

Integrated SNP Model: A Blueprint for Improving System Performance

**Working Document
February 6, 2006**

Developed by

National Health Policy Group

In collaboration with the

SNP Alliance Medicare/Medicaid Integration Work Group

This is a working document developed to facilitate dialog in efforts to integrate Medicare and Medicaid for dual eligible beneficiaries. It gives particular attention to improving *total* quality and cost performance for SNPs serving persons with severe or disabling chronic conditions. It builds upon concepts identified in the CMS's *State Guide to Integrated Medicare and Medicaid Models*; the experience of dual demonstration states, national Medicare demonstrations, including Evercare and the Social HMO; and other innovative programs jointly funded by Medicare and Medicaid. The NHPG and members of the SNP Alliance welcome your review and comment in our ongoing interest in improving the system performance capabilities of CMS, States and SNPs in serving dual eligibles.

Integrated SNP Model: A Blueprint for Improving System Performance

The following Integrated SNP Model is intended to serve as a blueprint for integrating Medicare and Medicaid benefits, administration and financing through Special Needs Plans (SNPs), including dual, institutional and chronic care SNPs targeting the dually eligible. We define an Integrated SNP as “any CMS approved Special Needs Plan that has federal and state contracts to provide Medicare and Medicaid benefits and is actively pursuing integrated financing, administration and care methods.”

The model was developed in response to the Centers for Medicare & Medicaid Services’ expressed interest in approaches for promoting integrated managed care programs for the dually eligible. The model builds upon key concepts identified in the CMS’s *State Guide to Integrated Medicare and Medicaid Models*; the experience of dual demonstration states and national Medicare demonstrations, including Evercare and the Social HMO; and other innovative programs funded by Medicare and Medicaid focused on high-risk beneficiaries.

The model gives primary focus to improving overall system performance capabilities in the care of high-risk beneficiaries, including frail elders, adults with disabilities, and other persons with late-stage or co-morbid chronic illness. The recommendations contained in this blueprint seek to eliminate administrative and regulatory inconsistencies or barriers between Medicare and Medicaid that impede the ability of specialty plans and programs to improve total cost and quality performance for this high-risk population. The recommendations include strategies that CMS likely can implement within existing regulatory authority as well as approaches that will require new statutory authority or an amendment to existing regulations.

The document should be considered *a work in progress*. We assume that the integration of Medicare and Medicaid is an evolutionary endeavor, with solutions dependent upon accrued learning and ongoing dialog among those directly involved in dual eligible policy and administration and SNPs specializing in care for this high-risk subgroup. All comments on the model and options outlined below are welcomed.

I. INTRODUCTION

In 2005, over 200 billion dollars were spent on care for persons dually eligible for Medicare and Medicaid. This represents approximately one-third of all State and federal expenditures associated with these two programs.

Most of the overlap in program expenditure relates to caring for persons with severe or disabling chronic conditions. While a certain level of efficiency can be gained by simply eliminating unnecessary regulatory differences, the work of integration should be driven primarily by the nature of care that is required by beneficiaries with multiple, ongoing and interrelated care needs. Beneficiaries of primary concern are frail elders, adults with disabilities, persons with multiple co-morbid medical conditions (e.g. complex diabetes,

congestive heart failure *and* COPD) and persons with late-stage chronic conditions such as end-stage renal disease (ESRD).

In most cases, these high-cost/high-need beneficiaries require multiple provider involvement and regular changes in care plans, pursued in response to the volatile, complex, ongoing nature of their condition. Rigid inconsistencies in Medicare and Medicaid financing, regulations, and oversight structures for plans and related network providers impede the ability of all concerned to improve total quality and cost performance.

A. Barriers to Integration

While serving many of the same people, Medicare and Medicaid embrace very different approaches to health policy and financing. Medicare is an “insurance” program with eligibility criteria based on age and disability status; Medicaid is a “welfare” program with eligibility based on income and meeting categorical definitions. For persons dually eligible for both programs, Medicare focuses primarily on physician, hospital and post-acute benefits, while Medicaid extends beyond acute care to community and institutional long-term care. While both programs provide coverage for some of the same services, such as home health care, the rules for coverage of the same service frequently differ by program.

While some cost and quality information exists about care for dual eligibles, neither CMS nor States routinely document this information in an integrated fashion for jointly funded care. They separately collect cost information by type of service provider, e.g. hospitals, physicians, nursing homes, and home health agencies; but they do not routinely aggregate information about total federal and state costs for persons dually eligible for both programs. They collect information within annual budget cycles, but they do not routinely collect longitudinal data, even though care for persons with severe or disabling chronic conditions involves years rather than days or months of service activity.

