What Do New Changes for Medicare-Medicaid Enrollees Mean for Health Systems, Providers, and Patients?

Webinar

June 20, 2019

The Commonwealth Fund

WEBINAR

Housekeeping

- All lines are on mute
- The webinar is being recorded and slides will be available afterwards
- For technical assistance, please contact representative at ReadyTalk

WEBINAR

About the Center

Our Mission: Bring the experience of consumers to the forefront of health innovation

Photos by Kevin Cantwell

Building consumer leadership

Improving health systems

Engaging policymakers

Conducting research

The Commonwealth Fund

CENTER FOR CONSUMER ENGAGEMENT in health innovation
A better way to better health. For everyone.

WEBINAR

Speakers

Ann Hwang, MD

Director, Center for Consumer Engagement in Health Innovation

Michelle Herman Soper

Director, Integrated Care, Center for Health Care Strategies

Melanie Bella

Chief of New Business and Policy, Cityblock Health, and Former Director, Medicare-Medicaid Coordination Office

Cheryl Phillips, M.D.

President and CEO

SNP Alliance

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Melanie Bella

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CITYBLOCK

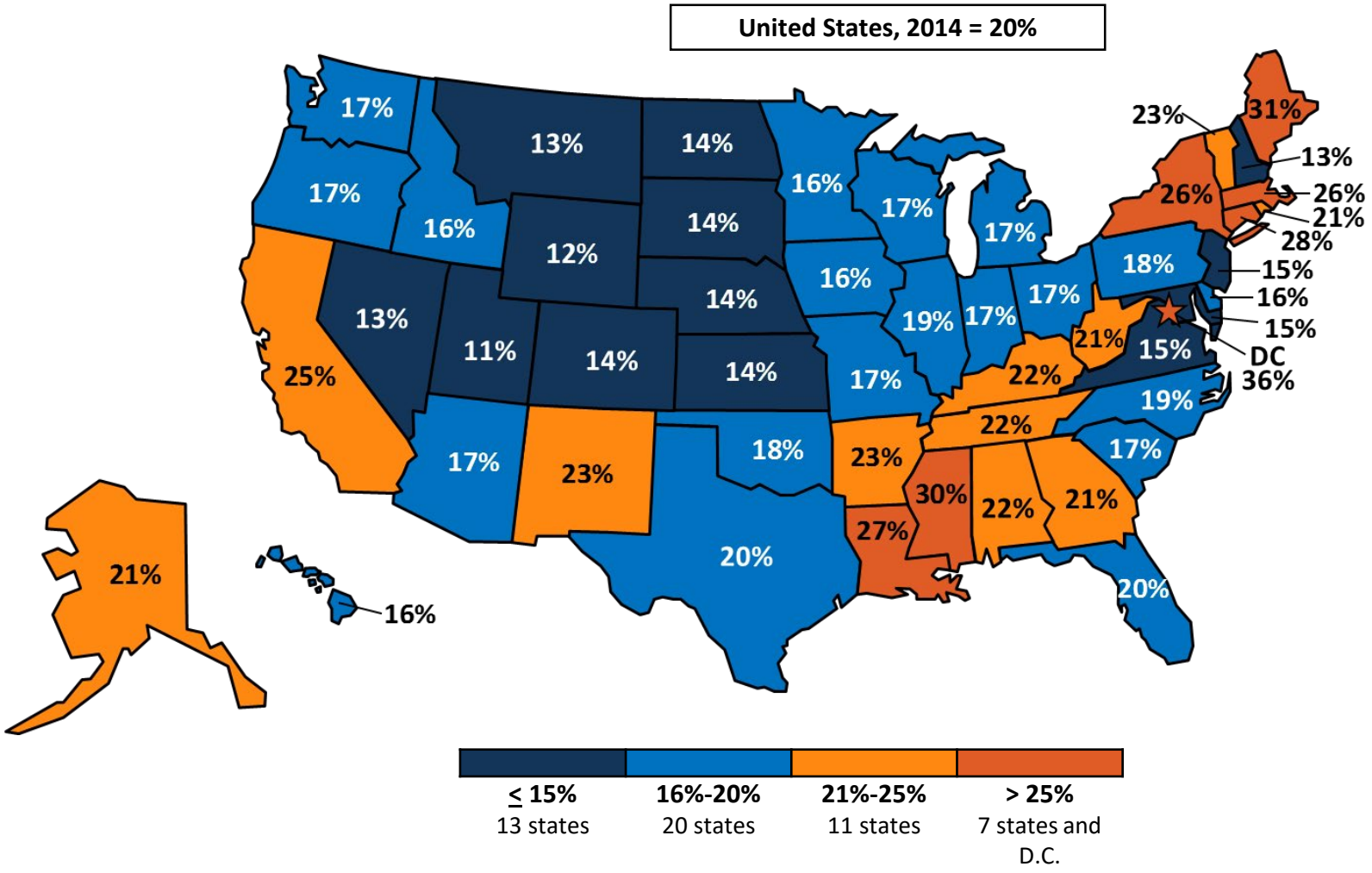
Snapshot of Medicare-Medicaid Enrollees

