LTQA Coffee Hour: Advancing Medicare-Medicaid Integration During the COVID-19 Pandemic

Key Takeaways from the LTQA Community Discussion

November 17, 2020

Introduction

Individuals dually eligible for Medicare and Medicaid have been disproportionately affected by the COVID-19 pandemic due to intersecting risk factors, including chronic conditions and racial and socioeconomic disparities. On top of this, dual-eligible individuals must navigate two complex and often conflicting insurance systems to receive care.

During LTQA's inaugural Member Coffee Hour on November 17, 2020, Allison Rizer of ATI Advisory presented new findings from analyses of Medicare Current Beneficiary Survey data and Centers for Medicare & Medicaid Services (CMS) preliminary COVID-19 outcomes as explored in a recent ATI Advisory blog post. She also shared Medicare-Medicaid integration policy opportunities states can pursue, even in the absence of a full MLTSS program (see the presentation slides here. Ms. Rizer's presentation was followed by an LTQA community discussion.

Presentation Summary

Ms. Rizer first presented an overview of risk factors and outcomes that contribute to high rates of adverse outcomes related to COVID-19 among dually eligible individuals. This population tends to have high rates of chronic conditions that are risk factors for COVID-19, such as mental illness (i.e. depression), respiratory conditions (i.e. emphysema, chronic obstructive pulmonary disease (COPD), or asthma), diabetes, serious heart conditions, and high body mass index (BMI). Dual eligibles are also more likely to have high levels of frailty and long-term services and supports (LTSS) needs, with 25% of full duals needing assistance with two or more activities of daily living (ADLs) and 18% residing in a facility.

In part due to these risk factors, dually eligible populations have experienced significantly higher rates of hospitalization due to COVID-19 than the Medicare-only population. There also exist significant racial disparities in COVID-19 hospitalizations between dual eligible and Medicare-only populations, with dually eligible Black, Hispanic, and American Indian/Alaska Native having the worst outcomes.

Ms. Rizer then outlined policy opportunities for states to address Medicare-Medicaid integration. Broadly, these opportunities include improving state understanding of the Medicare Advantage environment, implementing and leveraging a D-SNP program, and pursuing Financial Alignment Initiative (FAI) authority outside the traditional Medicare-Medicaid Plan (MMP) program. Other possible opportunities include maximizing the use of home- and community-based services (HCBS) and consolidating Medicaid benefits into one program.

For more information, please see the ATI Advisory blog post on this topic and Ms. Rizer's slides from the session.

Innovative State Model – Alabama
Ms. Rizer noted that Alabama pays MA plans, including non-D-SNPs, a premium to cover duals cost-share liability. The state has a contract with MA plans, and plans, providers, and the state reportedly appreciate the administrative efficiency. The approach also has saved the state Medicaid program money.

Key Takeaways from the Community Discussion

The LTQA community discussion touched on state integration challenges, racial disparities, non-medical supplemental benefits in Medicare Advantage, settings data, D-SNP integration requirements, and the outlook for the new administration. See **Table 1** below for possible next steps for LTQA members and resources on these topics.

State Integration Challenges

States are generally not able to focus on integration as they respond to COVID-19 and budget shortfalls. LTSS Directors are currently focused on delivering HCBS to people who previously received services in congregate settings and keeping their networks together as retainer payments end. Another immediate priority for states is implementing Electronic Visit Verification (EVV), as penalties start in January 2021. Other state challenges include:

- States require a specialized knowledge base around Medicare to tackle things like capitating MA plans. This expertise is hard to come by and retain. States need additional funding to hire staff and contract the needed expertise, or alternatively, foundations and CMS should fund organizations that provide states with the expertise.
- Because HCBS are an optional Medicaid benefit, there is concern that states will cut HCBS and related benefits for people with disabilities and older adults due to budget shortfalls.
- More than 20 states have been asked to make a 15-20% reduction in their Medicaid budgets. The temporary enhanced FMAP may not be sufficient to address increased need and budget shortfalls. Additionally, provider networks are struggling. As a result, duals integration is on the backburner.