In addition, Medicare and Medicaid each have their own approach to regulating plans and providers that results in multiple and costly administrative structures that perpetuates a fragmented approach to care. Medicare alone has over 22 different sets of ‘conditions of participation,’ with different rules in such areas as intake, assessment, care planning, discharge planning, quality assurance, and recordkeeping. Other government agencies, (e.g. the VA and the Administration on Aging) and insurance carriers, (e.g. long-term care and supplement insurance companies) also frequently offer benefits and services to the same high-risk persons, with additional and unique program requirements and oversight structures.

Most dually eligible beneficiaries not only must receive their care through a diverse array of unrelated providers, but many must access their Medicare and Medicaid benefits through different health plans. While Medicare Advantage (MA) plans can eliminate some of the inconsistencies in care approaches through uniform contracting and payment practices, care management programs, and various provider network arrangements, most

MA plans contract with providers who operate under other contracts and program requirements that perpetuate care fragmentation, in spite of the SNPs interest in offering coordinated care. Furthermore, care coordinators frequently are consumed with helping complex care patients access multiple services with a complex array of administrative requirements, which impedes their ability to provide the clinical support needed to help patients deal with the complexity of their chronic condition.

While SNPs are encouraged to develop specialty care arrangements for special needs individuals, they must function under virtually all of the same constraints as other MA plans. This quagmire of healthcare administration, financing and oversight makes it difficult for SNPs and specialty care providers to coordinate care (a critical element of complex chronic care) and reinforces a silo-based, crisis-oriented medical model that *causes* significant and unnecessary confusion, medical complications and costs.

It is clear that current law requires different payment methods, administrative structures and care approaches for the Medicare and Medicaid programs. Yet, it is critical for the two federal programs to operate interdependently to effectively address issues of cost and quality for high-risk beneficiaries— namely, persons with severe or disabling chronic conditions. Without re-alignment, the current bifurcated approach not only will create confusion and complexity for patients but it will perpetuate cost shifting between states and the federal government and between related providers and without regard for their cumulative effects on cost and quality.

To date, only PACE and health plans operating under Medicare/Medicaid demonstration authority have been able to integrate practices to any measurable degree. Medicaid agencies in Minnesota, Wisconsin and Massachusetts have established national dual eligible demonstrations in collaboration with CMS that aspire to become “fully integrated” and operate under various waivers that eliminate some of the more pervasive inconsistencies between Medicare and Medicaid. They have developed a unique set of program and administrative capabilities for serving special needs individuals. As these programs move from demonstration to mainstream plans, despite CMS demonstration guidance, these plans are frequently required to conform to basic Medicare Advantage requirements that force them to uncouple previously established practices. Without a proactive agenda by CMS to integrate Medicare and Medicaid requirements, these innovative market leaders are vulnerable to an unraveling of integrated policies and practices that have proven critical to their special care approach.

While some elements of this maze of confusion are rooted in law, administrative steps can be taken to improve total quality and cost performance through *aligning* incentives and *standardizing* policies and procedures in care of persons served by both programs, working within the limits of current law.

B. Facilitators of Medicare/Medicaid Integration

In spite of the pervasive challenges involved in aligning policies and procedures, four events provide promise for resolving some cost and quality problems associated with serving high-risk beneficiaries who are dually eligible for Medicare and Medicaid.

1. **Medicare Modernization Act.** In 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act (MMA) establishing Special Needs Plans (SNPs). SNPs were authorized to exclusively or disproportionately serve special needs individuals, defined as persons who are institutionalized¹, persons dually eligible for Medicare and Medicaid, and other persons with severe or disabling chronic conditions. While most dually eligible SNPs are at risk only for Medicare costs, and all SNPs must meet mainstream MA plan requirements, the SNP enrollment provisions and new MA risk-adjusted financing methods have produced market incentives for a host of new specialty care programs to emerge. Never before in the history of the Medicare program has there been such an explicit targeting of care for dually eligible beneficiaries and other high-risk populations – or such a rush to enter a new specialized MA market.
2. **Health-Based Risk Adjustment.** CMS is in the midst of implementing a risk-adjusted approach to Medicare payment, known as the CMS-HCC payment method, which is eliminating much of the inequity that exists in payment between health plans serving average or even low-risk members and those serving high-risk beneficiaries.² The risk-adjusted payment methodology will be fully implemented in 2007 for standard plans and by 2008 for certain demonstration plans.

