



SNP Alliance Position Statement

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Integrating Medicare and Medicaid for Dual Eligibles

Background

Today, our nation spends more than \$350 billion per year to care for 10.2 million dual eligible beneficiaries. Rapid growth in the number of dual eligibles will only increase pressure on federal and state budgets in the coming years. These low income beneficiaries comprise 20% of the Medicare population and account for about 34% of spending for each program. Dual eligibles have lower-incomes, less education, higher rates of Alzheimer's and dementia, severe disabilities, and multiple chronic conditions than typical "non-dual" beneficiaries. Adding to the problem, there is little coordination between Medicare and Medicaid, resulting in fragmented care, beneficiary confusion, administrative duplication and cost inefficiencies. For example, these beneficiaries must use three separate enrollment cards (Medicare Parts A/B, Medicare Part D, and Medicaid) to access their healthcare benefits. They receive member materials, letters, and communications from three separate entities and are often confused by which entity covers which benefit.

Congress Creates D-SNPs

Congress, driven by experience in a number of states showing that health care delivery can be improved for these low income people by integrating both Medicare and Medicaid services under a single health plan, created Dual Eligible Special Needs Plans (D-SNPs) in 2003. D-SNPs enroll only dual eligible beneficiaries 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 nearly 2 million dual eligibles nationwide, with over 120,000 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 Creates the "Duals Office" at CMS

Congress also created the Medicare-Medicaid Coordination Office (MMCO) "Duals Office" within 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. The Duals Office also approved an administrative alignment demonstration with the State of Minnesota based on the FIDESNP model. Other State Medicaid agencies continue to seek dual integration efforts outside the FAI, building on the D-SNP platform.

While these efforts have strengthened efforts to integrate Medicare and Medicaid, 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.

Recommendations

Congress Should Make D-SNPs Permanent and Stabilize the Financial Alignment Initiative

Permanent authority for D-SNPs, which expires in December 2018, is key to furthering integration efforts. Also, MMPs operating under the FAI are approved for only 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. Some states and plans are reluctant to make financial investments in advancing integration without assurance of a stable plan platform and additional time to integrate these complicated programs.

Congress Should Expand Authority of the Duals Office and Facilitate D-SNP Integration

Congress should provide additional authority for the CMS Dual Office to eliminate unnecessary duplication, conflicts and complexities for states and plans advancing dual integration outside the FAI. This should include authority to develop and/or modify policies and procedures to: (1) align procurement and contracting schedules and processes; (2) integrate delivery and notification of benefits and services; (3) coordinate and align enrollment, including use of a single enrollment card, (4) enable states and CMS to jointly review and oversee dual programs; (5) simplify member material and communication; (6) integrate plan assessments and model of care requirements; (7) align performance measures, data collection and reporting, consumer protections, and grievances and appeals; (6) align payment methods; (8) improve care for high-risk/high-need subgroups; (9) align policies and procedures for C-SNPs and I-SNPs with significant dual eligible enrollment, and (10) provide states with needed financing and support to advance integration.

The SNP Alliance applauds Congressional efforts to date in seeking solutions to managing the complexity of the dual eligible population and seeks these revisions to strengthen healthcare delivery for the most vulnerable patients in our country.