- In 2017, 12M there were 12M “dually eligible” individuals
  - 71% are full benefit, 29% are partial benefit
  - Roughly 60% are age 65 and older, 40% are under age 65
- Dual eligible individuals are medically, behaviorally, functionally and socially complex
  - 41% have at least one mental health diagnosis
  - 49% receive long-term care services and supports (LTSS)
  - 60% have multiple chronic conditions
  - 17% report that they have “poor” health status (vs. 6% of other Medicare beneficiaries)
- Dual eligibles account for a disproportionate share of spending
  - Medicare: 34%of spending, 20% percent of enrollees
  - Medicaid: 32% of spending, 15% of enrollees
- Dual eligible must navigate 2, sometimes 3, separate programs
  - Medicare: primary, acute, post acute services and prescription drugs
  - Medicaid: LTSS, behavioral health, Medicare premiums and cost sharing

Source: Medicare-Medicaid Coordination Office, Fact Sheet March 2019. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html

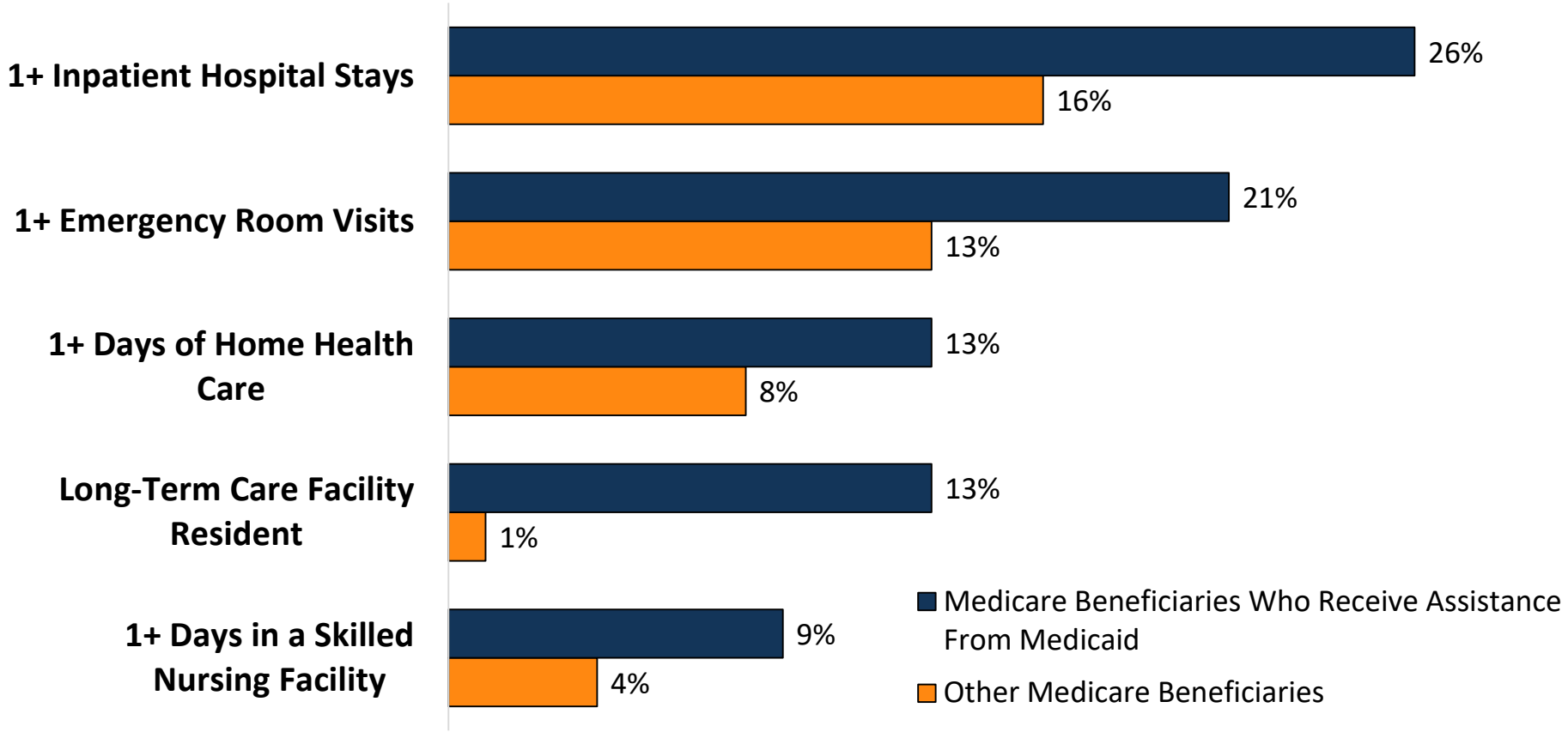
One in five people on Medicare receive assistance from Medicaid

Dual Eligible Beneficiaries as a Share of Medicare Enrollees, by State



SOURCE: Kaiser Family Foundation, "What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?" March 2017.