The overall improvement in payment produced by health-based risk adjustment makes it increasingly viable for plans to take the risk of exclusively or disproportionately serving high-risk beneficiaries. Accordingly, hundreds of SNP applications were filed and three-quarters of the roughly 275 approved were for dual SNPs. Most of these plans are only at risk for Medicare expenditures and may or may not target care for frail elders, adults with disabilities, and other high-risk patients. The degree to which risk-adjustment eliminates payment inequities for SNPs is still unclear. Even at full implementation, the current CMS-HCC payment method will not completely eliminate payment inequities between low-cost and high-cost beneficiaries and plans.³ Some conditions, such as CHF, have

¹ The MMA regulations define “institutionalized” to include individuals residing in the community who require an institutional level of care.

² Prior to enactment of risk adjusted payments, Medicare overpaid the lowest cost quintile by 2 and 1/2 times in relation to fee-for-service and under paid the highest cost quintile by 50%. The current payment method begins to shift some of the overpayment of care for low cost beneficiaries to alleviating some of the under payment of care for high-cost beneficiaries.

³ At full implementation, the CMS-HCC method should reduce under- and over payments to the first and fifth quintiles to about 23% each.

a single code which does not differentiate adequately between early and late stage conditions. In addition, some type of frailty adjusted payment will be needed to account for frailty and disability related costs. Assuming CMS moves forward with plans to implement the frailty adjuster across all MA plans, some of these costs will be accounted for. Additional information regarding the revised frailty adjuster is needed to determine the extent to which the total risk adjusted payment methodology will accurately predict risk for the highest cost beneficiaries, of which duals are a significant subset.

3. **Role Models for Integration:** Minnesota, Wisconsin, and Massachusetts have been operating under national demonstration status for a number of years, providing CMS, States, and emerging dual SNPs with a valuable base of experience. While none of these programs have been able to fully integrate care at the delivery level and a number of program complexities remain, their creativity in financing and program oversight, combined with a variety of ongoing Medicare and Medicaid waivers, have enabled them to move their demonstration efforts into mainstream SNPs. These demonstrations provide important learning for developing a more fully integrated program nationwide.
4. **CMS Medicare/Medicaid Integration Policy Group:** The CMS Administrator has recently announced a new initiative to promote Medicare and Medicaid integration through SNPs. While it is still early to evidence results, the commitment of the current CMS Administrator to improving care for the dually eligible and other high-risk populations holds promise for making important progress in dual eligible care.

II. INTEGRATED SNP MODEL

We define an Integrated SNP as “any CMS approved Special Needs Plan that has federal and state contracts to provide Medicare and Medicaid benefits and is actively pursuing integrated financing, administration and care methods.” The blueprint for establishing Integrated SNPs builds upon the Congressional intent of the SNP legislation to give special attention to improving cost and quality outcomes for the dually eligible, institutionalized and persons with severe or disabling chronic conditions. Under this model, any dual SNP, institutional SNP or chronic care SNP could be identified as an Integrated SNP as long as it meets this definition.

Our blueprint and related recommendations are based upon an operational understanding of Medicare and Medicaid regulations and oversight from the perspective of plans and providers; the experience of leaders involved in the dually eligible national demonstrations in Minnesota, Wisconsin and Massachusetts; and SNP leaders who have chosen to specialize in care of dual eligible and other high-risk beneficiaries.

A. Long-Term Goals and Assumptions

Under an “ideal integration model,” all administrative, financing and delivery structures would be aligned across Medicare and Medicaid, with particular regard for the unique conditions and concerns of persons with serious and disabling chronic conditions. Under an ideal model:

1. Medicare and Medicaid financing would be integrated and dual eligibles would receive care from one plan offering a single program that transparently combines all Medicare and Medicaid benefits and services.
2. There would be one risk-adjusted payment method, one set of regulations and one oversight structure.
3. Health plans would be provided with equitable financing and incentives to specialize in care of high-risk beneficiaries.
4. Delivery structures would be uniquely designed to meet the special care needs of people with serious and disabling chronic conditions.

Unfortunately, it is not possible to establish a fully integrated model as long as there are two programs – Medicare and Medicaid – and two payers—the state and federal government. Separate payment methods, benefit structures, program requirements and oversight procedures are written into law. Yet, significant progress can be made in improving total cost and quality performance for duals with severe or disabling chronic conditions by aligning Medicare and Medicaid incentives and standardizing program requirements within the context of current regulatory authority.

