

Examining the Extension of Special Needs Plans

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Chairman Burgess, Ranking Member Green, and Members of the Committee, thank you for the invitation to discuss the extension of Medicare Advantage Special Needs Plans, a critical vehicle for integrating care for individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees).

My name is Melanie Bella. My testimony today reflects my experience as a Medicaid Director where I experienced firsthand the misalignment between Medicaid and Medicare and, more recently, as Director of the Medicare-Medicaid Coordination Office (MMCO), created by Congress in 2010. The office acts as a liaison and translator both inside and outside CMS, with responsibility for making the two programs, as well as the federal and state governments, work better together.

When the Medicare and Medicaid programs were created, it was not with an eye toward how they would work together; they were created as distinct programs with different purposes. As a result, the programs differ in virtually all areas, including eligibility, covered benefits and payment. This is very difficult for the roughly 11 million people (6.5 million seniors, 4.6 million people under 65 with disabilities) who are eligible for both programs, the providers who serve them, and the public payers (e.g., state Medicaid agencies and Medicare Trust Fund) who finance their care.

As the number of people who rely on both programs grows and with annual costs exceeding \$350 billion, there is an increasing need to align these programs. Today, the majority of Medicare-Medicaid enrollees are not in programs that integrate their Medicare and Medicaid benefits. Medicare covers acute care needs, such as

hospitalization and post-acute care, and prescription drugs. Medicaid provides supplemental benefits, particularly long-term care supports and services, and helps with Medicare premiums and cost-sharing as well as in the financing of prescription drugs via the Part D “clawback”. The lack of alignment between the two programs can lead to fragmented care, cost shifting, inefficient spending and poor outcomes.

Three promising pathways for integration are Special Needs Plans (SNPs), Medicare-Medicaid Plans (MMPs) and the Program of All-Inclusive Care for the Elderly (PACE). Today’s hearing is focused on extending SNPs, a type of Medicare Advantage plan authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, that is allowed to tailor benefits to certain types of Medicare beneficiaries. There are three types of SNPs: dual eligible (D-SNPs), chronic care (C-SNPs) and institutional (I-SNPs). Current enrollment in SNPs is over 2 million, with the majority in D-SNPs. The focus of my remarks today will be on D-SNPs and their role in furthering the integration of Medicare and Medicaid benefits. Specifically, I will focus on D-SNP permanency, state considerations, and the role of the Medicare-Medicaid Coordination Office.

D-SNP Permanency

SNPs, currently set to expire in 2018, have undergone a series of temporary extensions. Just as PACE was made a permanent option for Medicare-Medicaid integration after a number of years of learning and refining the model, it is time to make D-SNPs

permanent. A core question is how much integration with Medicaid should be required of D-SNPs.

Since the inception of D-SNPs in 2003, Congress has taken important steps to make D-SNPs and Medicaid programs work more closely together. Where once there may have been little to no relationship between a D-SNP and state Medicaid agency, today D-SNPs must have a contract with the state Medicaid agency documenting key areas where they will work together, and a subset of D-SNPs, called Fully Integrated Dual Eligible (FIDE) SNPs, offer Medicare and Medicaid benefits through a single managed care organization.

The ultimate goal should be to achieve true clinical and financial integration of Medicare and Medicaid. This requires breaking down barriers that stand in the way of: (a) plans providing truly integrated Medicare and Medicaid benefits; (b) Medicare-Medicaid enrollees enrolling in such plans, often referred to as “aligned” plans; and (c) aligning the financing so that both states and Medicare have incentives to participate.

Permanently extending D-SNPs is a critical piece of advancing that goal as one barrier is the ongoing uncertainty of SNPs. Plans, states (existing and new), CMS, Medicare-Medicaid enrollees and other interested parties need the assurance of stability to continue to invest both time and resources on increasing the number of aligned plans and Medicare-Medicaid enrollees in those plans.

The Medicare Payment Advisory Commission (MedPAC) has recommended that Congress permanently reauthorize only D-SNPs that are integrated with Medicaid¹.

