SNP Alliance Proposal

Smart Growth Approach to Integrating Medicare and Medicaid for Dual Beneficiaries

September 2013

The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality."

--MedPAC, *Coordinating the Care of Dual Beneficiaries, Chapter* 5, Report to Congress: Aligning Incentives in Medicare, June 2010.

Background

Today, our nation spends over $300 billion per year in caring for 10.2 million persons who are dually eligible for Medicare and Medicaid. Dual beneficiaries account for 31% of Medicare fee-for-service (FFS) spending and 40% of Medicaid spending. Approximately eighty percent of dual expenditures are federal. Most of these costs are related to caring for frail elderly, adults with disabilities, and persons with serious illnesses. Approximately 60% of disabled and 20% of elderly dual eligible persons have mental disorders.

In addition, most duals are not just poor, but very poor. Approximately 58% of duals have incomes below 100% of the federal poverty level ($10,890 for individuals). Most with incomes above 150% of the Federal Poverty Level (FPL) have substantial health and long-term care needs.

As of December 2011, 19% of all Medicare FFS beneficiaries were dually eligible for Medicare and Medicaid, with 18.8% of all dually eligible persons enrolled in managed care. About half of this enrollment was persons enrolled in Special Needs Plans (SNPs). Dual eligible persons represent only about 8% of the total enrollment for regular MA plans. Using estimates provided in MedPAC's March 2013 Report to Congress, as of March 2013, approximately 1.4 million duals were enrolled in SNPs, the only MA plan besides PACE authorized to exclusively enroll and provide specialty care for dually eligible persons. Approximately 22,000 duals are enrolled in PACE.

The original 2003 SNP provisions were intended, in large part, to mainstream key elements of prior dual integration demonstrations that had been operating for decades. Recently, the CMS Dual Office, a number of State Medicaid agencies and MedPAC have provided ground breaking leadership in advancing the cause of integration. Many states are building off the D-SNP platform, and the Dual Office is requiring those participating in the Financial Alignment Demonstration (FAD) to meet MA-SNP Model of Care requirements.

National Integration Demonstrations

Currently, the core of integration is being advanced through the 15-State Dual Integration Demonstration and the FAD, as administered by the CMS Dual Office. The following characterize these developmental efforts:

1. Integration organized on a state-by-state basis.
2. 15 states have adopted a capitated, risk-based financing strategy; 7 states will use Managed FFS.
3. CMS and 7 states have signed memorandums of understanding to implement full capitation in 2013. 6 are under the FAD (CA, IL, MA, OH, NY, and VA) and 1 is under the State Design Demo (MN). One state has signed a FFS MOU (WA).
4. 7 states have withdrawn from the FAD, i.e. AZ, HI, MN, NM, OR, TN, WI and along with other states, will advance integration through other means.
5. Most fully capitated programs, inside and outside the FAD, are building off a D-SNP platform.
6. All are pursuing some form of passive enrollment for Medicare benefits; and most are using some form of mandatory enrollment for Medicaid.
7. Most states are building off health homes and ACO principles to craft targeted, total care approaches within the context of specialized managed care.
8. Savings of up to 5% by the third year will be shared by state and federal governments.
9. Details on financing, performance evaluation, and program oversight are still being resolved.

Many involved in dual integration demonstrations prior to their designation as SNPs are actively engaged in the SNP Alliance. The SNP Alliance offers the following considerations to improve the chances of success for the current and next-stage integration efforts.

Goals and Objectives

The SNP Alliance believes *full integration* of *all* Medicare and Medicaid financing, administration, and care management for duals can significantly improve *total* quality and cost performance in care of dual beneficiaries.

Managed FFS efforts can serve as a stepping-stone to full integration but not as an alternative endgame.

For dual beneficiaries, full integration will:
- Simplify access to benefits and services.
- Improve the experience of receiving care.
- Improve a person's health and wellbeing.

For state and federal governments, full integration will:
- Bend the per capita cost curve.
- Reduce administrative costs and cost-shifting.
- Achieve better results.