The model is based on the following assumptions:

1. Prepaid, integrated, specialized care is the preferred approach to serving high-risk Medicare and Medicaid beneficiaries.
2. SNPs provide a unique opportunity to improve overall cost and quality performance.
3. Positive outcomes best can be achieved when duals enroll in a single SNP that offers both Medicare and Medicaid benefits.
4. Improving cost and quality performance in care of dually eligible beneficiaries requires greater consistency between Medicare and Medicaid regulations and oversight, while recognizing limitations that exist within federal and state law.

The blueprint does not address, to any significant degree, important companion efforts to eliminate inconsistencies in payment methods and performance measurement. The SNP Alliance has outlined recommendations for addressing these issues in other material.

While this blueprint does reference, in selected cases, the need for legislation to address particular program impediments, it focuses primarily on eliminating inconsistencies and impediments to integrated care found in current Medicare and Medicaid regulations and administrative oversight requirements. The blueprint contains detailed recommendations for eliminating inconsistencies for specific administrative and oversight functions (e.g., enrollment, marketing, appeals and grievance rules, etc.).

The model does not prescribe a single approach or restrict states from establishing their own unique approach. It recognizes that not all states or SNPs are ready to pursue a Medicare/Medicaid integration program, as any dual SNP integration effort requires considerable State/Federal collaboration in establishing new program strategies. Some states also are not ready to bring Medicaid's financing of long-term care services into a risk-based financing model.

As a result, the model and blueprint is designed as a vehicle for *facilitating progress* in moving toward a more fully integrated approach to serving those dually eligible for Medicare and Medicaid. It gives priority to optimizing cost and quality performance in serving people who require a full continuum of primary, acute and long-term care. It recognizes the unique needs of community-based, prepaid care systems as well as the importance of being able to replicate any given approach on a larger scale, within and across states.

While specific elements are identified and specific recommendations are made, it is understood that Medicare/Medicaid integration is a work in progress and ongoing refinements are necessary through ongoing dialog among CMS, State and SNP leaders committed to improving cost and quality outcomes for the dually eligible. The model assumes that positive cost and quality outcomes are dependent upon compatible operating structures being developed at four levels: 1) the Centers for Medicare & Medicaid Services, 2) State Medicaid Agencies, 3) Special Needs Plans, and 4) SNP providers.

The model is intended to support efforts of the CMS Medicare and Medicaid Integration Policy Group. We encourage CMS to use this centralized leadership strategy to unify requirements and oversight procedures for SNPs accountable for providing both Medicare and Medicaid benefits under a single product.

B. Core Elements of Integrated SNPs

The Integrated SNP model is comprised of 10 elements:

1. A dually eligible beneficiary is able to receive Medicare and Medicaid benefits from a single Special Needs Plan.
2. The Integrated SNP uses a coordinated enrollment process with a single enrollment form. Loss of Medicaid eligibility would not require disenrolling a beneficiary from the MA plan.
3. All benefits are described in a single set of marketing materials and a standardized enrollee communication process.
4. Integrated SNPs are at risk for both Medicare and Medicaid costs and are allowed flexible use of funds within the limits of existing law, to better rationalize benefits across the two programs.
5. Payments are fair and equitable, taking into account the added risk burden of exclusively or disproportionately serving a high-risk population.

6. CMS and States use compatible contracting provisions for Medicare and Medicaid.
7. Grievance and appeals procedures are standardized and coordinated.
8. Quality improvement (QI) requirements are coordinated to create a single QI plan targeting the unique needs of chronically ill duals.
9. Medicare and Medicaid use compatible performance measures and methods.
10. Federal, State and SNP policies and procedures take into account the multidimensional, ongoing and interdependent nature of care for serving high-risk beneficiaries.

The way in which this model is implemented may vary from state to state and among SNPs; however, all elements are seen as necessary to optimize total cost and quality performance in serving high-risk populations. We encourage CMS to actively pursue development of this integrated model wherever States and SNPs are ready, willing and able to pursue an integrated approach.

C. Integrated SNP Model Objectives

To successfully implement the integrated SNP model, as defined, CMS should develop an operational plan designed to:

1. Simplify consumer access.
2. Improve care continuity.
3. Minimize inappropriate cost shifting between continuum providers and between Medicare and Medicaid.
4. Eliminate adverse medical events due to conflicts in provider requirements and/or Medicare and Medicaid rules and regulations.
5. Minimize administrative confusion, duplication and waste.

To achieve these objectives, it will be important for CMS to examine administrative inconsistencies between Medicare and Medicaid regulation and assess how it can enable States, SNPs and related provider networks to integrate care. The results of analysis will likely involve exploration of ways to standardize Medicare and Medicaid requirements for core MA functions, e.g. marketing and enrollment.

