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National Association of Medicaid Directors

# NAMD WORKING PAPER SERIES

## *Advancing Medicare and Medicaid Integration: Improving the D-SNP Model for Dually Eligible Beneficiaries*

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444 North Capitol Street, Suite 309 ▪ Washington, DC 20001 ▪ Phone: 202.403.8620 ▪ www.namd-us.org

# INTRODUCTION

State Medicaid directors and federal policymakers share the desire to improve the quality of care for dual eligible enrollees (those eligible for both Medicare and Medicaid), reduce unnecessary costs, and minimize disconnects between the two programs. This paper is part of the National Association of Medicaid Directors' ongoing body of work which focuses on approaches and tools for achieving these goals.[1]

Previous NAMD documents have discussed many of the current challenges as well as the opportunities for states to improve the system as part of their financial alignment demonstrations initiatives with CMS. NAMD continues to support the work of the Medicare-Medicaid Coordination Office (MMCO) and states to test new alignment models for the dually eligible population, but more is needed to fully fix the system.

In this paper, we address another possible pathway for integration that states are increasingly pursuing: Dual Eligible Special Needs Plans (D-SNPs). In addition to the well-documented fragmentation challenges that exist across states, there are challenges unique to integration initiatives involving the D-SNP program. Here we discuss these challenges and make recommendations so that states might more effectively employ the D-SNP platform to facilitate seamless coordination across the continuum of care.

We are grateful for the time and essential direction provided by the members of NAMD's D-SNP Workgroup. Their expertise and experiences combined with those of NAMD's full membership has led to a set of pragmatic policy recommendations that are critical for fixing the barriers to integration within the D-SNP program.

[1] National Association of Medicaid Directors policy priorities: http://medicaiddirectors.org/priorities/duals

## RECOMMENDATIONS

Further progress towards D-SNP integration will require a combination of federal legislative and administrative actions focused on reducing barriers and further supporting state initiatives to drive alignment between the D-SNP program and state Medicaid agencies. NAMD calls on federal policymakers to enact the following changes:

1. Permanently reauthorize D-SNPs that meet the state Medicaid agency's contracting requirements for integrating care.

2. Provide a uniform definition for "integrated D-SNP" that includes cross-cutting care coordination requirements and integrated systems.

3. Define the critical role of the state Medicaid agency in the contracting with and oversight of integrated D-SNPs.

4. Eliminate statutory misalignment in policies and procedures pertaining to enrollment, marketing and outreach, and grievance and appeals.

5. Allow the MMCO to grant the state Medicaid agency exceptions to Medicare's processes, timelines and requirements as well as waive Medicaid provisions which impede progress of the seamless delivery of patient-centered services across the care continuum.

6. Create a framework for MMCO to work with states to design integrated D-SNP agreements.

7. Create a permanent federal team to work with states on ongoing D-SNP administration issues.

# BACKGROUND

State Medicaid directors and federal policymakers share the desire to improve the quality of care for dual eligible enrollees (those eligible for both Medicare and Medicaid), reduce unnecessary costs, and minimize disconnects between the two programs. The Dual Eligible Special Needs Plan (D-SNP) –state contracting requirement as well as the financial alignment demonstration projects enabled by the Affordable Care Act (ACA), and creation of the Medicare-Medicaid Coordination Office (MMCO) are good first steps, but more is needed.

Previous NAMD documents have discussed specific areas of fragmentation between the programs as well as the opportunity for states to address some misalignments as part of their financial alignment demonstrations initiatives with CMS. NAMD continues to support the work of the MMCO and states to test new alignment models for the dually eligible population. In this paper, we address another possible pathway for integration that states may pursue: D-SNPs.

### *Current Situation*

According to the Congressional Budget Office, duals account for 13 percent of the combined population of enrollees but 34 percent of total spending.[1] Costs to provide care are high, health outcomes are poor, and the opportunity for innovation, cost savings, and better health care experiences for the dual eligible population are great.

Combined annual Medicare and Medicaid costs for the dually eligible population are about $300 billion of the roughly $900 billion spent annually on Medicare and Medicaid.[2] Much of the high cost is associated with high rates of chronic conditions like diabetes, cardiovascular disease, Alzheimer's and depression among people who receive both Medicaid and Medicare. Three in five have multiple ailments and more than two in five are mentally impaired. Nursing homes are an especially expensive form of health care and drive up cost. Among the dual eligible population, 70 percent of Medicaid costs are for long-term care including nursing homes. [3,4]

[1] See "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies" issued by the CBO, based on 2009 data : http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf
[2] See "Medicare-Medicaid Enrollee Profile: National Summary" issued by the CMS, based on 2007 data : http://www.integratedcareresourcecenter.com/PDFs/National_Summary_Final.pdf.
[3] Medicare Payment Advisory Commission (MedPAC), "Report to the Congress: Aligning Incentives in Medicare," June 2010: http://medpac.gov/documents/Jun10_EntireReport.pdf
[4] Congressional Budget Office, "Rising Demand for Long-Term Services and Supports for Elderly People," June 26, 2013: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44363-LTC.pdf

