Progress and Challenges

Congress' passage of the Bi-Partisan Budget Act of 2018 enabled significant movement towards long-standing goals for integrating Medicare and Medicaid for the nation's 12 million dually eligible beneficiaries. SNP Alliance members serve over 2 million dual beneficiaries enrolled in SNPs and MMPs, including 52% of the nearly one million dual beneficiaries now served under fully integrated SNPs and Medicare-Medicaid Plans (MMPs).

States and plans continue to implement contract amendments for care coordination, data sharing and uniform Grievance and Appeals due 2021 as required by the Medicare Medicaid Coordination Office (MMCO). However, limited state resources and operational misalignments remain. Conflicts in procurement policies and service areas, lack of enrollment in the same plan, and measurement disconnects still pose obstacles to expansion of integrated D-SNP models in some states. Policy leaders continue to try to address these barriers.

The SNP Alliance believes the starting point for consensus on design and expansion of any integrated models must be to clarify the primary goals and necessary elements for defining "integration" regardless of program authority, as outlined below:

Goals for Dual Integration

We believe, for dual beneficiaries, integration should:

- Simplify access to benefits and services.
- Improve the experience of receiving care.
- Improve a person's health and well-being.

For state and federal governments, integration should:

- Bend the per capita cost curve.
- Reduce administrative costs and cost shifting.
- Achieve better results.

For specialized managed care plans, integration should:

- Eliminate duplication and conflicts in policy.
- Eliminate impediments to specialization.
- Empower plans to transform how care is provided.

Elements of Dual Integration

1. **Fully aligned financing, policy direction and oversight.** Program policy and oversight functions are managed through a federal-state partnership with aligned federal-state authority, roles, responsibilities, and financing.
2. **Single set of benefits and services.** Eligible beneficiaries access a fully integrated set of benefits and services that include medical, behavioral health, and LTSS.
3. **Single source of access.** Eligible beneficiaries are enrolled in the same plan or sponsor for benefits and services. They receive a single set of integrated materials that describe a single set of benefit and services that can be accessed through a single set source with one enrollment card and a single benefit determination.
4. **SNPs/MMPs as program integrators.** SNPs/MMPs are responsible for administering the full spectrum of Medicaid and Medicare benefits and services for defined subgroups within service areas.
5. **Strong consumer protections.** Beneficiaries are fully informed of their options, rights, and opportunities, with ample time and support in making enrollment decisions and safeguards for high-risk/high-need beneficiaries. Appeals and grievance procedures for the spectrum of benefits and services are fully aligned.
6. **Risk-adjusted, capitated financing.** Plans are paid through population-based and risk-adjusted, capitated payment methods including all relevant federal and state funds that fully account for risk factors associated with targeted subgroups. All payer, plan, provider, and beneficiary stakeholders have aligned incentives.
7. **Interdisciplinary team approach for high-risk subgroups**. High-risk enrollees have a principle care provider and care manager with additional interdisciplinary team members to facilitate access to benefits and services as needs evolve over time and across care settings.
8. **Aligned care delivery systems and models of care (MOCs)**. Primary, specialist, acute, post-acute and pharmacy services are integrated with behavioral health and/or LTSS and home care around a tailored individual care plan that evolves with the member's needs. This is supported by integrated information system capabilities, simplified care transitions and aligned policies and procedures.
9. **Integrated, appropriate, efficient performance evaluation.** A streamlined set of core quality measures that are meaningful for a complex dual population are used across the Medicare and Medicaid programs. Performance evaluation reporting is linked and appropriate risk adjustment is applied to ensure accuracy and utility and inform quality improvement.

Next-Stage Priorities

1. Consolidate regulatory authority for all integrated programs under MMCO with designation of state leads.
2. Require full integration within 5 years. Each state to submit their plan within defined models offered by MMCO, subject to a federal "fallback" and "clawback" model where not adopted by that date.
3. Enhanced FFP or additional state resources for integrated program development and management.
4. Designs to include stronger incentives for states around shared savings and supplemental benefits.
5. Align measurement, reporting and MOCs at the PBP level when contracts span multiple states.
6. Provide CMS with limited waiver authority (which preserves consumer protections) to facilitate operational alignment including but not limited to plan procurements and service areas, enrollments and related processes, joint review of materials, SEPs for ongoing enrollment in integrated plans, integration of networks and application of best FAI practices to FIDE SNPs.
7. Increase SHIP funding and provide incentives for MAO brokers to enroll duals in integrated programs.