CMS also should look at the inconsistencies in requirements for related continuum providers. For example, the array of unrelated provider and professional-centric credentialing and certification requirements and provider-specific program requirements for intake, care planning, recordkeeping, discharge planning, etc. reinforce a silo-based approach to care. They impede the ability of related care providers to work together to maximize care continuity, simplify care transitions, and optimize total cost and quality performance as a person's condition evolves over time and across care settings. While health plans have some ability to create incentives for integrated care, most are forced to develop specialty care networks within a silo-based regulatory environment.

Hospitals have few incentives to spend extra money to reduce post-hospital care needs. Nursing homes have few incentives to spend extra money on medical care that could

prevent hospitalizations. Physicians have few incentives to coordinate with the multiple physicians and pharmacies involved in the care of frail elders or those with complex medical needs. Most providers follow best practice guidelines, based on their own professional requirements, but the lack of uniform policy for continuum providers results in patient confusion, unnecessary medical complications and excess costs.

While CMS seeks to eliminate inconsistencies between Medicare and Medicaid regulations and oversight functions, and between related continuum providers, CMS should also:

1. Aggressively pursue the elimination of adverse incentives and inequities in CMS-HCC payment methods for high-cost patients, expedite implementation of a frailty-adjusted payment method and further modify the basic CMS-HCC methodology to increase coding sensitivity to various stages of chronic illness.
2. Improve performance measurement for high-risk groups by:
 - a. Establishing a CMS Work Group to improve performance measures for high-risk patients.
 - b. Adopting an interim Continuous Quality Improvement (CQI) approach using process measures, e.g. single care plan across care settings; and a limited set of dashboard indicators, e.g. hospital rates for ambulatory care sensitive conditions (ACSCs).
 - c. Over-sampling duals in various data sets to improve accuracy in analysis of cost and quality improvement initiatives.
 - d. Developing plans to evaluate *total* quality and cost performance across Medicare and Medicaid.

D. Resolving Inconsistencies

In seeking to resolve inconsistencies in Medicare and Medicaid requirements, CMS leadership should consider a staged approach to analysis. CMS should:

1. *Identify administrative inconsistencies* between Medicare and Medicaid requirements and oversight, and among related continuum providers.
2. *Clarify the nature of the problem* for plans, providers and consumers in serving dually eligible beneficiaries and those with severe or disabling chronic conditions.
3. *Prioritize the importance of a policy change* relative to the potential for improving total cost and quality performance.
4. *Develop a preferred solution* for the chosen policy priorities, in consultation with State Medicaid agencies and SNPs specializing in care for dual eligibles.
5. *Identify a preferred implementation plan* including:
 - a. *Clarification of existing program requirements*, to eliminate any confusion or misunderstanding of current policy;
 - b. *Changing administrative practices* to enable administrative practice to be more efficient and more in keeping with the intent of current policy;

- c. *Modification of existing program requirements* to simplify program administration and improve total cost and quality performance; and/or
- d. *Pursuing changes in Medicare and/or Medicaid law*, where existing statutory requirements or the lack of statutory authority impedes integration.

In some cases, problem resolution may require clarification of an existing administrative policy; in others, a change in statute or regulation may be needed. Either way, the goal is to unify Medicare and Medicaid policies and administrative practices to enable Integrated SNPs and related providers to more efficiently and effectively address *the total care needs* of persons served, regardless of payer.

CMS should build upon the experience of States with established dual integration programs, using Medicare requirements, wherever possible, as the template for establishing uniform program requirements. CMS also should maintain existing state contracts or agreements that facilitate coordination or integration of Medicare and Medicaid rules as dual eligible demonstrations transition to mainstream SNPs and seek statutory authority, as needed, to maintain current agreements.

E. Implementation Priorities

The integration of Medicare and Medicaid requires a phased approach to implementation. The extent of inconsistencies and complexity of problem resolution is too extensive to be implemented quickly. Each change carries with it nuances that must be carefully weighed to avoid unintended adverse consequences. As a result, CMS should give priority consideration to resolving problems associated with six MA functions:

1. Contracting
2. Marketing/enrollee communication
3. Enrollment
4. Bidding
5. Quality improvement
6. Grievance and appeals

A framework for addressing a broad spectrum of regulatory issues is provided in Attachment A.⁴

The recommendations that follow are made primarily in relation to improving cost and quality outcomes for SNPs providing both Medicare and Medicaid benefits. Some of these recommendations also may apply to SNPs in general, but the focus is on the overlap between Medicare and Medicaid rather than with the regulation of SNPs per se or of dual SNPs in particular. For example, some dual SNPs only are responsible for Medicare benefits and selected changes may or may not apply to these dual programs.