# *Improving the D-SNP Model for Dually Eligible Beneficiaries*

***Problems with the Current Situation***

While chronic diseases and heavy use of nursing homes account for much of the cost, how the bills are split between the two payers (Medicare and Medicaid) contributes to high costs, mismanaged care and inefficient treatment. A report last year by the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency, concluded that conflicting incentives between Medicare and Medicaid leads health-care providers to avoid costs they are responsible for rather than coordinate care. In addition Medicare and Medicaid have several conflicting policies that result in administrative inefficiencies in the programs and confusion for enrollees.[5] We can and must do better.

***Medicare-Medicaid Integration Options***

Today, there are two primary federal efforts to focus on improving care for the dually eligible population. First, the D-SNPs were created within the Medicare Advantage program to focus on enhancing benefits for dual eligibles. In later years, the Medicare Improvements for Patients and Providers Act (MIPPA) required that new or expanding D-SNPs have contracts with the state Medicaid agency in order to drive integration between the D-SNPs and Medicaid.[6] The ACA extended this requirement to all SNPs effective in 2013. The contracting requirement has led to incremental integration between some D-SNPs and state Medicaid programs.[7] However, in many states, there remains no meaningful integration or even coordination of care across the service continuum, including in some instances where D-SNPs have contracts with the state Medicaid agency. Further, states that have chosen to focus on the D-SNP platform for integration continue to identify legislative and administrative barriers to alignment.

More recently, the ACA established the MMCO to focus on the delivery of high-quality, coordinated care for dually eligible individuals. The MMCO has the authority to test innovative payment and delivery system models.[8] To date, the MMCO's work with states has focused primarily on access to data and on developing and implementing two demonstration models to better align services and supports for the state's dually eligible population. These include a capitated model and a managed fee-for-service model. The

[5] MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2012: http://www.medpac.gov/chapters/Jun12_Ch03.pdf

[6] Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L.110-275): http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf

[7] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System," June 2012 http://www.medpac.gov/chapters/Jun12_Ch03.pdf

[8] The MMCO is established within CMS' Centers for Medicare and Medicaid Innovation (CMMI). Congress set in statute specific functions for the MMCO. However its waiver authorities are limited to those granted to the Secretary's authority for CMMI. Specifically the ACA gives the Secretary authority to waive such requirements of Title XVIII (Medicare) and Title XI (general provisions, administrative simplification, civil money penalties/fraud and abuse) of the Social Security Act as may be necessary *"solely for the purpose of carrying out this section with respect to testing models described in subsection (b)."* The authority granted to waive provisions of Title XIX (Medicaid) applies to only three sections of the law: the requirement that Medicaid programs must be operated statewide; the requirement that states must have a public process to determine provider payment rates; and the requirement, within a section pertaining to Medicaid managed care, that no federal funds are available to pay for managed care except under a contract with the State under which prepaid payments are made on an actuarially sound basis.

MMCO has not yet issued comprehensive guidance addressing how it could work with interested states to improve upon the D-SNP platform to achieve these goals and to test other innovative options.[9]

***D-SNP and Medicaid Misalignments***

The fragmented system of care for dual eligibles makes it challenging for CMS, states, and providers to offer an integrated continuum of care with aligned clinical and financial structures. This fragmentation makes it difficult, if not impossible, for people that need services the most to navigate the complex system that has evolved over time.

The efforts to redesign the system of care must consider that Medicaid and Medicare are distinct programs, and that each state has a unique program designed to meet the needs of their beneficiaries. Medicaid programs are differentiated on a number of critical factors, including the following:

- Procurement/contract timelines which can be driven by the start of a state fiscal year, state budgets, or other programmatic characteristics
- Member materials describing Medicaid services (including prescription drugs), rights and policies/processes
- Quality assurance processes
- Nuances in provider networks driven by geography or enrollee needs
- Systems capacity
- Healthcare delivery system structure
- Marketplace maturity of managed long-term care programs
- Beneficiary, provider and advocacy priorities that have led to unique state policies and approaches
- Political dynamics that have shaped Medicaid program policies and operations over many decades

In contrast, the D-SNP program must adhere to the nationally uniform Medicare Advantage program rules. This singular approach may not recognize the unique and varied needs of the dual eligible population. It also creates misalignments with the state-specific structure for the Medicaid program, which can and does target initiatives to certain subpopulations or conditions. Many of these areas of misalignment result in confusion for beneficiaries and impede access to the highest quality care. They also produce administrative inefficiencies and perpetuate clinical and financial misalignments.