Racial Disparities

Racial disparities in COVID hospitalizations among the dual eligible population are especially pronounced – for example, Black dual eligible beneficiaries have more than double the hospitalization rates due to COVID as white dual eligible beneficiaries, while white dual eligible beneficiaries have similar hospitalization rates as Black Medicare-only beneficiaries (Medicare-only beneficiaries having lower hospitalization rates all around). Recent CMS show a nearly eight-fold increase in hospitalization rates for Black dual eligible beneficiaries compared with white non-duals.

Medicare Advantage Non-Medical Supplemental Benefits

Offerings of new Medicare Advantage non-medical supplemental benefits increased from 2020 to 2021. This can be one avenue to address some issues that dual eligible beneficiaries are at risk of, i.e. food insecurity and lack of internet.

Settings Data

Integrated programs other than PACE are reportedly not showing better outcomes for duals during the pandemic. Socioeconomic factors, such as lack of access to high-speed internet, are predictors of whether people are able to stay home/isolate during the pandemic, and this may explain the outcomes.

D-SNP Integration Requirements

Auditing next year is likely to focus on integrated grievances and appeals, which plans have a little more control over than data sharing. Data sharing is not something most states are working on at the moment.

Outlook for the New Administration

CMS is committed to alignment. While the pandemic has slowed these efforts, we are likely to see more in the coming year. The Biden administration is likely to prioritize expanding access to HCBS. The Direct Contracting model is an innovative model for states.

Table 1: LTQA Community Discussion Highlights, Possible Next Steps, and Resources

Topic	Discussion Highlights	Possible Next Steps for LTQA Members	Resources
State Integration Challenges	States are generally not able to focus on integration as they respond to COVID-19 and budget shortfalls. LTSS Directors are currently focused on delivering HCBS to people who previously received services in congregate settings and keeping their networks together as retainer payments end. Another immediate priority for states is implementing Electronic Visit Verification (EVV), as penalties start in January 2021.	Advocate for increased funding for states to work on integrated models	• ADvancing States and CHCS Briefs on Integration for States • ATI Advisory Blog on Medicaid-Capitated D-SNPs
Racial Disparities	Racial disparities in COVID hospitalizations among the dual eligible population are especially pronounced – for example, Black dual eligible beneficiaries have more than double the hospitalization rates due to COVID as white dual eligible beneficiaries, while white dual eligible beneficiaries have similar hospitalization rates as Black Medicare-only beneficiaries (Medicare-only beneficiaries having lower hospitalization rates all around). Recent CMS data show a nearly eight-fold increase in hospitalization rates for Black dual eligible beneficiaries compared with white non-duals.	Advocate for funding in the next COVID package to address racial inequities in the dual eligible population	• Justice In Aging Issue Brief on Centering Equity for Dual Eligible Beneficiaries

Medicare Advantage Non-Medical Supplemental Benefits	Offerings of new Medicare Advantage non-medical supplemental benefits increased from 2020 to 2021. This can be one avenue to address some issues that dual eligible beneficiaries are at risk of, i.e. food insecurity and lack of internet.	Advance learning from plan and provider experiences of offering new non-medical supplemental benefits in Medicare Advantage	• LTQA and ATI Advisory Roadmap and Policy Brief on Advancing Non-Medical Supplemental Benefits in Medicare Advantage
Settings Data	Integrated programs other than PACE are reportedly not showing better outcomes for duals during the pandemic. Socioeconomic factors, such as lack of access to high-speed internet, are predictors of whether people are able to stay home/isolate during the pandemic, and this may explain the outcomes.		• Better Care Playbook Blog on the PACE Response to COVID-19 • National Bureau of Economic Research Working Paper on Social Distancing, Internet Access and Inequality • BMA Report on Medicare Experiences with Telehealth during COVID-19
D-SNP Integration Requirements	Auditing next year is likely to focus on integrated grievances and appeals, which plans have a little more control over than data sharing. Data sharing is not something most states are working on at the moment.		

Outlook for the New Administration	CMS is committed to alignment. While the pandemic has slowed these efforts, we are likely to see more in the coming year. The Biden administration is likely to prioritize expanding access to HCBS. The Direct Contracting model is an innovative model for states.		• MLTSS Association Value Proposition for MLTSS Health Plan Participation in CMMI Direct Contracting model