SNP Alliance Proposal

Removing Barriers to Integrating Medicare and Medicaid Services for Dual Eligibles

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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 1.65 million dual eligibles in 38 states, with over 100,000 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 (FA) demonstration in which 9 states are integrating Medicare and Medicaid health services through Medicare-Medicaid Plans (MMPs) under fully capitated payment arrangements. Today, over 300,000 dual eligibles are enrolled. CMS/MMCO also approved an administrative alignment demonstration with the State of Minnesota based on FIDESNP models. A number of other State Medicaid agencies continue to seek dual integration efforts outside the FA demos, largely building on the D-SNP platform.

While major progress has been made, states are not required to contract with D-SNPs. Many states that would like to integrate with Medicare view the current demos and D-SNPs as too complex and unstable given technical and operational obstacles to integration in both programs.

Next Steps for Medicare-Medicaid Integration

Stabilize Integration Platforms through Permanent Extension of D-SNPs and Clarifying FA MMPs' Future

D-SNPs operate under temporary authority and have been subject to a series of short extensions. Authority expires again in 2016. Permanent authority for D-SNPs is key to further integration efforts. FA demonstrations are approved for three-year periods and evaluations are not expected to be complete before they expire, making the future of these demonstrations unclear. States and plans will remain reluctant to make further integration investments without assurance of stable platforms and time to make them work.

Expand MMCO Authority and Amend Medicare Statutes to Facilitate D-SNP Integration

Integration is technical and complex, requiring operational coordination between CMS, states, and health plans. CMS/MMCO authority should be enhanced and it should be designated the primary contact for states interested in pursuing integration, including states operating outside of demonstration authority. Medicare statutes should be amended to allow the MMCO to develop regulatory and operational policies that facilitate State contracting with D-SNPs for integrated services, including coordinated enrollment processes, use of a single enrollment card, joint review and simplification of member materials, coordination of member communications and plan contracting schedules, as well as integration of models of care, performance measures, data collection and reporting, consumer protections and plan oversight, and grievance and appeals. At minimum, MMCO should have primary responsibility to coordinate CMS and State policies in these areas.

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