⁴ This framework was developed by Mark Joffe, legal counsel for the SNP Alliance.

Observations and recommendations should be seen as a *first step* in a more rigorous review of regulatory barriers to integrated care. While recognizing inconsistencies in existing federal and state law and an inability to address all issues in a short period of time, CMS should issue formal policy guidance as soon as possible, where fixes do not require new statutory authority or changes in regulations.

1. Contracting

Issue: Under current contracting arrangements there is extensive duplication of process and considerable confusion in trying to meet conflicting or inconsistent requirements.

Goal: The goal of this integration effort would be for CMS and states to develop an agreement on how to coordinate Medicare and Medicaid policy for SNPs with Medicare and Medicaid contracts.

Strategy:

- a. CMS would review and approve Integrated SNPs as part of its overall MA application process. CMS would notify the State of any applicant seeking designation as an Integrated SNP (with Medicare and Medicaid benefits administered through a single SNP) and consult with the State as part of its review and approval process to ensure for a coordinated response.
- b. CMS would organize its review of Integrated SNP applications through a national Medicare/Medicaid Integration team, including representation from CMS' Medicare *and* Medicaid components, with a goal of promoting uniform policies and practices wherever possible.
- c. When possible, SNPs would operate under a single contract for Medicare and Medicaid services among CMS, the State and the health plan to promote uniform or compatible requirements. Where single contracts are not feasible, the MAO would contract with CMS to provide Medicare benefits and with the State to offer Medicaid benefits under a single SNP. In either case, contracts would include state requirements for implementing MA rules and regulations. In the case of separate contracts, CMS and the State would standardize the form and content of the contracts, where agreeable to all parties, or implement compatible requirements, where differences are necessary. CMS would explore ways to standardize contracting language (or to use model contracting language) and methods across States to the extent possible. CMS and the State would work to resolve conflicts administratively whenever possible.
- d. Integrated SNPs would be allowed to provide benefits covered under both Medicare and Medicaid through State certified Medicaid providers who are not Medicare certified providers as long as enrollees also have the right to receive these benefits through a Medicare certified provider.

- e. CMS and the States would coordinate the contracting process with qualified SNPs that demonstrate the capacity to provide directly, or by subcontracting with other qualified entities, the full continuum of Medicare and Medicaid covered services.
- f. Integrated SNPs would be allowed to specialize in care for persons with disabilities and/or frail elders or subsets of these groups (e.g., physically or developmentally disabled or mentally impaired) where SNPs demonstrate special care requirements and expertise.
- g. Integration provisions for CMS and State relationships would be established through State Plan Amendments, through memorandums of understanding (MOU), or other agreements, as necessary and appropriate.

2. Marketing/Enrollee Communication

Issue: Under current contracting arrangements, dual eligible beneficiaries are confused about what is and is not covered, and under what arrangements. Integrated dual eligible SNPs are forced to explain and manage duplicative and sometimes conflicting program requirements.

Goal: Enable SNPs to use a single set of marketing materials and to standardize the enrollee communication process

Strategy:

- a. CMS and State Medicaid agencies will use a coordinated review and approval process for marketing/enrollee communication materials.
- b. Integrated SNPs will be able to direct its marketing efforts and information about enrollment periods to the special needs population the plan is approved to serve.
- c. Integrated SNPs will be allowed to use integrated marketing and member materials and letters that reflect both Medicare and Medicaid services and policies so there is one clear set of materials for all beneficiaries enrolled.
- d. CMS, States, and integrated SNPs would agree to standardize and integrate outreach and education materials; enrollment and disenrollment materials; benefit coverage information; and operational letters for enrollment, disenrollment, claims or service denials, complaints, internal appeals, external appeals and provider terminations and other relevant documents. Having standard documents will simplify administration for plans that operate in more than one state.
- e. Medicare templates should provide the basis for the integrated Summary of Benefits and Evidence of Coverage. The Summary of Benefits should incorporate a list of each state's Medicaid benefits and a clear description of beneficiary cost-sharing obligations. The format should differentiate benefits and cost-sharing obligations among dual eligibles, Medicare-only and Medicaid-only beneficiaries.

CMS would use the Medicare Plan Finder to post integrated Summaries of Benefits that also indicate when there are no co-payment requirements. An integrated Summary of Benefits would enable dual beneficiaries to see the benefits that would be available to them in the event that they lose their Medicaid eligibility but continue to be eligible for Medicare coverage.

