Integrated Care for Individuals with Dual Eligibility

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Kaiser Center for Total Health

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Exploring Opportunities to Advance Medicare-Medicaid Integrated Care

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Exploring Opportunities to Advance Medicare-Medicaid Integrated Care

LTQA Member Symposium:
Integrated Care for Individuals with Dual Eligibility

Michelle Herman Soper
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December 9, 2019
About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans.
Significant Growth in Integrated Care Programs for Dually Eligible Beneficiaries

Note: MA, WI, and MN are still integrated in 2019. NC was considered integrated/aligned in 2009, but the NC Medicare Health Care Quality Demo ended in 2011.
Federal Factors Encouraging Integrated Care

- New state demonstrations and opportunities for shared savings
- Balanced Budget Act of 2018
  - D-SNP permanency
  - New D-SNP integration standards
- Policies that promote aligned enrollment
- PACE
# 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 to existing, promising models (i.e., geographic scope)
- New states can work with CMS and stakeholders to explore testing new ideas under 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
- 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
New D-SNP Integration Standards

D-SNPs must meet at least one of the following criteria effective CY 2021:

1) Cover Medicaid behavioral health services and/or LTSS to be either:
   » A Fully Integrated Dual Eligible SNP (FIDE SNP), or
   » A Highly Integrated Dual Eligible SNP (HIDE SNP) or

2) Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for group of high-risk enrollees to improve coordination during transitions of care

Current CHCS Projects Advancing Integrated Care

- **Integrated Care Resource Center (ICRC):** Provides technical assistance (TA) to states pursuing FAI demonstrations, D-SNP-based, and other integration models in partnership with Mathematica (Centers for Medicare & Medicaid Services)

- **Promoting Integrated Care for Dual Eligibles:** Works with nine integrated health plans to identify and disseminate successful strategies for integrating care for dually eligible members (The Commonwealth Fund)

- **Better Care Playbook:** Developing an online resource center of the latest evidence-based and promising approaches to improve care for people with complex needs, including dually eligible beneficiaries (Six Foundation Collaborative)

- Partnership with **ADvancing States:** Producing three issue briefs in partnership with ADvancing states on: (1) the value of pursuing Medicare-Medicaid integration to Medicaid agencies (*released Nov 20*); (2) state considerations for embarking on a new integration initiative; and (3) using data to manage dually eligible beneficiaries

- Planning new work in 2020 to examine factors for states’ integration success and opportunities to help states in various stages move forward
Key Factors for State Success—And Needed Supports

- State capacity
- Marketplace
- Political will and policy landscape
- ROI
Considerations for States Advancing Models or New to Integrated Care

- What’s worked and why?
- Where do we start? What is the most realistic (and incremental) way forward?
  - Understanding our duals population
  - Assessing the current D-SNP market
  - Examining ways to increase D-SNP and Medicaid coordination
- How can information sharing with D-SNPs support Medicaid care management goals?
- How can we promote aligned enrollment?
- Are providers on board?
ADvancing States Dual Eligible and Medicare Project

Damon Terzaghi
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ADvancing States
ADvancing States Overview

• National Association that represents state agencies providing LTSS and other services and supports to Older Adults and People with Disabilities
  – 56 members (50 states, DC, 5 territories)
  – Previously known as NASUAD until August 27, 2019
• Led by a board of directors comprised of state agency officials
• Provides direct technical assistance, research, regulatory and policy analysis to states
• Facilitates state-to-state information sharing via teleconferences/webinars, e-mail surveys, policy committees, and national conferences
• Educates and advocates for state agency interests in front of Congress and the Federal Government
In December 2018, the ADvancing States board directed the Association to:
- Increase the membership’s knowledge of Medicare; and
- Support members as they engage in Medicare alignment.

2019 Project Includes:
- Series of webinars on select Medicare issues;
- Three papers on Medicare & Dual Eligibles:
  - Case for Integration;
  - Considerations for Planning;
  - Available Data & Potential Uses.
Paper One: The Value of Integration

• Highlights the value of integrated care for state Medicaid agencies

• Key Findings:
  – Improved beneficiary experience, health outcomes and quality of life due to improved service coordination;
  – Increased program efficiencies due to aligned financial incentives to provide person-centered care; and
  – Improved Medicaid program administration and management due to better access to Medicare data and increased capacity manage the population.
Examples of Barriers to Integration

• State Capacity:
  – State employment (FTEs) has been static or declined over the past decade despite increased demands;
  – Medicaid administration requires different knowledge/skillset than Medicare integration;
  – IT infrastructure (or lack thereof) may not have capacity to handle Medicare data;
  – Not many individuals understand both systems (and a lot are at consulting firms!)

• Plan and provider willingness to participate;

• Financial incentives for integration, if any, require states to assume front-end risk & CMS to receive majority of reward.