Specifically, areas of non-integration between the D-SNP and Medicaid programs include:

[9] For example, see April 10, 2013 letter from Tom Betlach, Director, Arizona Health Care Cost Containment System (AHCCCS)

- Temporary authority for the D-SNP program under Medicare Advantage versus the state administered Medicaid entitlement program
- Business system standards for the behind-the-scenes, day-to-day integration functions, including enrollments, payments, care management, and utilization management
- Separate assessments and models for care
- Separate policies for performance and quality improvement initiatives
- Different policies with respect to enrollment in managed systems of care
- Misaligned enrollment time periods based on a single federal Medicare Advantage policy and distinct state enrollment time periods
- Separate reviews of member materials by the state and respective CMS Regional Office that lead to conflicting or erroneous information
- Two separate processes required for individuals to enroll in Medicare and Medicaid
- Two benefit packages with duplication across certain services
- Different standards and processes with respect to medical necessity determinations
- Two cards, two sets of member materials and two provider directories
- Two sets of notices
- Inefficiencies for beneficiaries needing Medicaid coverage for services denied by Medicare
- Duplicative provider billing requirements
- Two different member service responses
- Potential conflicts between Medicare and Medicaid provider networks and network adequacy standards
- Lack of a consistent vehicle for CMS and states to communicate about entry and exit of plans to the D-SNP market
- Different approaches and requirements with respect to monitoring and oversight of health plan operations

The D-SNP-state contracting requirement and the establishment of the MMCO represent important steps towards integration. However, CMS has not yet presented a clear pathway for how the opportunities in the MMCO's financial alignment demonstration initiative can carry over into D-SNPs either under the demonstration authority or under regular D-SNP arrangements. Federal policymakers must address this gap in guidance for states.

***Improvements to the D-SNP Integration Pathway***

Further progress towards D-SNP integration will require a combination of federal legislative and administrative actions focused on reducing barriers and further supporting state initiatives

to drive alignment between the D-SNP program and state Medicaid agencies. This includes action to:

- Establish the D-SNP program as a permanent pathway for states to integrate care for the duals
- Provide a uniform definition for “integrated D-SNP” that includes cross-cutting care coordination requirements and integrated systems
- Clearly define the critical role of the state Medicaid agency in the contracting and oversight of integrated D-SNPs
- Eliminate statutory misalignment in policies and procedures pertaining to enrollment and grievance and appeals
- Allow the MMCO to grant exceptions to Medicare’s processes, requirements and timelines and waive Medicaid provisions which impede alignment initiatives
- Focus MMCO initiatives on integrated D-SNP agreements with states
- Create a permanent federal team to work with states on ongoing D-SNP administration issues.

Policymakers should view these as interdependent recommendations necessary to create a successful, sustainable path forward, rather than standalone proposals. Taken together, we believe the recommendations will lead to improvements in beneficiary health and functional needs and system-wide improvements with higher quality and reduced costs for Medicare and Medicaid.

# *Recommendations to Congress*

## *RECOMMENDATION 1: ESTABLISH THE D-SNP PROGRAM AS A PERMANENT PATHWAY FOR STATES TO INTEGRATE CARE FOR THE DUALLY ELIGIBLE POPULATION.*

The President and Congress should permanently authorize the Dual Eligible Special Needs Plan program to solidify this as a pathway that states may use to improve coordination between Medicare and Medicaid.[10] Reauthorization must be done in conjunction with certain statutory and regulatory changes to streamline the delivery of care for duals, as discussed in the remainder of this paper.

Long-term authority with an enhanced state role to address areas of non-integration will improve the health care outcomes for duals and reduce cost by offering:

- ***Stable dual coverage***. Alleviating the uncertainty of authorization provides states, consumers, and D-SNPs the opportunity to structure long term solutions for dual eligible members. Frequent, short authorization periods limit state and private sector investment in the D-SNP delivery system. This dynamic needlessly limits alignment options and may threaten the stability of coverage for beneficiaries currently enrolled. While periodic review of policy is important, abbreviated authorization periods have made it difficult for states to plan for and finalize the scope of services, cost-sharing arrangements and contract terms with health plans that serve duals.

- ***Improved continuity of care, coordination and outcomes for enrollees***. The MIPPA contracting requirements, as amended by the ACA, were a good first step to foster alignments between Medicare and Medicaid to improve the health of duals.[11,12] However, the statutory requirement does *not* provide states a meaningful role in resolving the clinical, financial or administrative conflicts between D-SNPs and Medicaid that are necessary to improve the health of duals. States need statutory authority for a defined, ongoing role to resolve remaining areas of non-integration, particularly in programmatic areas where there is overlap between the D-SNPs and Medicaid as previously discussed. Enhancing state

