The SNP Alliance

A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

Policy Brief:
States Can Benefit from Partnering with Dual-Eligible Special Needs Plans (D-SNPs)

(February 2015)

States and Dual-Eligible Beneficiaries Face Multiple Challenges

Today 10.7 million seniors and people with disabilities are "dually eligible" for both Medicare (administered at the federal level) and Medicaid (administered at the state level) health coverage. People can be covered by both programs if they are 65 or older or have disabilities and have income below state thresholds. Dual-eligible beneficiaries face challenges because they are more likely than beneficiaries with only Medicare coverage to have multiple, complex, and chronic medical conditions and require long-term services and supports (LTSS). While they have high needs for both Medicare and Medicaid covered services, they must navigate two distinct and largely uncoordinated programs. The lack of coordination between Medicare and Medicaid can lead to duplication and fragmentation of care, beneficiary and caregiver confusion, and administrative complexities for patients, providers and program administrators. Rapid growth in the number of dual-eligible beneficiaries, primarily due to the aging of the baby boom generation and increased rates of disability, along with potential caregiver workforce shortages in the U.S are projected to put severe pressure on Medicare and Medicaid budgets.

Congress Gave CMS and States Tools to Move Toward Integration

Dual-Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans that offer models of clinical care and benefit packages to exclusively meet needs of dual-eligible beneficiaries. Congress established D-SNPs in 2003 in part to serve as a vehicle for integrating Medicare and Medicaid components as tested through prior national demonstration experience in Massachusetts, Minnesota and Wisconsin. In 2008 Congress stipulated that D-SNPs only enroll dual-eligible beneficiaries. Congress also approved legislation in 2010 to establish the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS) to increase alignment between Medicare and Medicaid in ways that improve care outcomes and experience for dual-eligible beneficiaries.

Faced with challenges and new authority from Congress outlined above, CMS and states are considering approaches for integrating Medicare and Medicaid benefits and services in ways that improve care for beneficiaries and control total health care costs. Thirteen states have opted to participate in CMS' Financial Alignment Demonstration between Medicare, Medicaid and state-selected Medicare Medicaid Plans (MMPs). Other states are using D-SNPs as a platform for further coordinating Medicare and Medicaid. CMS also approved a D-SNP demonstration in Minnesota which could help pave the way for further enhancements of D-SNP integration capabilities. 336 D-SNPs now operate in 38 states with 1.65 million enrollees. The SNP Alliance is committed to advancing full integration of Medicaid and Medicare for dual-eligible beneficiaries through D-SNPs and MMPs. We recognize that States are moving toward integration at different speeds and progress may require incremental steps along the way.

D-SNPs Can Help States Better Manage Medicaid Benefits and Costs

- The Medicare Improvement and Patient Protection Act (MIPPA) requires D-SNPs to have contracts with state Medicaid agencies in order to operate. MIPPA contracts give states a vehicle for establishing relationships with D-SNPs so they can address both state and dual-eligible beneficiary needs through integrated benefits and coordinated care.
- Congress gave states considerable leverage through MIPPA to work closely with D-SNPs to integrate services and deliver results. MIPPA contracts with D-SNPs enable states to establish a framework that assures health plans contribute to the goals and success of the Medicaid program. While states are not required to contract with D-SNPs, about 15% of dually eligible beneficiaries are already enrolled in D-SNPs under these contracts.
- Some states and D-SNPs have built highly integrated systems for serving dual-eligible beneficiaries through MIPPA contracts, aligning fiscal incentives, reducing administrative duplication and operational conflicts, and simplifying what is usually a complex and confusing experience for beneficiaries. Most of these MIPPA integration features have not required demonstration authority.
- The value for states working with D-SNPs extends beyond sharing short-term savings with Medicare and includes long-term benefits to both beneficiaries and States in terms of improved quality, access, and costs.

- Some states have been reluctant to invest in integrating Medicaid and Medicare services. One reason has been states do not directly share in Medicare savings that might accrue as a result of their efforts. Another has been concerns over Medicare cost shifting to state paid services. (Access to potential Medicare savings is available under the FAD but this approach does not work for all states.) These issues are more likely to arise when states do not integrate services with Medicare. States that engage with D-SNPs to work on integrated operations and service delivery have more leverage to reduce cost shifting and share in benefits of integration than states that do not work with D-SNPs.
- States need access to practical resources for understanding Medicare and D-SNP operational features in order to take advantage of opportunities for integration. D-SNPs can assist states by providing information to state staff and helping identify areas that might be logical next steps towards better coordination and/or integration.