People on Medicare who receive assistance from Medicaid use more medical services than other people on Medicare



NOTE: Excludes Medicare beneficiaries in Medicare Advantage plans
SOURCE: Kaiser Family Foundation, "What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?" March 2017.

Challenges Created by Medicare and Medicaid Silos

- Fragmentation in administration, delivery, financing
- Misaligned incentives lead to cost shifting, inefficient spending, poor outcomes
- Highly complex system for beneficiaries and providers to navigate and use effectively

When both payers are involved, you can't look at one in the absence of the other

Promising Integration Vehicles

	Medicare Advantage Dual Eligible Special Needs Plan (D-SNP)	Medicare-Medicaid Demonstration Plan (MMP)	Program of All-Inclusive Care for the Elderly (PACE)
Medicare A, B and D benefits	✔	✔	✔
Medicaid LTSS benefits	May have separate Medicaid risk contract	✔	✔
Rate Structure (all are risk-adjusted)	Capitated for Medicare	Blended, capitated for Medicare and Medicaid	Separate, capitated for Medicare and Medicaid
Authorization	Permanent	Through 2022 (varies by state)	Permanent
Current Enrollment	2.5 M	385,000	45,000

Why Is This So Hard? What Are We Learning?

Challenges

- Disrupting the status quo
- Making the case for integration – to both beneficiaries and policymakers
- Limited state capacity/bandwidth
- Locating and engaging beneficiaries
- Increasing provider buy-in & appetite for financial risk
- Integrating LTSS, BH and other non-medical services
- Cost shifting and gaming
- Scaling

Early Successes

- Positive beneficiary experiences and outcomes
- Critical learning about assessments, care plans and care teams
- Integration of LTSS, BH and other non-medical services
- Unprecedented level of investment in infrastructure, people and community supports
- Meaningful risk adjustment and payment changes

Thank You

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CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

New Opportunities to Test Integrated Care

Michelle Herman Soper

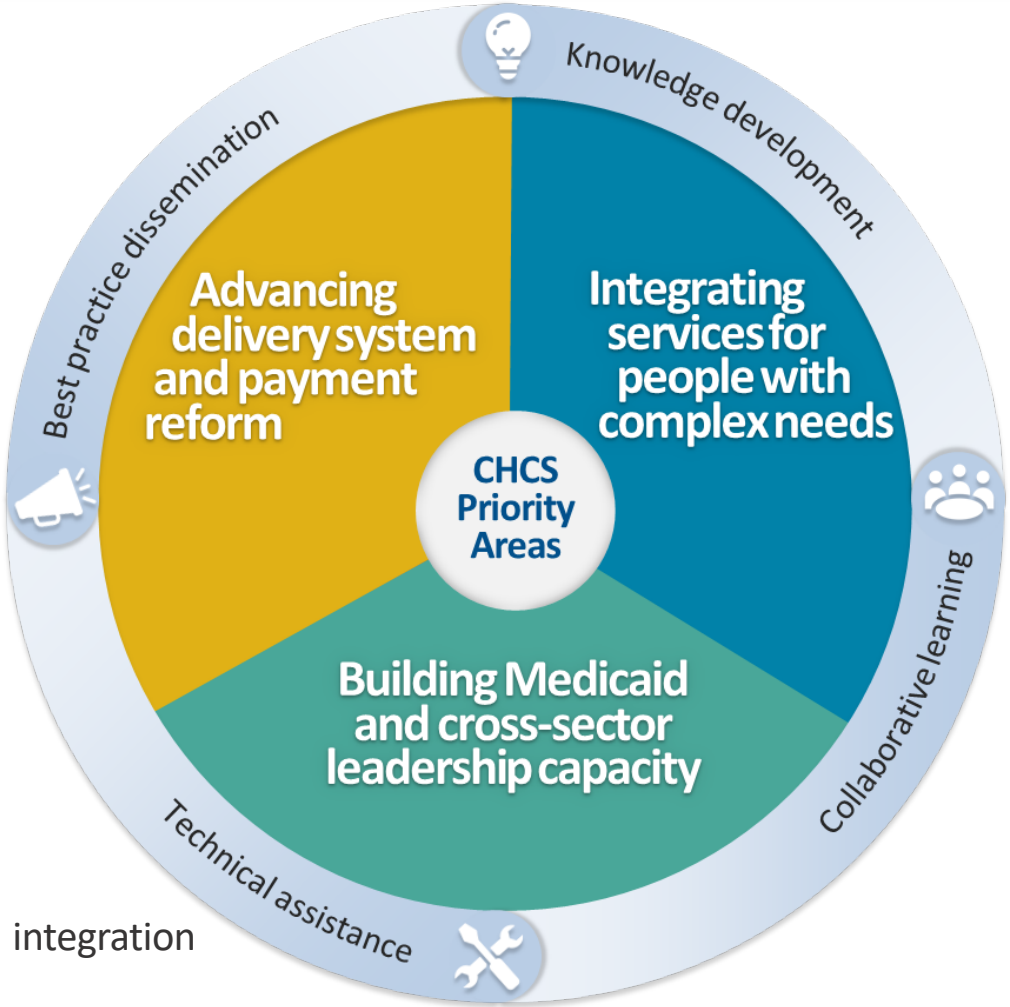
Director of Integrated Care, Center for Health Care Strategies

