests that CMS look to existing demonstrations as a guide for identifying target group, where specialty care for frail elders and adults with disabilities is not only allowed but encouraged. Frail elders and adults with disabilities and those who advocate on their behalf, see themselves as having unique care needs. Geriatric medicine has evolved primarily to address the special care needs of frail older persons. Multiple disability programs have evolved from documented evidence that persons with various types of disability receive better quality and cost outcomes through specialty care interventions.

SOLUTION: CMS should allow dual, institutional, and/or chronic care SNPs to specialize in care of frail and/or disabled persons. It should:

- 3.1 Establish guidance for MA plans seeking to specialize in care of frail and/or disabled adults, with consideration given to the following definitions as guidance for special care focus.

Frailty: “An aggregate expression of risk resulting from age or disease-associated physiologic accumulation of sub-threshold decrements affecting multiple physiologic systems. Central to the clinical definition of frailty has been the concept that no single altered system defines this state, but that multiple systems must be involved.” CMS could further indicate, but not require, in demonstrating eligibility that frailty includes: “a) generalized weakness, b) poor endurance, c) weight loss and/or undernourished, d) low activity (even homebound), and e) fear of falling and/or unsteady gait.” Source: Linda Fried, et. al. “Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improving Targeting and Care”, *Journal of Gerontology, Medical Sciences*, 2004, Vol. 59, No. 3, 255-263. (This definition would allow SNPs to specialize in serving frail elders, perhaps the largest special needs group in the Medicare population, without using age specific criteria, a major concern of CMS staff.)

Disability: “A difficulty or dependency in carrying out activities essential to independent living, including essential roles, tasks needed for self-care and living independently in a home and desired activities important to one’s quality of life.” Source: Pope A. Tarlov A. *Disability in America: Toward a National Agenda for the Prevention of Disabilities*. Washington, DC; National Academy Press; 1991.) CMS should allow SNPs to specialize in various types of disability, including but not limited to developmental disability, physical disability, mental retardation and/or persons with severe or disabling mental illness.

4. SEND WRITTEN CLARIFICATION OF INTEGRATION OPPORTUNITIES

ISSUE: There are multiple, duplicative and conflicting requirements for administering Medicare and Medicaid for the dually eligible, including those related to: 1) contracting provisions and methods, 2) marketing/member communication, 3) enrollment policies and procedures, 4) bidding policies and procedures, 5) quality assurance measures and methods, and 6) grievance and appeals procedures. There are differing views among SNPs, State Medicaid agencies and regional offices as to whether an inability to integrate various functions or activities rests in a misunderstanding of what is required, administrative

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inconsistencies, regulatory requirements, or federal or State statute. This has resulted in a great deal of confusion and difficult in trying to streamline or simplify various dual activities. In some cases duplicative or conflicting policies and procedures have prevailed unnecessarily. In other cases, SNPs and/or States have been required to uncouple previous integration practices.

SOLUTION: CMS should clarify in a single document existing CMS policy on Medicare/Medicaid integration, where CMS has the authority to allow states and plans to integrate functions and whether this authority is the form of regulations, the Medicare Managed Care Manual, Final SNP Guidance, Memoranda of Understanding with states, etc. To the extent that policy rests within dual demonstration documents such as Memoranda of Understanding, CMS should clarify whether such policy can be applied to other states and plans outside demonstration authority. This should include:

- 4.1 The degree to which CMS, States and plans can standardize the form and content of contracting requirements for provision of Medicare and Medicaid benefits.
- 4.2 The degree to which integrated SNPs can use a single set of marketing materials and standardized enrollee communication methods.
- 4.3 The degree to which Integrated SNPs can use integrated Medicare and Medicaid enrollment forms, using a coordinated enrollment and/or disenrollment process.
- 4.4 The degree to which States and Integrated SNPs can standardize grievance and appeals procedures with uniform requirements.

5. WORK WITH CONGRESS TO MODIFY THE SNP EVALUATION.

ISSUE: Currently, CMS is required to submit a report to Congress that evaluates the impact of establishing Special Needs Plans on “the cost and quality of services provided to enrollees, no later than December 31, 2007.” This timeline does not allow CMS sufficient time to establish appropriate quality measures for evaluating the cost and quality effects in managing care for persons with interdependent frailty, disability, and/or co-morbid illnesses, as a person’s condition evolves over time and across care settings. Moreover, the timeframe for data collection is during the period where there are higher than normal costs related to new program development and during a period where plans are unable to evidence cumulative effects in effort to the prevent, delay or minimize disease and disability progression relative to a normalized illness trajectory. Integrated SNPs have the added burden of living with conflicting rules and requirements and/or attempting to change them when other providers and plans can simply ignore the problem and sub-optimize cost without regard for their adverse cumulative effects. Moreover, there is neither the time nor the structure in place for CMS to develop methods to compare SNP interventions with other MA and fee-for-service methods without biasing the evaluation design toward use of short-term acute care protocols that are NOT germane to the Congressional charge for SNPs to specialize in care of persons with severe or disabling chronic conditions.