[10] Currently the SNP program is authorized through 2013. In its March 2013 report to Congress, the Medicare Payment and Advisory Commission (MedPAC), issued a similar recommendation: http://www.medpac.gov/documents/Mar13_entirereport.pdf
[11] Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L.110-275): http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf with final regulations issued by the Centers for Medicare and Medicaid Services, available at: http://www.gpo.gov/fdsys/pkg/FR-2011-04-15/pdf/2011-8274.pdf. Section 3205 of the ACA Affordable Care Act amends 164(c)(2) of MIPPA.
[12] For additional information on the eight contract requirements, see: MIPPA State Contracting Options, available at: http://www.cms.gov/SpecialNeedsPlans/Downloads/MIPPA_State_Contracting_Options_010410.pdf

involvement will allow Medicaid agencies to align the specific model of care, services, provider network and accountability mechanisms expected of D-SNP plans, while still maintaining beneficiaries' access to the full range of Medicare services and protections.

- ***Consistency across integration initiatives.*** Extending and improving the D-SNP program is an important option for states pursuing a financial alignment or alternative D-SNP-based demonstration proposal with the MMCO as well as for states seeking to streamline D-SNPs and the state Medicaid program through the state plan. Ensuring that beneficiaries are provided consistent information, services and access is essential regardless of the approach. Further, states require enhanced authority so they may define whether and how the D-SNP program will operate in areas where there is an MMCO-approved alternative demonstration program. Currently, D-SNPs may operate in the same geographic area as health plans participating in a state's financial alignment demonstration. However, this situation may create unnecessary confusion for beneficiaries if the competing programs disseminate different materials to beneficiaries and operate under different rules. It can also create confusion and misaligned incentives for providers since they may be subject to different requirements under the demonstration as compared to those under the D-SNP program.

- ***Opportunity to conduct a comprehensive assessment of different integration models.*** A permanent authorization allows for robust assessment of the integrated D-SNP model. The states could compare the experience of an integrated D-SNP to other alignment models currently available through the MMCO. They would determine which, if any, would most effectively promote care coordination of high-quality services in the state as compared to the bifurcated system that exists today.

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## *RECOMMENDATION 2: ESTABLISH A UNIFORM DEFINITION FOR "INTEGRATED D-SNP" THAT INCLUDES COORDINATION AND INTEGRATION EXPECTATIONS ACROSS THE CONTINUUM OF CARE.*

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A critical component for improving the delivery of care for the dually eligible population is to establish a single definition for a clinically and financially integrated D-SNP which also mitigates operational barriers that otherwise would continue to impede integration. Specifically, federal policymakers should define an integrated D-SNP as one that:

- Assumes clinical and financial responsibility for Medicare and some or all Medicaid medical, behavioral, and long-term care services and supports; OR

- Assumes clinical and financial responsibility for Medicare and some or all Medicaid behavioral and medical services; OR
- Assumes clinical and financial responsibility for Medicare and some or all Medicaid long-term care services and supports and medical services.

While the federal government would set the overarching clinical and financial requirements for integrated D-SNPs, the state Medicaid agency would determine the type of integration approach applicable in its state, including any additional requirements integrated D-SNPs would be obligated to meet in order to operate in the state. Notably, these requirements are also consistent with the recommendations MedPAC outlined in its March 2013 report to Congress.[13]

***Medicare-Medicaid with D-SNPs will continue to evolve over time***

A maximum three year transition period to the integrated D-SNP definition would allow states and D-SNPs to develop the state-specific integrated model. The three year window is necessary to accommodate the different levels of readiness across the states as well as other state-specific programs or operational features. For example, several states already have fairly mature managed care programs, including managed long-term services and supports, with high levels of integration with D-SNPs. These states may have the expertise and capacity to transition to integrated D-SNPs in fewer than three years. Many other states recently implemented or have plans to implement managed care programs in one or more of the clinical service areas. This latter group of states may need the full three years to develop the integrated model with D-SNPs and align implementation of the model with the state's procurement processes.

The maximum three-year transition period for D-SNPs would allow for the following improvements:

- ***Phased clinical integration.*** A three-year transition enables states to develop the appropriate systems, infrastructure, and business relationships with D-SNPs to establish integrated programs. The level of integration will evolve over time as states build the necessary infrastructure and expertise across the continuum of medical, behavioral, long-term services and functional services and supports. As their capacity and experience mature, states would include additional populations in their coordination initiatives with the integrated D-SNPs.

- ***Opportunity for CMS and state officials to address state-specific integration challenges.*** Federal regulatory policy can provide the overarching parameters for the

[13] MedPAC, "Report to Congress: Medicare Payment Policy," March 2013: http://www.medpac.gov/documents/Mar13_EntireReport.pdf

state role in managing the D-SNP program. Still, there will be state-specific Medicaid nuances that federal and state policymakers must address during this transition period. They will need time to develop solutions appropriate to the state Medicaid program in order to meet the needs of dually eligible enrollees, including resolving disconnects between Medicare Advantage and Medicaid provider network requirements, coordinating member materials, and formalizing the care coordination activities between Medicare and Medicaid providers.