While full integration and aligned plans should be the goal, the requirement for plans to

be aligned and taking risk for both Medicare and Medicaid benefits needs to take into account a ramp-up period for states to get to full integration on the Medicaid side. In addition, to reap the benefit of requiring full integration, mechanisms to ensure Medicare-Medicaid enrollees are enrolled in aligned plans must be used. Today, even in states where aligned plans are an option, large numbers of Medicare-Medicaid enrollees are not enrolled in these plans, thus not benefiting from having one enrollment card, a coordinated care team, enhanced services, etc. Potential mechanisms include lifting the moratorium on seamless conversion, improved coordination of enrollment processes, enhanced outreach to promote aligned plans, and a willingness to examine policies that may erode continuity of care (e.g., when and how often Medicare-Medicaid enrollees make enrollment choices, curtailing use of brokers, etc).

State Considerations

States that have gone down the path of integration, whether with D-SNPs, MMPs or PACE, will tell you it is not an easy one. Medicaid agencies are resource constrained – in terms of both people and dollars – and often feel the benefits of integration are not equitable between the two payers. For example, if Medicaid expends dollars to improve care for Medicare-Medicaid enrollees and Medicare benefits in the form of reduced admissions/readmissions or better drug management, Medicaid does not get to share in any of those savings. This has been a major barrier to date in the broader context of Medicare-Medicaid integration.

To support the goal outlined above of true clinical and financial integration with D-SNPs, state Medicaid agencies need to move toward capitation of their LTSS and behavioral health benefits. To devote the resources necessary to do so, they need capacity, incentives, flexibility around administrative requirements (more detail below) and tools to make sure Medicare-Medicaid enrollees are enrolled in and receiving care from these aligned plans. And, importantly, they need assurance that if they go down this path, the future of D-SNPs is not uncertain.

Medicare-Medicaid Coordination Office

Created by Congress in 2010, the Federal Coordinated Health Care Office, or MMCO, is uniquely positioned within CMS to drive the integration of Medicare and Medicaid in ways designed to improve outcomes and control or reduce costs. Just as Congress is seeking to raise the bar for D-SNPs in order to further advance integration, Congress could raise the bar for MMCO in terms of its responsibilities and authority. An expanded role for MMCO has been suggested by two other Congressional Committees as well as the Bipartisan Policy Centerⁱⁱ, among others. Specifically, MMCO could be given expanded authority to work with states that have either implemented or are in the process of developing aligned programs to:

- Align procurement and contracting timing and processes;
- Coordinate enrollment processes, including the use of a single enrollment card;
- Enable joint review of marketing and enrollment materials;

- Simplify member materials, such as the summary of benefits, annual notice of change, comprehensive formulary and enrollment form;
- Integrate assessment and model of care requirements to include LTSS, behavioral health and social determinants of health;
- Improve the grievance and appeals process to allow use of an integrated notice and align timeframes for filing appeals;
- Coordinate external quality reviews and quality improvement initiatives;
- Align payment incentives with Medicaid value based purchasing initiatives;
- Utilize network standards based on Medicare-Medicaid lives; and
- Deploy a joint state/CMS contract oversight team.

Because all states are in different places and will require some flexibility and adaptation, it would be difficult to specifically mandate the list above. However, Congress could direct the Secretary, through MMCO, to align and simplify administrative requirements that have become burdensome to states, CMS, enrollees and plans, thus creating roadblocks to true integration. Expanded authority for MMCO should come with the expectation that consumer protections are also aligned and upheld.

Closing

The issue of Medicare-Medicaid integration is one of the few in health care today where there seems to be bipartisan interest in working together to come up with solutions. As Congress looks beyond SNP reauthorization, I would encourage continued thinking

about shared savings models between state Medicaid agencies and Medicare as well as keeping an eye on the state-based financial alignment duals demonstrations.

Currently, close to 400,000 Medicare-Medicaid enrollees are receiving care through a MMP, which is fully integrated both clinically and financially. CMS and each respective state Medicaid agency jointly oversee and finance the demonstration. The state-based demonstrations, begun in 2013, have staggering end dates, some through 2020. They have begun providing valuable learning but need continued time to be able to mature and produce the full effect of expected outcomes. MMPs are in the period of testing and modifying, similar to the process of testing and modification that PACE went through before becoming permanent and being discussed today for SNPs and their path to permanency. All three (SNPs, MMPs, PACE) are critical pathways for integration and should be supported and strengthened.

Thank you for the opportunity to appear before you today and for your continued interest in Medicare-Medicaid integration and in raising the bar for the programs available to the people who depend on them.

ⁱ Medicare Payment Advisory Commission. "Report to the Congress: Medicare and the Health Care Delivery System," March 2013. Available at: http://www.medpac.gov/docs/default-source/reports/mar13_entirereport.pdf.

ⁱⁱ <https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.