- f. CMS would refine its Summary of Benefits software so that it can produce an integrated Summary of Benefits that includes Medicare and Medicaid benefits. As a short-term strategy, CMS could produce clear policy guidance verifying that hard copy changes to the Summary of Benefits are permitted to produce integrated benefit summaries, clarify copayment requirements, and provide illustrative examples of materials that integrate Medicare and Medicaid benefits and that have been approved by CMS.

3. Enrollment

Issue: For SNPs that offers both Medicare and Medicaid benefits, they are required to follow different and sometimes conflicting policies and procedures.

Goal: Permit Integrated SNPs to use integrated Medicare/Medicaid enrollment forms using a coordinated enrollment and disenrollment process.

Strategy:

- a. The SNP could choose, but not be required, to develop a Third Party Administrator (TPA) arrangement with the State, whereby the State processes and facilitates enrollment into the Integrated SNP for both Medicare and Medicaid through a single coordinated enrollment form and process. Medicare and Medicaid enrollment and disenrollment notices would then be issued by the State rather than the SNP. The State (as a TPA) would need to meet all MA and HIPAA requirements for electronic enrollment submission to CMS.
- b. CMS would permit, but not require, the SNP and the State to coordinate the effective dates for elections for Medicare and Medicaid enrollment under the SNP Special Election Period, including allowing for mid-month enrollments and disenrollments.
- c. CMS would permit continuous open enrollment for all special needs beneficiaries and establish procedures so that implementation runs smoothly.
- d. Excluding enrollees of chronic care SNPs who are not dual eligibles or institutionalized from continuous open enrollment policy creates a number of complications for beneficiaries that are eligible for multiple SNP categories. Further guidance should be issued to maximize beneficiary choice.

4. Bidding

Issue: Under current arrangements, dual SNPs are required to follow procedures established for all MA plans, in spite of material differences. In some cases, this creates an unfair comparison of bids, complicates management of Medicare and Medicaid benefits, and creates financial disincentives to maximize total quality and cost performance.

Goal: To modify existing bidding requirements for SNPs, taking into account the benefits and beneficiary profile to be addressed.

Strategy:

- a. Integrated SNPs that receive capitated payments from Medicare and Medicaid would be permitted to utilize funding streams (within the limits of the law) to maximize cumulative cost savings and total quality performance.⁵
- b. Integrated SNPs would be exempt from bidding requirements for Part A and B, consistent with requirements established for PACE as an integrated dual model.
- c. CMS should convene a group of auditors and SNPs to explore options for modifying integrated SNP auditing requirements to enable care managers and related providers to make decisions about what service or combination of services are most efficient and effective for addressing the multidimensional care needs of any given enrollee, while responding to general accountability requirements under Medicare and Medicaid.⁶
- d. CMS should consider using some of the “savings” that are accrued to Medicare from dual SNP bids through the sharing some of these savings with States, to encourage (or not penalize) States in spending money for duals (on Medicare cost sharing and/or benefit enhancements) that improve *total* cost and quality outcomes.⁷
- e. CMS would differentiate the desk review process for dual SNP bids so that CMS staff can recognize basic differences between SNPs and standard MA plans (e.g.,

⁵ In the long run, there should be a single risk-adjusted capitated payment for duals that accounts for all Medicare and Medicaid benefits. This would require a single funding source, not permitted under current law without waiver authority.

⁶ Current bidding requirements unintentionally create incentives to unnecessarily duplicate administrative and service functions for Medicare and Medicaid and prescribe or deny services that may not be in the best interest of the patient or of efficient program administration. For example, it is possible for care management activity funded by one program, (e.g. Medicare) to reduce expenditures in another, (e.g. Medicaid) without recognition of its cause/effect relationship. It is also possible to deny services in one program, (e.g. Medicaid not covering the cost of medical management in a nursing home) resulting in increased costs in another (e.g. Medicare costs related to hospitalization). It is important to develop bidding and auditing requirements that enable plans and providers to produce the best total cost and quality outcome, with appropriate “allocation of costs” to Medicare and Medicaid.

⁷ Some elements of this process may require legislation, but CMS should explore options for improving total quality and cost performance under current payment policy.

on the cost side) to eliminate some of the queries going back to plans. For example, SNPs would be expected to have higher care management costs than standard plans.

5. Grievance and Appeals

Issue: While this does not affect a large number of beneficiaries, current grievance and appeals requirements create significant complications for a vulnerable group of beneficiaries who believe they have been treated inappropriately or unfairly. In some cases, this complex and confusing process has the potential to impair a beneficiary's ability to obtain a prompt and fair review.

Goal: To standardize grievance and appeals procedures to the degree it is possible under current law, with uniform requirements wherever possible.