D-SNPs Can Provide Additional Benefits for Beneficiaries

- **One coordinated source for all Medicare and Medicaid benefits.** Currently most dual-eligible beneficiaries are enrolled in a separate Part D plan for most drug benefits while other Medicare benefits (including some pharmacy benefits) are covered by Medicare fee-for-service and by Medicaid. Dual-eligible beneficiaries must use three separate cards to access to all benefits and are often confused by what source covers which benefit. D-SNPs are required to provide all Medicare Part D drug benefits along with other Medicare benefits. By enrolling in D-SNPs that also provide state Medicaid services, members can access all pharmacy benefits as well as all other services through one plan and one card, simplifying access to services.
- **Enhanced care coordination capabilities.** SNPs are required to provide coordinated models of care including interdisciplinary teams, individual care coordination, coordinated Medicare and Medicaid enrollments and provider networks and services, and health plan oversight tailored especially to individual needs of dual beneficiaries not otherwise required under Medicare. These models of care can augment state requirements.
- **Simplified member materials**. Integration and simplification of duplicative and conflicting member materials, membership cards, enrollment processes and member services.
- **Supplemental benefits.** D-SNPs can collaborate with states in providing additional benefits not available under either Medicare or Medicaid. They also have flexibility in administering benefits such as waiving the three day hospital stay required prior to skilled nursing facility coverage or substituting cost effective services to meet unique individual needs.

D-SNPs Can Improve Total Quality and Cost Performance in Serving Beneficiaries

- **Coordination of Medicare and Medicaid benefits.** D-SNPs provide outpatient medical, acute hospital care and Part D benefits; states can require D-SNPs to coordinate these with Medicaid benefits, such as behavioral health and LTSS to improve communications and coordination between providers, assure access to preventive services and help beneficiaries with chronic care and complex needs navigate multiple providers and services.
- **Improvements in primary and acute-care management of chronic conditions and health outcomes.** States do not have direct contracts with key Medicare primary and acute care providers whose practices ultimately influence state Medicaid costs for dually eligible beneficiaries. As a result, providers and the dual beneficiaries they serve may be left out of state Medicaid care improvement initiatives. By working with D-SNPs, states can extend their evidence-based practice initiatives to Medicare providers and dual beneficiaries.
- **Better alignment in care delivery incentives for managed LTSS programs.** States and D-SNPs can work together on aligning Medicare-covered benefits and Medicaid LTSS services to reduce cost shifting between the programs and better enable states to reach LTSS goals for reducing unneeded institutionalization.
- **Access to data.** CMS is not currently able to provide timely, detailed data to states about the use of services by dual-eligible beneficiaries under Part D and Medicare Advantage. D-SNPs can agree to share utilization, encounter data, Part D data and quality improvement results with states through their MIPPA contracts so states can design effective benefits and programs and set appropriate goals.
- **Efficiencies in administration and oversight.** States and D-SNPs can reduce duplication and inconsistency between Medicare and Medicaid administration and oversight, such as separate HEDIS and CAHPS data collection and coordination of quality reporting, assessment and care planning activities by creating MIPPA contract provisions that streamline activities; for example, merged performance improvement measures.
- **Expanded provider payment and delivery reforms.** Working with D-SNPs, states can expand the populations and providers included in state delivery system reform efforts such as bundled payments, cost sharing pools, pay for performance, and accountable care or total cost of care mechanisms tied to performance. Including Medicare providers and dual-eligible beneficiaries can improve the effectiveness of state reforms.

Many states will require assistance and Medicare knowledge to pursue integrated models. CMS has established an Integrated Care Resource Center (ICRC) through a joint effort between Mathematica Policy Research (MPR) and the Center for Health Care Strategies (CHCS) to assist states, including help in working with D-SNPs. (See integratedcareresourcecenter@chcs.org). States can also contact Rich Bringewatt, President of the SNP Alliance, at rich@nhpg.org or 202-624-1516 to discuss ways for building integrated programs using the D-SNP platform.