- ***Improved alignment of deadlines for Medicare D-SNP and Medicaid contracting and materials.*** CMS requires D-SNPs to meet the uniform Medicare schedule for application, marketing and other materials. However, Medicare's rigid schedule conflicts with the state-specific procurement timelines and related policy decisions which are often structured around the state fiscal year. For example, the Medicare process currently begins almost two years before the start of the actual plan year (e.g. fall of 2012 for plan year 2014). During this time, states seeking to improve alignment must procure for and negotiate with D-SNPs that will also participate in the Medicaid program. In many instances, it is difficult for states to know both which D-SNPs are interested in participating in Medicaid and, of these, which CMS will ultimately approve to participate in the Medicare Advantage D-SNP program.

After the three year timeframe, authority would expire for those D-SNPs that do not meet the specified integrated definition, although a state may complete its integration process sooner. The state would develop a comprehensive transition plan for enrollees that would take effect in such circumstances. In order to minimize potential disruptions in service delivery, states would include the following in their enrollee transition plans:

- Enrollee education and outreach regarding the transition to an approved integrated D-SNP plan and alternative service delivery options
- Requirement that ineligible plans share information about services previously provided
- Qualifications for integrated D-SNPs eligible to receive passive enrollment[14]
- Policies for ensuring continuity of providers and services.

The maximum three-year transition period allows policymakers to balance the shared goal of full integration with the reality of state systems transformations and planning needs and timelines. However, the integrated definition is not intended to preclude any state selecting the

[14] Many states already have a passive enrollment policy for certain populations in their Medicaid program. Passive enrollment allows a state to automatically enroll a beneficiary in a plan chosen by the state Medicaid agency unless – before the effective enrollment date – the beneficiary chooses to enroll in a specific Medicaid plan. Many states require plans to authorize payment for a non-network provider during the beneficiary's transition period. In the case of Medicare services for the dually eligible population, beneficiaries also currently can elect to remain in original Medicare. CMS has explicitly permitted states to use passive enrollment in the financial alignment demonstrations approved to date. To date, most states plan a voluntary enrollment period followed by a passive enrollment period.

D-SNP program as its pathway to improve coordination for the dually eligible population. The proposed changes are prospective for states that may explore integration pathways at any point in the future. Ultimately, the policies governing the transition to integrated D-SNPs must meet state systems as they are today.

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### *RECOMMENDATION 3: CLEARLY DEFINE THE ROLE OF THE STATE MEDICAID AGENCY IN CONTRACTING AND OVERSIGHT OF INTEGRATED D-SNPS*

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Long-term authority for the integrated D-SNP program must be paired with a statutorily authorized role for the state Medicaid agency. A defined role for Medicaid agencies will allow states to drive greater administrative alignment and systematic coordination of care. Doing so will create a better experience for enrollees and facilitate the flow of information gathered in one area of care– acute care, long-term services and supports, or behavioral services – to other providers involved in the development and implementation of treatment plans.

Specifically, Congress should clarify the following parameters for the state-D-SNP contracting arrangements:

- The state Medicaid agency retains authority to define the procurement process for selection of Medicaid plans, including those plans that will have opportunity to serve as integrated D-SNPs.
- The state Medicaid agency retains authority to determine the scope of clinical and financial responsibility that D-SNPs must assume, consistent with the revised definition for D-SNPs described above.
- Integrated D-SNPs must comply with the state Medicaid agency's initiatives to target subsets of the state's dually eligible population
- The state has authority to hold plans accountable for the targeted initiatives and features of the state Medicaid program, as well as requirements set forth in the state's MIPPA agreements pertaining to integration and coordination of care for dual eligible members.

Congress must address gaps in the state's authority for contracting with D-SNPs to ensure beneficiaries retain access to the full scope of benefits and services they are entitled to under both programs *in a coordinated fashion*. Clarity in these areas will give states the contracting tools they need to hold D-SNPs accountable for state-specific goals, program characteristics, and operational and administrative responsibilities. For example, states may want to include language in their D-SNP contract that aligns with the state's Medicaid home and community-based programs, health homes, and other waivers and state plan programs. Several states

also currently have statutory exclusions – known as "carve-out" arrangements – for certain benefits or diagnoses from Medicaid managed care programs.

## *RECOMMENDATION 4: ESTABLISH A UNIFIED SET OF RULES FOR INTEGRATED D-SNPS*

It is well known that Medicare and Medicaid have complex administrative and procedural rules. In addition to their complexity, several key aspects of the two programs are simply incompatible. While states have worked with CMS to make progress in some areas, statutory requirements continue to hamper further movement towards alignment between the programs, including in states that choose to utilize D-SNPs as their integration platform. Notably, these policy conflicts translate into real world problems for individuals who are forced to navigate the idiosyncrasies of dual eligibility for Medicare and Medicaid.

