DUAL ELIGIBLE COALITION

Timeline of Congressional & Administration Actions to Integrate Care for Dual Eligible Beneficiaries

2008 – Medicare Improvements for Patients and Providers Act (MIPPA)

The passage of MIPPA in July 2008 required that, effective January 1, 2010, Medicare Advantage (MA) organizations offering new Dual Special Needs Plans (D-SNPs) or seeking to expand the service areas of existing D-SNPs, must enter into contractual relationships with States "to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under Title XIX."[i]

2010 – Affordable Care Act (ACA)

The ACA included several provisions promoting the integration of Medicare and Medicaid benefits for dual eligible beneficiaries:

- Section 2602 created the Federal Coordinated Health Care Office, commonly referred to as the Medicare-Medicaid Coordination Office (MMCO), within the Centers for Medicare & Medicaid Services (CMS). MMCO is charged with improving care and reducing costs for dual eligible beneficiaries, and rationalizing administration between Medicaid and Medicare.
- Section 3021 created the Center for Medicare and Medicaid Innovation (CMMI), also within CMS. Congress specified 18 specific models of interest for testing, two of which involved state integration and dual eligible beneficiaries.
- The ACA extended the authority for the continued operation of SNPs and made significant changes to MA payments.

2011 – CMS Moving Forward on Duals Demos

In July 2011, CMS requested letters of intent from states interested in participating in the Financial Alignment Initiative (FAI) demonstrations. By October 2011, 37 states and the District of Columbia submitted letters of intent to participate in one or both of the FAI models (capitated and managed fee-for-service).

2012 – Special Needs Plan Models of Care (MOC) Must be Approved by NCQA

Beginning January 1, 2012, all SNP Models of Care must be approved by the National Committee for Quality Assurance, as required by the ACA.

2013 – D-SNPs Must Have Certain Contract Elements in Place with Medicaid Programs

MIPPA, as amended by the ACA, required all D-SNPs to have contracts with the states in which they operate, effective January 1. These State Medicaid Agency Contracts, also called "MIPPA contracts," require D-SNPs to provide Medicaid benefits, or arrange for benefits to be provided, and serve and coordinate care for dual eligible enrollees.

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At a minimum, DSNP MIPPA contracts with states must document eight elements (42 CFR §422.107):

1. The DSNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits.
2. The categories of eligibility for dual eligible beneficiaries to be enrolled under the Special Needs Plan (SNP) (full Medicaid, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, etc.).
3. The Medicaid benefits covered under the SNP.
4. The cost-sharing protections covered under the SNP.
5. The process by which the state will identify and share with the SNP information on providers contacted with the state Medicaid agency.
6. The process by which the SNP will receive real-time information to verify enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the SNP.
8. The contract period for the SNP.

2013 – First Duals Demos Begin

2015 Duals Demos Gain Steam

In July 2015, states were offered the opportunity to extend their scheduled end dates by two years.

2017 – Duals Demos Reach Peak Participation, Initial Observations Available

In January 2017, CMS offered three states—Washington, Massachusetts, and Minnesota—an additional two-year extension. As of December 2017, 13 states were participating.[ii]

CMS contracted with RTI International for a comprehensive evaluation of the initiative including beneficiary experience, budgetary effects, and the effects on access to care, quality of care, and health outcomes; early findings on stakeholder engagement, care coordination, enrollment and beneficiary safeguards have been posted to the CMS website.[iii] Since October 2013, enrollment has grown from fewer than 500 beneficiaries to over 404,000 beneficiaries in December 2017. [iv]

2010 to 2017 – Growth of D-SNP Plan Offerings

From 2006 to 2017, the increase in the number of individuals choosing to enroll in MA tripled, from 11% to 35%.[v] In 2006, there were 256 D-SNPs with 491,877 enrollees; as of February 2017, there were 378 D-SNPs with 1,922,183 enrollees--about 20 percent of the total dual eligible population.[vi] CMS modified its MA payment rates to correct for the under-prediction (thus underpayment) of full benefit dual eligible beneficiaries and over-prediction/overpayment for regular MA and partial dual eligible beneficiaries.