Strategy:

- a) CMS and the states should develop an integrated appeals and grievance process that incorporates Medicare Advantage and Medicaid managed care requirements into a uniform appeals process.
- b) This process should:
 - i) Be simple, understandable and “consumer friendly” for dual beneficiaries;
 - ii) Promote standardization of procedures across states to the extent possible without jeopardizing state oversight of Medicaid covered benefits;
 - iii) Provide a process for timely access to Medicaid coverage of services being appealed for coverage by Medicare;
 - iv) Assure beneficiary access to medically necessary services are not denied during the appeals process.

6. Quality Assurance

Issue: Prevailing quality measures and methods are inappropriate for assessing total quality and cost performance in serving high-risk beneficiaries. The presence of frailty, disability, and/or co-morbid illness is seldom taken into account with existing quality measurement, even though these conditions are pervasive among high-risk Medicare and Medicaid beneficiaries.

Goal: To eliminate conflicts and unreasonable burdens for integrated SNPs as soon as possible, and lay the foundation for establishing a more appropriate process for evaluating SNP performance in serving high-risk beneficiaries.

Strategy:

- a. CMS should establish a stakeholder workgroup that includes representation from SNPs, states and other relevant stakeholders to establish a core set of performance measures that are sensitive to the needs of people with complex chronic

conditions. Outcomes measures should be identified that assess quality across the spectrum of managed and unmanaged programs.

- b. CMS should adopt an interim CQI approach to SNP evaluation involving process measures, e.g. single care plan across care settings; and a limited set of dashboard indicators, e.g. hospital rates for ACSCs.
- c. Integrated SNPs should be able to submit a single quality improvement plan for chronically ill duals to fulfill existing MA and Medicaid quality improvement requirements.
- d. Integrated SNPs should be permitted to submit HEDIS and CAHPS data and a modified HOS using a standardized format which integrates both Medicare and Medicaid.

The SNP Alliance has provided more detailed recommendations regarding these provisions through other materials.

F. CMS/State Relations

Issue: States are key players in efforts to integrate Medicare and Medicaid and to promote SNPs as the vehicle for integration and to promote SNP development in general. Implementation of private Medicaid SNPs can have a significant impact on public programs and states should have an opportunity to coordinate efforts. The role and disposition of states will have a significant impact on SNP's implementation efforts and viability.

Goal: To develop a coordinated approach to program oversight in consultation with State Medicaid agencies involved in establishing integrated programs for serving the dually eligible.

Strategy:

1. Identify a senior-level executive team to review and resolve key differences in Medicare and Medicaid rules, regulations and procedures.
2. Encourage States to advance full integration of duals through SNPs.
3. Allow States to advance integration efforts through State Plan amendments.
4. Maintain dual demonstrations under current regulatory structures and apply learning to other States wherever possible and appropriate under current law.
5. Work with States to establish integrated SNPs in accordance with the goals, elements and provisions outlined in this document.

G. Other Considerations

In addition to these recommendations, CMS should give consideration to the following.

1. Data/Reporting

- a. CMS should work with States to collect baseline data/information on the dually eligible population on an ongoing basis.
- b. CMS should work toward ensuring that data collection and reporting requirements are compatible between Medicare and Medicaid.
- c. Data requirements should take into account the nature of chronic conditions, to facilitate working toward reporting of systems performance across settings and over time—where systems performance recognizes the importance of interdisciplinary care, the cumulative effects of provider behaviors across time and setting, disability prevention, functional outcomes, individuals and families who are informal care providers, etc.

2. Network Development

- a. CMS should encourage states to adopt rigorous standards for Integrated SNPs that allow SNPs to selectively contract with only those providers that meet quality standards for specialty care networks established by the plan.
- b. CMS should establish dual provider certification to enable integration efforts at the provider level.
- c. CMS should give special focus to improving care continuity across continuum providers in order to optimize care continuity and simplify care transitions.
- d. CMS should simplify reporting and recordkeeping for physicians and related care management teams and related care providers to develop and follow a single plan of care and more effectively address the care needs of multiple problem patients.

The above recommendations are provided as a first step in seeking to improve quality and cost performance in care of persons dually eligible for Medicare and Medicaid. The National Health Policy Group and the SNP Alliance look forward to further discussion with Congress, CMS, State Medicaid agencies pursuing integration of Medicare and Medicaid, new and emerging SNP organizations serving or seeking to serve Medicare and Medicaid beneficiaries using integrated methods, and others who share our vision for improving care for those dually eligible for Medicare and Medicaid, and for those with serious and disabling chronic conditions, in particular.