A unified set of rules would help to mitigate several of these barriers.[15] Congress should grant the Secretary for the Department of Health and Human Services authority to develop unified rules for D-SNPs that would accomplish the following objectives:

- ***Consolidate marketing and outreach materials for the dually eligible population.*** Beneficiaries currently receive separate marketing and educational materials for Medicare and Medicaid benefit packages, even though they may be offered through a single health plan or provider. Streamlining the flow of information to beneficiaries would provide beneficiaries with a more holistic picture of the benefits available. Beneficiaries would be better able to assess the continuum of care and services that a health plan or provider is offering.

- ***Establish a single administrative process and an eligibility verification system for enrollment.*** Today, in many states dually eligible individuals must complete separate enrollment processes for Medicare and Medicaid even if their plan is responsible for the individual's Medicare and Medicaid services. Consistent with the concept of an integrated D-SNP, streamlined rules should be developed to allow the beneficiary to complete one process to enroll in a health plan to provide all of the services they are entitled to under the Medicare and Medicaid programs.

[15] MedPAC, "Report to Congress: Medicare Payment Policy," March 2013: http://www.medpac.gov/documents/Mar13_EntireReport.pdf

Of note, however, is that the single administrative enrollment process may not be sufficient for resolving the full scope of challenges with enrollment coordination. Today, some states coordinate the enrollment for Medicaid and Medicare into a D-SNP "behind the scenes," but they have identified information and update gaps between the Medicare and Medicaid eligibility verification systems. This has led to operational issues in some programs. Therefore CMS should examine the feasibility of partnering with states on a system that allows for real-time Medicare and Medicaid eligibility and enrollment verification for all integrated Medicare-Medicaid coordination plan enrollments.

- ***Strengthen the state option to conduct passive enrollment, implement mandatory enrollment and lock-in policies.***[16] State Medicaid agencies currently have authority – and extensive experience with – administering passive enrollment, mandatory enrollment and lock-in policies for the Medicaid portion of the beneficiary's services. Parallel authority is needed for the Medicare component of the benefit package. Today beneficiaries may enroll in different health plans for their Medicare and Medicaid benefits or they may be required to enroll in a Medicaid health plan but remain in the unmanaged Medicare fee-for-service program. These situations make it difficult for states to facilitate better-coordinated and beneficiary-centered care that could be available by combining the full continuum of services dual eligibles need into a single benefit package, delivered by a single organization responsible for coordinating all services.[17]

- ***Coordinate grievances and appeals for the dually eligible population***. CMS has taken steps to implement an integrated denial notice for Medicare and Medicaid.[18] However, dually eligible beneficiaries must still navigate different appeals and grievances procedures depending on which program is financially responsible for the benefit at issue. Instead, there should be a single pathway for individuals to pursue their appeals and grievance regardless of whether the service at issue is guaranteed under the Medicare or Medicaid program, taking into account unique circumstances (e.g., court orders) that may exist in states.

[16] Passive enrollment is a process through which beneficiaries receive multiple notices about their enrollment options. Typically if the beneficiary does not opt out of the program, he or she is passively enrolled into a health plan in his or her geographical location. States also may utilize tools to ensure the health plan is best suited for the beneficiary's full range of needs. In conjunction with the financial alignment demonstrations that states are working with the MMCO to implement, CMS has said that states may not lock beneficiaries who are dually eligible for Medicare and Medicaid into managed care programs for fixed periods of time. Though no official guidance has been issued from CMS, a letter was sent last summer by CMS to state Medicaid directors that took a position against locking in beneficiaries for any set length of time.

[17] See, for example, the discussion by CBO about the challenges to integration which include the lack of authority for mandatory enrollment for Medicare services. See page 25 of the June 2013 white paper: http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf

[18] See, MA Denial Notices: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html (accessed August 29, 2013)

Notably, these recommendations are largely consistent with those issued in MedPAC's March 2013 report to Congress.[19] Further, the MMCO also has undertaken a comprehensive review of these and other barriers which, when combined with the office's ongoing work with states on financial alignment demonstrations, should help to inform a regulatory framework.

Unified rules in these areas would afford a more rational way to administer these policies and procedures for CMS and states as well as the dual eligible population. Doing so also presents an opportunity to smooth the experience of the dual eligible individual as he or she evaluates options for receiving coordinated services.

## *RECOMMENDATION 5: GRANT THE MMCO AUTHORITY TO HARMONIZE D-SNPS WITH STATE-SPECIFIC MEDICAID REQUIREMENTS*

In addition to resolving specific clinical and procedural areas of misalignment, Congress should establish a mechanism to address other barriers which stand in the way of D-SNP and Medicaid alignment.