2018 – Bipartisan Budget Act of 2018 (BBA18) Raises the Bar for D-SNP Integration

Section 50311(b) of BBA18 created a new Section 1859(f)(8) of the Social Security Act in order to increase integration of D-SNPs. D-SNPs must better integrate long-term services and supports (LTSS) and/or behavioral health services with state Medicaid agencies. Plans will have a contract with state Medicaid agency to:

- to provide Medicaid LTSS and/or Medicaid behavioral health benefits either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or
- (2) that specifies a process to share information with the state, or the state's designed (such as a Medicaid MCO), on hospital and SNF admissions of high-risk individuals who are enrolled in the D-SNP.

D-SNPs must establish procedures to unify the Medicare and Medicaid appeal and grievance processes.

In December, CMS issued State Medicaid Director Letter *Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare* (SMDL # 18-012) outlining new Medicare-Medicaid Financial Alignment Initiative-related opportunities for current demonstration states "and other states in the coming months."[vii]

2019 – BBA18 Provisions Implemented, MedPAC Mulls Further Steps Toward Full Integration

During 2019, 12.2 million Americans were concurrently enrolled in both the Medicare and Medicaid programs. In April, CMS issued State Medicaid Director Letter *Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare* (SMDL #19-002) opening up participation or expansion of existing FAI demonstration models and offering states the opportunity to propose new, state-specific models.

Contract Year (CY) 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P) seeks to implement D-SNP provisions of the Bipartisan Budget Act of 2018 which permanently authorized Medicare Advantage Special Needs Plans, including D-SNPs.

MedPAC's June 2019 *Report the Congress* found that D–SNPs are available in 42 states and DC and have 2.2 million enrollees, which accounts for between 15 percent and 20 percent of the dual eligible population. However, the level of integration between D–SNPs and Medicaid is generally low, and only about 18 percent of D–SNP enrollees are in plans with a significant degree of integration. MedPAC identified four potential policies that would improve the integration between D–SNPs and Medicaid:

- prohibiting beneficiaries who receive partial Medicaid benefits from enrolling in D–SNPs or requiring plan sponsors to cover them in separate plans;
- requiring D–SNPs to have comprehensive Medicaid contracts;
- limiting enrollment in D–SNPs to dually eligible beneficiaries who are enrolled in an MLTSS plan from the same parent company, an approach known as aligned enrollment; and
- preventing plan sponsors from offering look-alike plans.

2020 – CMS Limits "Look-Alike" Dual Eligible Special Needs Plans

In May, CMS finalized a proposed rule limiting Dual Eligible Special Needs Plan (D-SNP) "look-alikes." CMS explained that "look-alike plans have similar levels of dual eligible enrollment as D-SNPs but avoid the federal regulatory and state contracting requirements applicable to D-SNPs." The agency said its "phasing out D-SNP look-alikes will strengthen the ability of states and CMS to meaningfully implement existing and new statutory requirements for D-SNPs that Congress created in the BBA." Under the final rule, CMS will not enter into a contract:

- Starting for 2022, for a new MA plan, other than a SNP, that projects in its bid that 80 percent or more of the plan's total enrollment will be entitled to Medicaid, or
- Starting for 2023, for a renewing MA plan, other than a SNP, that has actual enrollment of 80 percent or more of enrollees who are entitled to Medicaid, unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.

The final rule allows time for existing D-SNP look-alikes to phase out. CMS said that under the final rule, "D-SNP look-alikes would be able to transition their membership into a D-SNP or another qualifying zero-premium plan offered by the MA organization beginning for the 2021 plan year."

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[i] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/SNPs_How_To_Document_111710.pdf.

[ii] https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf.

[iii] https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf.

[iv] https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf.

[v] Data Analysis Brief: *Managed Care Enrollment Trends among Dually Eligible and Medicare-only Beneficiaries, 2006 through 2017*, CMS Medicare-Medicaid Coordination Office, December 2018.

[vi] https://aspe.hhs.gov/basic-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges#overview.

[vii] 2020 Medicare Trustees Report: "After the introduction of MMPs in October 2013, enrollment grew nationally from approximately 3,400 enrollees in a single State to over 386,000 enrollees across nine States in October 2019 (down from ten States in October 2017, as the demonstration ended in Virginia in December 2017). Several of these contracts are set to expire in 2020 while other contracts have been extended through 2022. It is assumed that once the contracts expire, the majority of MMP enrollees will remain in the MA program by switching to SNPs."