Webinar: What Do New Changes for Medicare-Medicaid Enrollees Mean for Health Systems, Providers, and Patients?

June 20, 2019

About the Center for Health Care Strategies

- **CHCS**: A non-profit policy center dedicated to improving the health of low-income Americans
- **Integrated Care Resource Center:*** A major project, conducted in partnership with Mathematica, that supports states pursuing integrated care models



* Find ICRC resources on Medicare-Medicaid integration for states and other stakeholders at https://www.integratedcareresourcecenter.com/

Financial Alignment Initiative: Impetus and Early Demonstration Activity

- Sec. 2602 of the Affordable Care Act created the Medicare-Medicaid Coordination Office (MMCO) at CMS
- Goals of demonstration models: to integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees, and improve quality and care experience and reduce costs
- 26 states submitted proposals
- 12 states launched a demonstration under the Financial Alignment Initiative; MN has an administrative alignment demonstration

Financial Alignment Initiative Demonstration Models

Capitated

CA, IL, MA, MI, NY, OH, RI, SC, TX, VA*

- Joint procurement of high-performing health plans (Medicare Medicaid Plans or MMPs)
- Three-way contract: CMS, state, health plan
- Single set of rules for marketing, appeals, etc.
- Blended payment, built-in savings
- Voluntary, passive enrollment with opt-out provisions

Managed Fee for Service

CO*, WA

- FFS providers, including Medicaid health homes or accountable care organizations
- Seamless access to necessary services
- Quality thresholds and savings targets

* No longer operates a demonstration

What's the Latest? Recent Research

- Early demonstration evaluation results* from 6 states:
  - Inpatient utilization: Reduction (3 states); Increase (1 state)
  - Skilled nursing facility admission: Reduction (3 states); No significant change (1 state)
  - Long-stay nursing facility placement: Reduction (3 states); Increase (1 state)
  - Medicare costs: Reduction (3 states); No significant change (3 states)
- Washington's MFFS evaluation (3 years): Gross Medicare Parts A & B savings of 11%
- High MMP enrollee satisfaction: In 2018, 90% rated health plans a 7 or higher (out of 10); 65% rated their plan as a 9 or a 10
- Integrated D-SNP analysis: Minnesota Senior Health Options study found that dually eligible beneficiaries in an integrated plan, compared to non-integrated plan, were:
  - 48% less likely to have a hospital stay;
  - 6% less likely to have an emergency department visit; and
  - More likely to use primary care and home-and community based services.

*Evaluations at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html

Three New Opportunities: April 24, 2019 State Medicaid Director Letter

#1: Capitated model Financial Alignment demonstration

- Current capitated states can request extensions and/or changes such as geographic scope to existing, promising models
- New states can work with CMS and stakeholders to explore testing new ideas under the current framework

#2: Managed fee-for-service model Financial Alignment demonstration

- New states can explore a MFFS model demonstration, using an approach similar to WA's high-intensity intervention for high-risk beneficiaries