Often these barriers are state-specific in nature and can originate in court decrees or state laws and regulations that are beyond the purview of the Medicaid agency. In addition, existing regulations, including MIPPA's contract requirements, do not consider how D-SNPs should operate in states that are implementing financial alignment demonstrations as the platform to improve coordination across the continuum of care for the dually eligible population.

Specifically, Congress should grant the MMCO authority to address these situations by doing the following:

- ***Expand the MMCO's authority to waive provisions of the Medicaid statute.*** While the MMCO's existing waiver authority has allowed states and CMS to make progress towards their alignment goals, states have found that this authority is limited in that it does not fully account for all the ways in which Medicaid's rules may conflict with those for Medicare.[20] To truly drive alignment between the programs, the MMCO requires broader Medicaid waiver authority equal to that already provided for Medicare. It also would allow the MMCO

19 MedPAC's March 2013 report did not make a recommendation to Congress concerning passive enrollment or mandatory enrollment or lock-in policies.

[20] Title XIX (Medicaid) applies to only three sections of the law: the requirement that Medicaid programs must be operated statewide; the requirement that states must have a public process to determine provider payment rates; and the requirement, within a section pertaining to Medicaid managed care, that no federal funds are available to pay for managed care except under a contract with the State under which prepaid payments are made on an actuarially sound basis.

to modify Medicare processes or policies if the state Medicaid agency identified this as the most feasible pathway for integration. Waiver authority would be employed with the clear intent of improving the care for dually eligible enrollees. Consistent with the MMCOs existing authority, the Medicaid waiver authority would not be used to undermine the entitlement to Medicaid services and protections.

- ***Establish a Medicare exceptions process for alignment initiatives.*** States pursuing the integrated D-SNP platform for integration may need exceptions to Medicare's singular approach to the D-SNP program. Today, the D-SNP rules are linked to those governing the Medicare Advantage program. This presents challenges for states as they try to harmonize Medicare's timelines, oversight, reporting and other requirements with Medicaid requirements and court decrees to which the state may be subject.

The modified authority to align Medicaid with Medicare and to grant states exceptions to Medicare rules would serve to ensure states and CMS can adopt the most appropriate policy for the beneficiary. These authorities are essential for facilitating ongoing D-SNP alignment agreements between states and CMS, as described in the following section.

### *RECOMMENDATION 6: THE MMCO SHOULD FACILITATE INTEGRATED D-SNP AGREEMENTS WITH STATES.*

Over the last several years, the MMCO facilitated D-SNP efforts to meet the requirement to contract with state Medicaid agencies by the 2013 contract year.[21] The MMCO's efforts should not stop there. As previously noted these contracts are limited in their ability to resolve other major areas of non-integration. The MMCO should focus resources on resolving areas of non-integration between Medicaid and D-SNPs.

Specifically, the MMCO must convene staff from CMS' Medicare D-SNP and Medicaid divisions as well as state Medicaid agencies to facilitate agreements between interested states and CMS. The agreement would serve to memorialize the respective federal and state roles for oversight.

***CMS-State D-SNP agreements can improve efficiency and effectiveness of Medicare-Medicaid integration.***

The integrated D-SNP agreement would focus on the individual and joint agency roles and responsibilities. It would identify specific activities where Medicare and the state Medicaid agency would conduct coordinated – not duplicative – activities, particularly with regard to which level of government will conduct oversight to ensure compliance with the coordinated set of rules for the D-SNPs in the state. This approach also ensures that the dually eligible population will benefit from the state Medicaid agency's proximity to beneficiaries and their sites of care.

States wishing to leverage the D-SNP model to improve the beneficiary experience would work with CMS to determine which components would be addressed in the state-specific integrated D-SNP agreement. Issues that are not addressed in the agreement would be handled as they are today. Table 1 below identifies the major components of the integrated D-SNP agreement and examples of the specific activity within each component. The goal of the agreement is to streamline administration through one level of government, but it is equally essential that the agreement encourages ongoing collaboration between CMS and the state agency.

[21] MMCO Alignment Initiative update, March 12, 2013: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/AlignmentInitiativeUpdate.pdf

**Table 1. Components of CMS and state agreements for integrated D-SNP programs**

| *Agreement Category* | *Components* |
|---|---|
| **Submission timeframes and deadlines** | • Alignment of Medicare and Medicaid timelines for submission of materials for contracts and readiness documents. |
| **Oversight of marketing materials and activities** | • Review, approval and oversight of integrated D-SNP informational materials.<br>• Specify the role of brokers. |
| **Oversight of member outreach and education** | • Review and oversight of consolidated information for beneficiary plan options and benefit packages. |
| **Enrollment policies** | • State option to conduct passive enrollment, implement mandatory enrollment and lock-in policies.<br>• State specifies the frequency and tools for ensuring beneficiaries receive timely and accessible information on the changes and their options. |
| **Services** | • Alignment of policies for any services that may be outside the scope of the definition of the integrated D-SNP, pharmacy, durable medical equipment, and nursing services. |
| **Network adequacy reviews** | • Alignment of requirements concerning network adequacy reviews, including the standards and exceptions process that will be applied, and the role of CMS and the state Medicaid Agency, consistent with the clinical definition for the integrated D-SNP. |
| **Quality assurance** | • Alignment of quality measures, including the elimination of duplicate or substantially similar measures currently required by Medicare and Medicaid.<br>• Alignment of priorities to focus on quality measures appropriate to the population or subpopulations of the dual eligibles enrolled in the integrated D-SNP.<br>• Alignment of reporting requirements for quality measures. The agreement also could specify which level of government would manage the quality review and reporting processes. |
| **Plan performance measurement** | • Alignment of management of review and requirements for public reporting of performance. |