For specialized managed care plans, full integration will:
- Eliminate duplication and conflicts in policy.
- Eliminate impediments to specialization.
- Empower plans to transform how care is provided.

Vision for a Dual Integration Program

To achieve these goals, all stakeholders must move toward establishing a new program with the following elements:

1. **A single federal/state program.** All funding, program policy and oversight are managed through a single program structure with aligned federal and state authority, roles, responsibilities, and shared financing.
2. **Single access.** Eligible beneficiaries would receive a single set of materials that describe a single set of benefits and services that can be accessed through a single source, using a single enrollment card.
3. **Passive enrollment with strong consumer protection.** Dual eligible persons would be fully informed of their options, rights, and opportunities, with ample time and support in making enrollment decisions and obtaining care arrangements of unique importance to them.
4. **Health plans as program integrators.** Health plans would be responsible for administering a full spectrum of Medicare and Medicaid benefits and services to defined subgroups living within defined service areas.
5. **'All in' risk-adjusted, capitated financing.** Plans would be paid using a single, prospective, population-based, risk-adjusted, capitated PM/PM payment method that encompasses all federal and state funds and fully accounts for all risk factors associated with serving a plan's target enrollment. (*See Issue Brief on Payment*)
6. **Enriched health homes as integrators of care**. Dual beneficiaries would be able to work with a single primary care/care manager and related interdisciplinary care team to help access and manage their volatile, complex and ongoing care needs as they evolve over time and across care settings.
7. **Affiliated specialized care networks.** Primary and acute services would be integrated with behavioral health and/or long-term care services so that persons served by related care providers would follow a common, individual care plan, supported by integrated information system capabilities, simplified care transitions and aligned policies and procedures.
8. **Appropriate, parsimonious and aligned oversight.** All reporting and evaluation methods would be fully integrated, using simplified and meaningful measures and methods appropriate for beneficiaries served. (*See Issue Brief on Performance Evaluation*)
9. **System management methods.** Federal, state, and plan administrators would use methods to: eliminate cost shifting through a systems, not provider-based approach, integrate program administration, and improve "total" quality and cost performance across the care continuum. (*See Issue Brief on Integrating Program Administration*)
10. **Shared savings.** Federal and state governments, as well as plans, providers and consumers, would share in the benefit of savings accrued by this new program.

Pathway to Success

1. **Build on Momentum.** Some states and related SNPs in Arizona, Oregon, Massachusetts, Minnesota, Wisconsin, etc. as well as PACE, Evercare, Social HMOs, and the National Chronic Care Consortium have been involved in dual integration efforts for decades. Initial SNP provisions were intended to mainstream standard operating procedures contained in many of these prior demonstrations. It's important to build on prior experience while advancing new methods. *(See Plan Selection Criteria)*
2. **Balance Medicare and Medicaid authorities.** Some believe care for duals should be controlled by States and built on a Medicaid platform. Others believe duals are best served through a national program built on a Medicare platform. It is critical to find common ground in advancing new structures.
3. **A Master Plan for Full Integration.** It is impossible to fully align all elements of care for duals at once. CMS and states must establish a master plan for advancing full integration of roles, responsibilities and authority, and for payment, policy and performance evaluation methods over time.
4. **Protect the vulnerable.** It is absolutely vital to protect the most vulnerable high-cost/high-risk subgroups in transitioning to full integration and ensure current specialty care options are maintained if not enhanced.
5. **Make upfront investments for long-term savings.** Improving long-term quality and cost performance requires new operating systems. Aggressive upfront savings can reduce costs in the short-term, but it also can impede the ability to establish methods that are central to improving quality and costs over time.
6. **Permanently extend SNP platform.** While the SNP Alliance embraces current national demonstration efforts, it is equally important to eliminate the confusion, complications, and waste associated with caring for ALL dual beneficiaries. Congress should provide stability for states and plans advancing dual integration over time by permanently extending D-SNP authority, including provisions for eliminating key financial, policy and oversight barriers.