#3: State-specific models

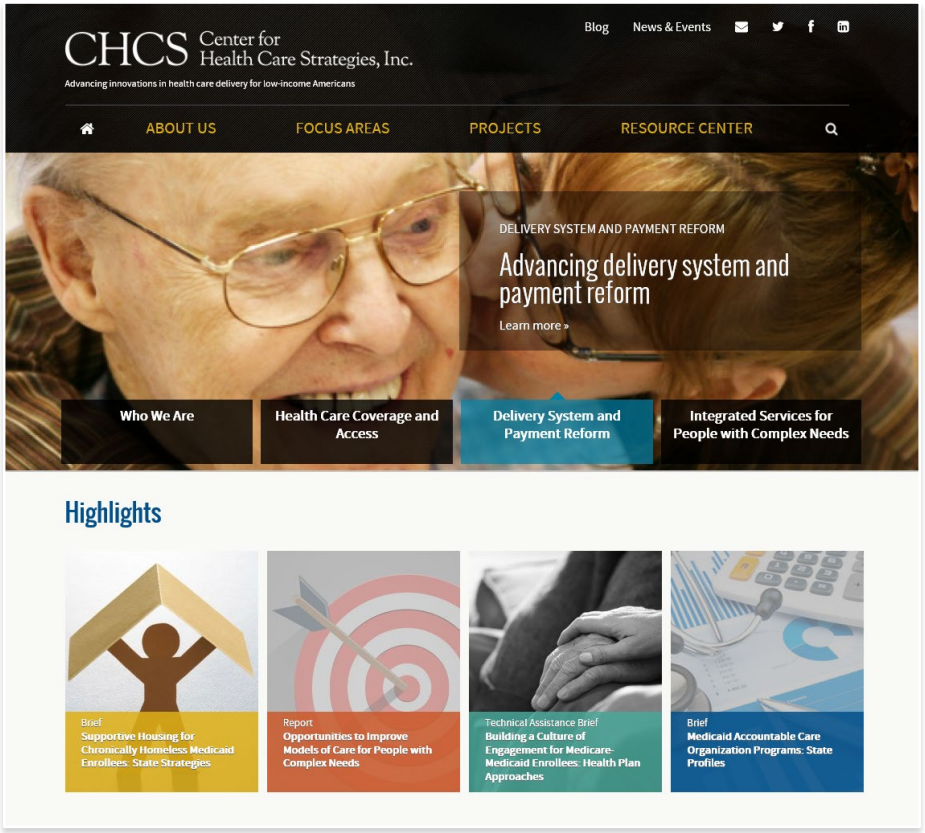
- States may propose to test new *state-developed* models for better serving dually eligible individuals
- Interested in flexible, accountable, and person-centered concepts that:
  - Address social determinants of health
  - May include value-based payment reform methodologies
  - Include robust stakeholder engagement
  - Promote beneficiary empowerment and independence
  - Increase access to coordinated and high-quality care
  - Reduce expenditures
  - Preserve access to all covered Medicare benefits, cost-sharing protections and choice of provider

Lessons from and Considerations for Implementing New Demonstrations

- Upfront investments are key for program design and launch
  - IT and data infrastructure or platform
  - Health plan capacity and interest
  - Medicare knowledge and expertise
- Political, leadership and stakeholder support is best achieved through robust engagement
  - Develop shared goals, address common concerns, commit to collaboration
  - Ongoing efforts to maintain support over time
- Demonstration parameters and care interventions should consider:
  - Population-specific and possible significant unmet needs
  - Person-centered care goals and oversight
  - Impact of requirements on providers
- Realistic expectations for shared savings potential/financial risk
- Ongoing alignment barriers in some areas

Visit CHCS.org to…

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries



Contact Information

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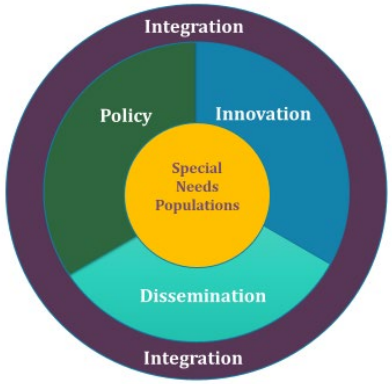
Advancing Integration for D-SNPs

