A National Nonprofit Leadership Organization

SNP Alliance Recommendations:
S. 4264: Advancing Integration in Medicare and Medicaid (AIM) Act (Scott, Casey, Cassidy)

SNP Alliance

The SNP Alliance is a national non-profit leadership organization dedicated to improving policy and practice for serving high risk and complex needs individuals through Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 26 health plan organization members serve over 2.8 million special needs individuals in 47 states and the District of Columbia. We are pleased to submit these suggestions for improvement of this legislation related to recent MACPAC recommendations. We also refer you to our evaluation criteria for integrated programs here.

Introduction

In view of the large growth in DSNP membership and investment by states and health plans in this model (DSNPs operate in 47 states and serve over 4.5 million of the country's approximately 12 million people with dual eligibility), CMS has finalized regulations that would strengthen DSNP-Medicaid partnerships. CMS also will terminate the Financial Alignment Demonstration (an integrated model with shared savings for states) under CMMI authority by the end of 2025, leaving the DSNP-Medicaid model as the primary vehicle for integration of Medicaid and Medicare for dually eligible individuals. Further, MACPAC has outlined recommendations for moving integrated programs forward within the DSNP platform that have gathered bi-partisan interest.

As evidenced by the long history of successful integrated programs built on partnerships between Medicaid agencies and MA D-SNPs, significant integration of Medicare and Medicaid is achievable within the current framework of D-SNPs that also provide Medicaid services through aligned State Medicaid plan contracts (examples include MN, MA, NJ, ID, TN, AZ, NY, and others). Research and member satisfaction data in early state programs and several others who have followed that path indicate benefits to the dually eligible individuals of additional care coordination and simplification of access is possible. The more highly integrated models offered in some states indicate more can be accomplished within this model by continuing to build on this infrastructure and previous investments without radical change—even without shared savings options. However, the circumstances of state and plan investment, expertise and persistence in those states is unique and hard to replicate in most states. While most states do contract to allow D-SNPs to operate, many arrangements are not well integrated and integration options are not widely available.

This bill reflects many of the MACPAC recommendations and would require states to develop and submit Medicaid State Plan Amendments indicating their planned strategies for implementing integrated Medicare and Medicaid options, which is a very important first step. The SNP Alliance and

others have expressed support for MACPAC's recommendations, recognizing them as an important step in increasing access to integrated programs to improve service delivery to dually eligible individuals.

However, there are administrative, operational, and regulatory misalignments between Medicare and Medicaid that need correction to achieve meaningful programs and to make it feasible for both plans and states to reach higher level of integration that are not addressed in this bill. These misalignments are often highly technical and not always immediately obvious. Many are related to systems and data sharing mechanisms that need change or improvement and result in administrative barriers to states and plans, some of which might be reduced or avoided with clearer direction and authority from CMS.

Ideally this bill would also incorporate funding for states to support additional administrative activities needed to develop, manage, and evaluate these programs, such as provided in proposed S. 4273, and additional funding for MMCO for oversight, technical support for states, and policy regulation of the SPAs. However, if part of the goal of this bill is to avoid significant scoring, there are several additional CMS authorities to address such misalignments that should be able to be incorporated without incurring significant scoring while still moving integration forward. Therefore, given the narrower focus of this bill, our recommendations at this point center on how to best craft authorities needed to address some of the more technical obstacles to integration. Below are additional authorities and clarifications that should be addressed in S. 4264.

Concerns and Recommendations

1. ***Concern:*** New paragraph (88) of 42 U.S.C. 1396a) added to amend Title 19 under this bill requires that each state submit a state plan amendment (SPA) to CMS for an integration strategy which would coordinate and integrate Medicaid and Medicare coverage for full benefit dual eligible individuals. However, there is no corresponding amendment to Title 18 to address how Medicare administrative and operational features will be modified to align and coordinate with or facilitate these Medicaid integration strategies.

   Recommendation: CMS should be directed to have a mechanism to address additional administrative misalignments between Medicare and Medicaid to facilitate these SPA strategies. Language should be added to clarify that CMS/MMCO also has authority under Medicare Title 19 to waive or change administrative and operational technical requirements or processes to support these SPAs and that the Secretary should designate the FHCO (MMCO) to address these misalignments by developing and implementing regulation and operational policy to address them to ensure SPAs can be workable. MMCO should also be directed to outline a limited number of model pathways incorporating a set of flexibilities from which states that fall into categories differentiating their situations could choose to match their needs.