| | |
|---|---|
| **Grievance and appeals** | • Alignment of other policies and process for beneficiaries and providers that may not be captured in other statutory or regulatory efforts to align these procedures. |
| **Program integrity** | • Alignment of requirements and oversight activities to clearly delineate federal and state responsibility for oversight and remove duplicative policies. |

The agreement would take into account the CMS and state resources and capabilities, and the federal requirements where CMS has a statutorily mandated role in the oversight process. It also would delegate how CMS and the state would coordinate monitoring and evaluation of the quality of integrated D-SNP programs. For example, one but not both programs would bear responsibility for conducting ongoing quality assurance reviews and overseeing enrollee outreach and education.

Policymakers should ensure that such agreements could be modified when needed to incorporate future federal or state legislation, additional processes, or other changes to improve program and service delivery in each state. CMS and the state would work collaboratively to manage the agreement, and review, monitor, and approve activities as necessary in the designated areas of responsibility. The agreement would serve as a continuing blueprint of policies and operational responsibilities for the federal and state agencies.

### *RECOMMENDATION 7: ESTABLISH A PERMANENT FEDERAL TEAM THAT WILL WORK WITH STATES ON ONGOING D-SNP ADMINISTRATION ISSUES.*

In the absence of a true partnership, breakdowns in communication and misalignments throughout the Medicare Advantage D-SNP and Medicaid contracting and operational processes can lead to suboptimal care for dually eligible beneficiaries, hamper effective plan contracting and management activities, and inefficiently use federal and state taxpayer resources. The CMS-state integrated D-SNP agreement would be an important step in addressing the fragmentation between the D-SNP and Medicaid programs. However, the agreement does not immediately rectify the silos that exist between federal Medicare staff and state Medicaid agencies as it relates to the D-SNP program.

In addition to the agreements, the MMCO should establish a dedicated D-SNP team that would work with states to address misalignments that arise in daily administration and affect all those involved – beneficiaries, CMS, states, and plans. The federal D-SNP team would serve as a

consistent point of contact for states as issues arise with D-SNPs. It also would facilitate a uniform process for disseminating Medicare information impacting the D-SNP program to state contacts.

The following are examples of critical daily administration issues on which the federal team and states need to regularly communicate to improve the beneficiary experience and avoid duplication of effort by the Medicare and Medicaid programs:

- Entry and exit of D-SNPs, including evaluations to determine whether a plan meets the revised qualifications for an integrated D-SNP as defined earlier in this paper;
- Identification of risks to health, safety or welfare of enrollees. The teams also would develop and implement solutions to any such risks;
- D-SNPs that have corrective action plans with either CMS or the state;
- Transition planning for enrollees, if necessary;
- Verification of dual status prior to enrollment in Medicare; and
- Other issues that would disrupt care for beneficiaries.

CMS also should continue to meet the demand for information from states newly interested in exploring the D-SNPs as a platform for integration. While helpful, CMS' existing D-SNP Resource Center is underutilized – by CMS and states – and limited in its scope.[22] New content could be added to highlight how states have used D-SNPs to drive integration. The following are examples of the types of resources that would assist states:

- Basic coordination agreement for states to adapt with their D-SNPs
- Examples of agreements that cover cost sharing and cost sharing/extended Medicaid benefits
- Immediate identification of Medicare changes applicable to the SNP program.

The Resource Center has potential to improve collaboration with states, particularly those who are newly exploring the option of improving integration using the D-SNP model.

[22] CMS State Resource Center http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/StateResourceCenter.html

# CONCLUSION

We must act now. NAMD's proposals represent necessary first steps for addressing the full scope of obstacles to alignment between D-SNPs and Medicaid. We recognize that the details of these recommendations may involve difficult decisions and that other issues may not find resolution in the short-term. NAMD and its members are prepared to collaborate with Congress, the Administration, beneficiaries, and other stakeholder groups to ensure ongoing improvement for this population and increasing efficiencies for the federal government and states.

***The National Association for Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). NAMD provides a focused, coordinated voice for the Medicaid program in national policy discussion and to effectively meet the needs of its member states now and in the future.***