Cheryl Phillips, M.D.
President and CEO
Special Needs Plan Alliance

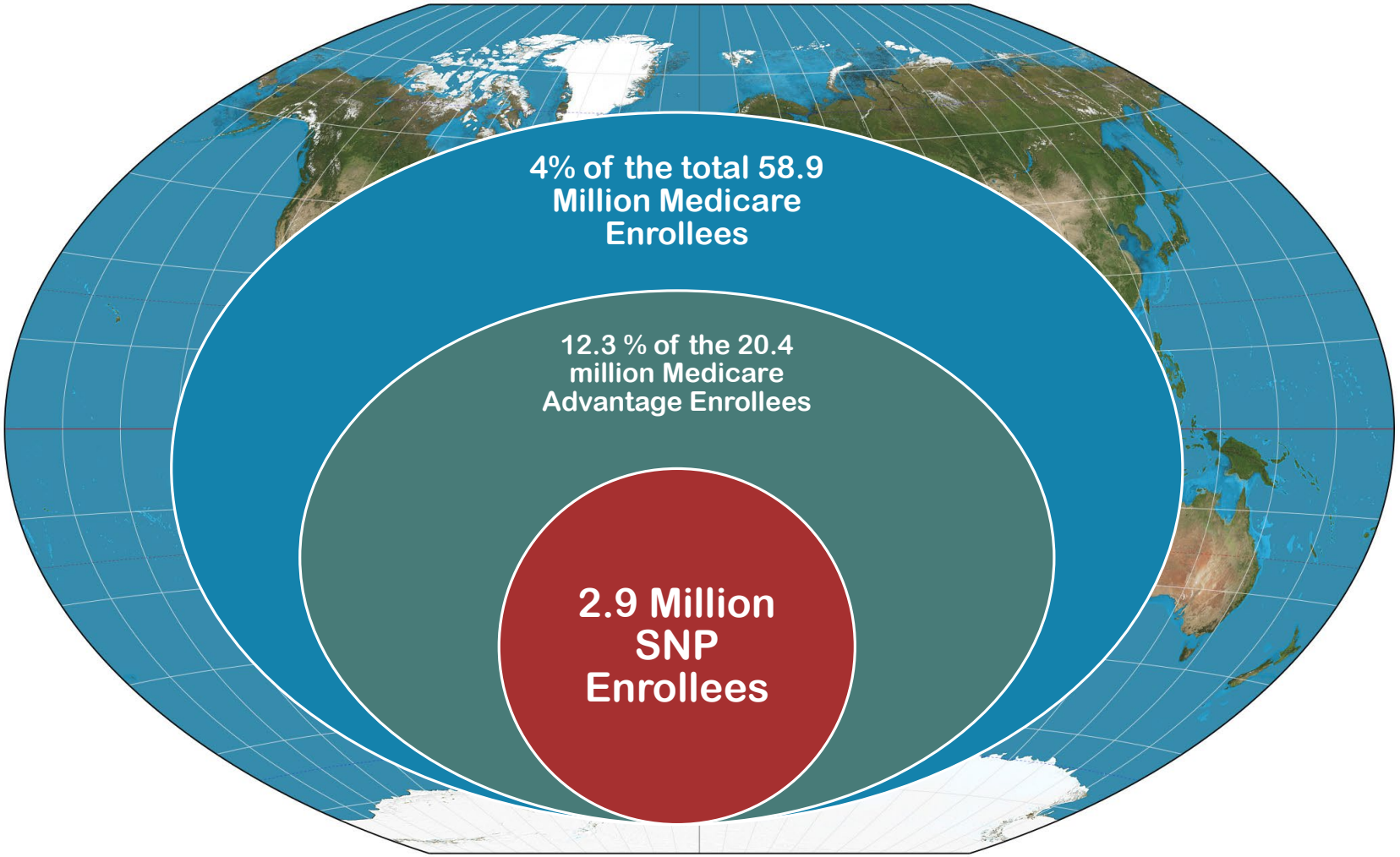
SNP Alliance
The National Voice for Special Needs and Medicare-Medicaid Plans
A National Nonprofit Leadership Organization

The SNP Alliance – Introduction

- SNPA a national leadership organization whose mission is to improve care and services for high-need and high-cost individuals through specialized managed care.
- Our members represent approximately 400 SNPs and Medicare-Medicaid plans, with over 1.9 million individuals enrolled (over half of the current national enrollment)



Special Needs Plans in the World of Medicare



Three Types of Targeted Managed Medicare

Special Needs Plans

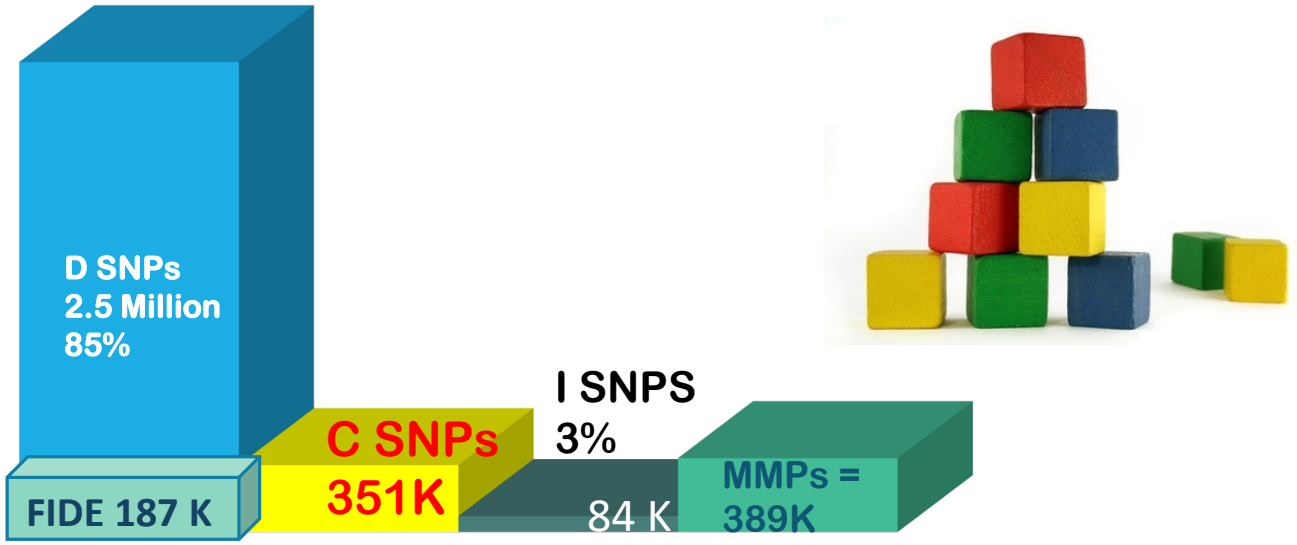
Are a type of managed Medicare (MA) plans - > **2.9 million enrollees**