   As proposed by ACAP, such regulatory flexibility would be limited to changes to Medicare Advantage (or Medicaid requirements) which create administrative misalignments that make it challenging for a beneficiary to enroll in an integrated D-SNP or for a plan to administer the benefits under both programs, such as Medicare Advantage enrollment timelines and processes (note that it would not be the intention of this policy to provide the Medicare-Medicaid Coordination Office with the flexibility to implement passive enrollment or lock-ins); requirements regarding the approval of Medicare Advantage marketing materials; and review of

member Medicare Advantage communications more broadly. To be approved, the Medicare-Medicaid Coordination Office would need to ensure that the proposed changes do not reduce beneficiary access to care, quality of care, or freedom of choice.

2. ***Concern:*** Congress should clarify its intent that the MMCO has authority over programs serving dual eligible individuals. As written, these SPAs would go to the Secretary for approval, but within CMS, SPAs are normally reviewed and approved through CMCS. Yet the MMCO has generally been in charge of other integration policy for dually eligible individuals. The Bipartisan Budget Act of 2018 provided additional authority to MMCO within CMS, but the extent of this authority is unclear and internal CMS barriers continue to impede integration. For example, multiple offices at CMS have different authority over D-SNPs and Medicaid. Without changes, the current language in this bill could be interpreted to further "muddy the waters" as to what entity within CMS will have authority to review these SPAs and how they are incorporated into current Medicare and Medicaid integration policy.

   Recommendation: Add language that would clarify its intent that the MMCO has authority over programs serving dual eligible individuals and would clearly place authority within MMCO to administer the SPA process and subsequent implementation and oversight of these specific SPAs and strategies. This should specifically include language that allows MMCO to develop and issue any necessary regulation and guidance related to alignment of policy and operational processes CMS deems necessary for implementation under both Medicaid and Medicare to remedy this problem.

3. ***Concern:*** The SPA must be submitted to the Secretary for approval within 2 years of enactment of the legislation, but actual implementation of the state strategy and timelines for such are not entirely clear in the bill language. While there is a delay allowed for necessary state legislation, the bill does not mention a deadline for actual implementation of the strategy.

   Recommendation: Language should be added to provide reasonable timelines for implementation of the submitted SPAs. Deadlines could be based on the status of integration activities in the states, with more time allowed for states that have minimal experience.

4. ***Concern:*** Under section (tt) (1) (B) the plan must describe the "eligibility requirements and benefits available under such strategy." However, there is no mention of maintenance of effort for current eligibility and benefit levels under either program.

   Recommendation: A Maintenance of Effort for Medicaid (and also for Medicare eligibility and non-supplemental benefits) requirement to ensure that states don't propose to reduce eligibility or benefits to dually eligible beneficiaries under this new strategy should be added.

5. ***Concern:*** There are additional elements that could strengthen this proposal and assist in increasing state interest integrated options for beneficiaries that we believe would not require significant costs such as addressing or further researching some aspects of financial integration.

Some states have made it clear that without options for shared savings to avoid cost shifting to Medicaid they do not see the opportunity in integrated programs. Most researchers have agreed that some form of shared savings is important to improve availability of integrated programs and CMS has requested input on how such options could be achieved under the DSNP platform. More information about these suggestions can be found in the joint SNP Alliance and ATI report here. These include:

a) Providing authority to the Secretary and MMCO to develop aligned definitions and instructions for a virtual Medicaid Loss Ratio (MLR) across both Medicare and Medicaid that could be used by states and participating D-SNPs to track total costs of care and to model benchmarks and corridors to facilitate shared savings and risk sharing. This could also support state and plan collaboration on how best to target supplemental benefits to dually eligible and partially dually eligible individuals in states.

b) Direct the Secretary authority to test models that allow a refined financial approach with states, on a D-SNP/FIDE SNP foundation (e.g., state upside and downside risk).

c) Direct the Secretary to allow more flexibility in the encounter data submission process to recognize alternative payment models that cross programs and to reevaluate Medicaid third party liability provisions that result in disparate reporting requirements across Medicare and Medicaid to assure that Medicaid is payer of last resort, or alternatively, include these provisions in CMMI authority to waive and test demonstrations around these concepts.

Conclusion

The SNP Alliance is committed to quality, excellence and health equity in service delivery to the individuals enrolled in our member plans. We appreciate this opportunity to provide comment and seek to work together to enhance the lives and well-being of all Americans—primarily those with complex needs. We are happy to answer any follow-up questions or provide additional information, should that be helpful.

Respectfully,

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