SOLUTION: CMS should:

- 5.1 Focus the SNP evaluation for the Report to Congress on descriptive information about the plans, beneficiaries and the implementation process. Focus the assessment of SNP impact on quality on identifying what programs and processes for promoting quality were implemented to create a basis for future quantitative evaluations and the development of best practices. Limit the assessment of SNP impact on cost to factual information found in bid-data without attempting to evaluate “cost-effectiveness” at this early date based on the amount of savings or premiums. Incorporate the SNP Alliance quality domains into the set of process measures used.
- 5.2 Establish new system performance measures and methods, as soon as possible, to evaluate SNP performance in serving persons with severe or disabling chronic conditions as their interdependent and ongoing care needs evolve over time and across care settings.

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6. ADDRESS VARIOUS SPECIFIC ISSUES OF UNIQUE IMPORTANCE TO SNPs.

ISSUE: There are a variety of operational issues that affect specialty care plans more than other MA plans. One of those relates to the policy that SNPs, like any other MA plan, must maintain an arms length relationship with providers to ensure that potential enrollees are afforded the opportunity to make an independent decision about where and how they access Medicare and Medicaid benefits. In traditional MA plan this arms length relationship is not a problem in that the decision to enroll generally is not tied to a particular problem. For SNPs that specialize in care of high-risk beneficiaries, it is critical that beneficiaries become aware of their plan's availability as soon as possible after the time a person is diagnosed with a condition or set of conditions that defines their eligibility status. The window of opportunity for enrollment is much more narrow than for a traditional plan and the enrollment is much more dependent on the advice and counsel of a beneficiary's primary care physician and related health care professionals. Second, the latest CMS guidance provides beneficiaries only one special election period to enroll in a Chronic SNP, but unlimited SEPs for dual and institutional beneficiaries, and limits their ability to disenroll to the rules applicable to any other Medicare Advantage plan. Some SNPs have been operating under approved marketing materials that indicate a continuous open enrollment. Other Chronic SNPs find it unreasonably restrictive and inconsistent with policies established for other high-risk beneficiaries.

SOLUTION: CMS should work with the SNP Alliance in crafting a policy that:

- 6.1 Ensures patients the right to make an independent decision; and at the same time enables the patient to know about and enroll in a SNP opportunity that is timely and relevant to their immediate need.
- 6.2 Apply the same continuous open enrollment policy through SEPs or OEPIs for all SNPs, including for Chronic SNPs.

CONCLUSION

Special Needs Plans provide an important foundation for improving total quality and cost performance in serving persons with severe and disabling chronic conditions— one of healthcare's highest-cost and fastest-growing service groups. Many of these persons are dually eligible for Medicare and Medicaid and require services from the spectrum of primary, acute and long-term care providers. Frequently, these high-risk beneficiaries need multiple Medicare and Medicaid services to be provided at the same time or through a coordinated sequence of related activity. Unfortunately, current financing, administrative and oversight methods contain incentives for States, plans and providers to sub-optimize costs within the framework of existing Medicare or Medicaid structures and predefined provider arrangements, without regard for their effects on a persons overall health and well being or for the totality of costs that may evolve over time and across care settings.

CMS is making a concerted effort to eliminate some of the more pervasive inconsistencies between Medicare and Medicaid policies and oversight through efforts of the Medicare and Medicaid Integration Work Group. The SNP Alliance applauds this effort and recommends that CMS give overall priority to the proposed issues and solutions. We further recommend that CMS adopt the following sequence in seeking to eliminate regulatory barriers to improving total quality and cost performance:

- 1) Clarify (as soon as possible and in writing) the degree to which States and Integrated SNPs can integrate Medicare and Medicaid functions under the existing statutory authority.
- 2) Standardize and integrate methods for reviewing Integrated SNP applications and bids and for monitoring Integrated SNPs performance to whatever degree possible.

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- 3) Work with States and the SNPs that have experience in integrated care to identify issues that require a change in existing rules and regulations and develop a plan of action for eliminating regulatory barriers to integration as soon as possible.
- 4) Identify issues that require a change in the law to better align payment methods, regulations and oversight functions in serving persons dually eligible for Medicare and Medicaid; and develop and activate a plan of action for obtaining Congressional authority as soon as possible.

The Alliance understands the difficulty of changing practices that have been in place for years, for aligning Medicare and Medicaid requirements that are root in fundamentally different approach to health policy, and in finding common ground among CMS, States and Special Needs Plans, each with its own business interests. Recognizing these difficulties, the SNP Alliance stands ready to work with CMS to whatever degree possible to advance the cause of integrated care as quickly as possible.