Began enrollment in 2006 / received permanency – January, 2018

3 types:

- **Chronic Condition** – serving those with serious and potential life-threatening chronic conditions. (C-SNPs)
- **Dually-eligible** – serving those with both Medicare and Medicaid enrolled in managed care (may be aligned or not aligned). (D-SNPs)
- **Institutional** – serving those who are at the state definition of "institutional level of care" for at least 90 days. Most are in NHs, but not all. (I-SNPs)

How the SNP Types Stack UP Nationally



Total National SNP Enrollment Feb, 2019 = 2,910,189

The Focus on Medicare-Medicaid Integration

- Aligning services to best meet the individual's needs
- Coordinating medical and LTSS benefits – avoid redundancy / gaps / reduce confusion and system complexity
- Ability to target needed additional benefits
- Acute care is a significant driver of LTSS utilization (particularly long-stay NH)
- Further supports longer term shift to community-based services

SNP Permanency 2018 and CMS Rulemaking April 1, 2019

BBA 2018 defined, and CMS codified in regulation the minimum standards for D-SNP Integration – effective 2021 Contract year. D-SNPs must meet ONE or more of the following criteria, *"to the extent permitted under State Law":*

1. FIDE SNP

- MCO contract inclusive of MLTSS and BH consistent with state policy
- Must include 180 nursing facility days per year

2. HIDE SNP

- Parent org has capitated Medicaid MLTSS and/or BH contract
- May include PIHP and PAHP contracts

3. Care Transitions

- Notify state when "high-risk" full dual is admitted to hospital or SNF
- States define process

Care Coordination

CMS is clarifying and strengthening the meaning of "arranging for [Medicaid] benefits" for all DSNPs.

Examples and Requirements:

- Verify eligibility for LTSS, BH services and make arrangements for Medicaid service provision
- Awareness of and coordination with the other "payers" for unaligned members
- Education/coaching on the roles of Medicaid and DSNP
- Training plan staff and network providers on availability of LTSS and BH services in Medicaid

Appeals & Grievances Coordination

CMS is implementing a coordinated A&G process for all DSNPs in 2020 and a unified A&G process for exclusively aligned DSNPs in 2021

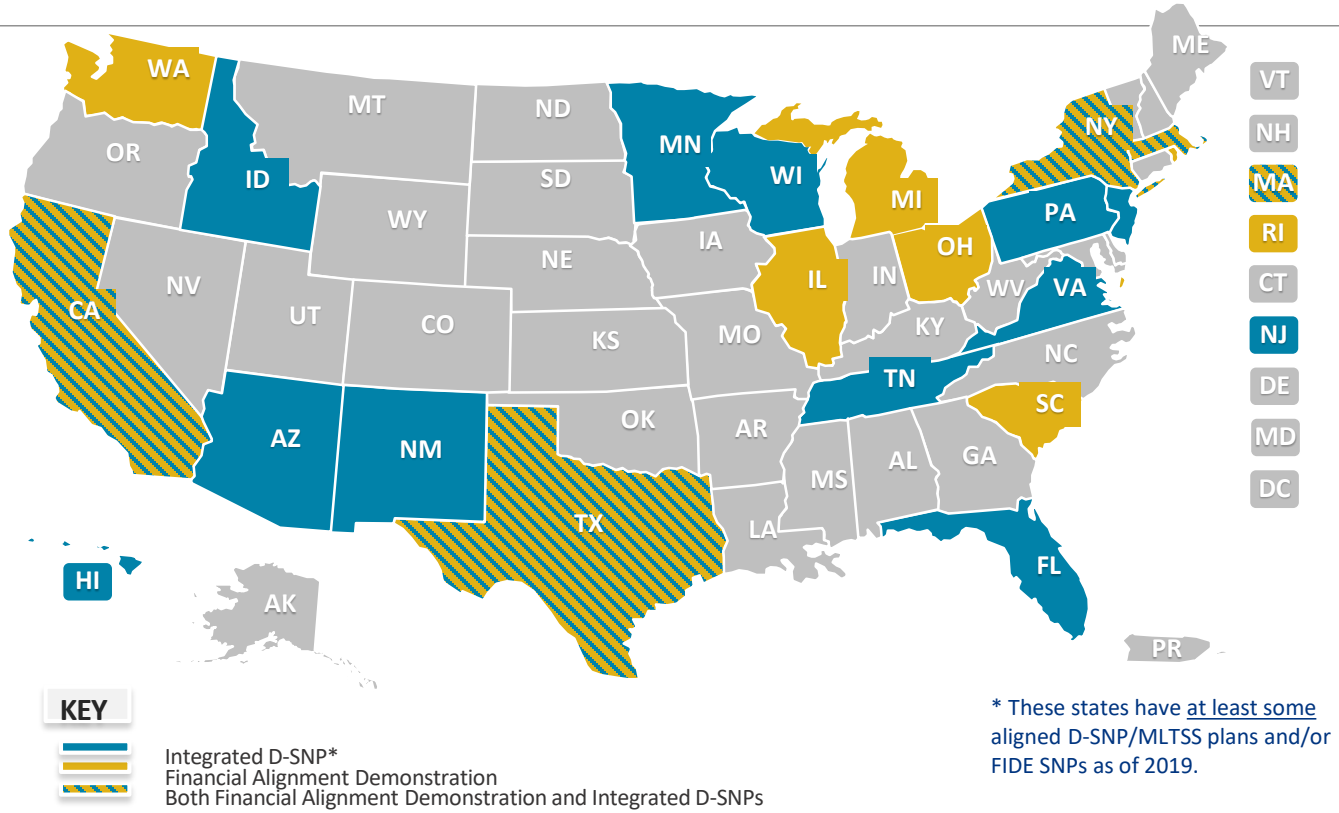
All DSNPs (2020)

- Must offer to assist with obtaining Medicaid services, resolving grievances, requesting authorization of services, and navigating A&G
- Must provide enrollee reasonable assistance in completing A&G forms and taking procedural steps
- May coach the enrollee on how to self-advocate

FIDE/HIDE with Exclusively Aligned Enrollment (2021)

- Integrated organization determinations (Medicare determinations and adverse benefit determinations)
- Integrated reconsiderations (MA reconsideration/ appeal of adverse org determination)
- Integrated grievance (dispute or complaint about providers)

States at the Forefront of Integration in 2019



* These states have at least some aligned D-SNP/MLTSS plans and/or FIDE SNPs as of 2019.

Flexibility in Supplemental Benefits

UNIFORM FLEXIBILITY

Guidance Memo 4-27-18

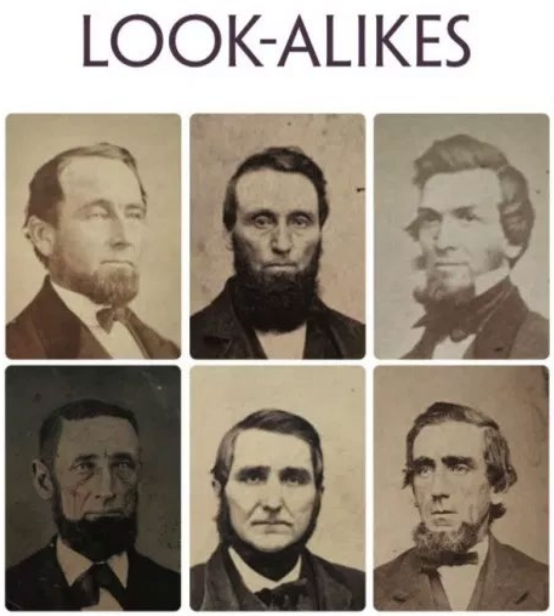
- CMS reinterpreted "uniformity requirement"
- May target benefits, but must provide for equal tx of enrollees with the same health status or disease status
- CMS also reinterpreted "primary health related", if an item or service that is used to dx, compensate for physical impairments, addresses fxnl/psychological impact of injuries or health conditions, or reduces avoidable healthcare utilization

SPECIAL SUP BENEFITS FOR CHRONICALLY ILL (SSBCI) –CY 2020

Guidance Memo - April 24, 2019

- Defines "chronically ill"
- Plans need not submit processes used to identify enrollees who qualify – waiver of uniformity requirements
- BROAD discretion in developing items and services that may be offered (10 general categories listed)
- If benefits may be individualized, unclear how plans will include these in their bids.

Emergence of the "Look Alikes"



General MA plans, targeted to those dually-eligible, but without any Medicaid coordination or integration.

Growth of these plans are driven by a number of market and policy forces

CMS specifically raised the issue in the *CY2020 Final Call Letter.* Potential ways to address:

- Require to make them meet D SNP requirements
- Further limits on marketing
- Beneficiary notification when an integrated option is available in that service area
- Possible further rule-making by CMS

CMS and States have the opportunity to make D SNPs more attractive – make it be a product of choice for duals

Will Medicare beneficiaries be able to navigate all this?

- Special Needs Plans for those dually eligible for Medicare and Medicaid (D-SNPs) are an important vehicle to integrate care and services for those with complex medical issues who also have long term service and support and/or behavioral health needs.
- D-SNPs will be able to continue enrollment after 2021 if they meet one of the 3 described requirement for integration, as defined in the Balanced Budget Act of 2018.
- Considerable barriers exist for plan to move into "fully integrated" D SNPs – at the state and federal policy level
- Consumers are facing a myriad of options and choices – most of which they do not well understand.
- Helping people navigate with clear and usable information must be a priority for CMS, states and health plans.

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Questions?

Thank You

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