CHCS Center for Health Care Strategies, Inc.

Improving the quality and cost-effectiveness of publicly financed health care

National Update on Efforts to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

July 11, 2014

Agenda

I. Welcome and Introductions

II. Dual Eligibles – Who are they now?

III. Platforms for Service Delivery and Integration

IV. Overview of MLTSS Landscape

V. Movement to Integrated Care

VI. D-SNPs and State Contracting Options

VII. Questions and Answers

Welcome and Introductions

Sarah Barth, JD
Director, Long Term Services
Center for Health Care Strategies

Alexandra Kruse, MS, MHA
Senior Program Officer
Center for Health Care Strategies

CHCS
Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

- **Priorities**: (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

Working With States

Implementing New Systems of Integration for Dual Eligibles (INSIDE)

- Supported by The SCAN Foundation and The Commonwealth Fund
- Brings together 16 states implementing programs of integrated care for group learning and innovation sharing, as well as opportunities to work with federal partners
- Arizona, Arkansas, California, Colorado, Idaho, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington

Working With Community-Based Health Organizations

Promoting Integrated Care for Dual Eligibles (PRIDE)

- Supported by The Commonwealth Fund
- Brings together seven integrated health organizations to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees
- PRIDE consortium membership:
  - CareSource (OH)
  - Commonwealth Care Alliance (MA)
  - Health Plan of San Mateo (CA)
  - *i*Care (WI)
  - Together 4 Health (IL)
  - Ucare (MN)
  - VNSNY Choice (NY)

Working With Centers for Medicare and Medicaid Services

Integrated Care Resource Center (ICRC)

- Established by CMS to help states advance integrated care delivery for dual eligibles
- Technical assistance and online resources provided by CHCS and with Mathematica Policy Research
- Engage stakeholders at every level in design and implementation
- Build on existing relationships between state Medicaid agencies, providers, and beneficiaries
- Ensure beneficiary protections under Medicare
- Include quality standards and rigorous evaluations
- Establish payment strategies that encourage provider participation and create potential state and federal savings

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Dual Eligibles - Who are they Now? The Numbers

- 10.2 million Americans are eligible for Medicare and Medicaid (known as Medicare-Medicaid enrollees or "dual eligibles")
- 7.4 million are "full duals"
- 17.7% increase, from 8.6 million to 10.2 million between 2006 and 2011 (One in five Medicare enrollees)
- In comparison, the number of Medicare-only beneficiaries grew by only 12.5%

Source: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013.

Dual Eligibles - Who are they Now? Trends

- The number of dual eligibles < age 65 increased by 15.6% since 2006 while those ≥ age 65 increased by only 5.2%
- Half qualified for Medicare because of disability (physical or mental) rather than age
- More likely to be younger, female, and of racial/ethnic minority status
- Nearly one-fifth have three or more chronic conditions
- Those over the age of 65 are much more likely to have been diagnosed with three or more chronic conditions
- Those under age 65 in were more likely than those 65 or over to have been diagnosed with a mental illness
- More than 40 percent use long-term services and supports

Sources: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013; *Dual-Eligible Beneficiaries of Medicare and Medicaid:, Health Care Spending, and Evolving Policies*, Congressional Budget Office, June 2013.

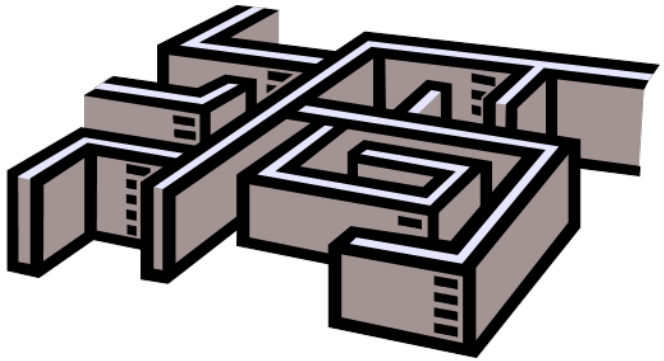
Spending on Duals and Delivery System Trend

- In 2009, the federal and state governments spent more than $250 billion on dual eligibles' health care benefits
  - Dual eligibles are 13% of combined population of Medicare beneficiaries and aged, blind, or disabled Medicaid beneficiaries and account for 34% of combined Medicare and Medicaid total program spending
- The managed care enrollment rate for full benefit Medicare-Medicaid enrollees grew from 7.8% in 2006 to 15.2% in 2011

Source: *Data Analysis Brief Medicare-Medicaid Dual Enrollment from 2006 through 2011,* Prepared by Medicare-Medicaid Coordination Office, February 2013.

What Does Care Look Like for Duals Without Coordination and Integration?

- Fragmented and uncoordinated
- Difficult to navigate
- Gaps in care
- Not focused on the individual
- Cost-shifting between states and the federal government
- Institutional bias, not communities



At the Center: The Individual

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I work or do other activities that are important to me.
- I have relationships with family and friends I care about.
- I decide how I spend my day.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

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Platforms for Service Delivery and Integration

Approach	Examples
PACE	Most states
Medicaid FFS with enhanced care coordination	CO, NC
Medicaid Managed Long-Term Services and Supports	AZ, CA,DE, NJ, FL, KS, MI, MN, NM, NY, TX
Joint State & Federal Financial Alignment Initiatives	CA, CO, IL, MA, MN, NY, OH, SC, VA, TX, WA
Dual Eligible Special Needs Plan Platform	AZ, HI, NM, TN
Fully Integrated Dual Eligible Special Needs Plans	MA, MN, WI

Key Component - Fundamental Elements of a Person-Centered Care Model

- Active participation in service planning and delivery
- Holistic service plans based on comprehensive needs assessment
- Coordination and referral for services not covered by programs
- Meaningful choices of service alternatives
- Self-direction of community-based services

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MLTSS - State Experience

- MLTSS programs doubled from 8 to 17 between 2004 – 2012 with 19 as of July 2014
- By end of 2014, 26 states are projected to have MLTSS programs
- Currently, 12 states have mandatory enrollment, 7 voluntary, and 1 has both
- Number of MCOs in the MLTSS market has expanded accordingly
- Most offer consumer-directed options *

**The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update,* Truven Health Analytics for Centers for Medicare and Medicaid Services, July, 2012.

States with MLTSS Programs

- Arizona
- California
- Delaware
- Florida
- Hawaii
- Kansas
- Massachusetts
- Michigan
- Minnesota
- New Jersey
- New York
- New Mexico
- North Carolina
- Ohio
- Pennsylvania
- Tennessee
- Texas
- Washington
- Wisconsin

Promoting Rebalancing and Choice of MLTSS

Mechanism	State
Plans responsible for NF and HCBS under blended capitation rate (full risk, full profit)	MN, NJ, WI
Plans responsible for NF and HCBS under blended capitation rate (risk and profit shared with state)	AZ, HI, TN
HCBS available as an entitlement (enrollment not capped) for NF level of care	TN, TX, WI
Higher rate for HCBS services	MN
Transition allowance benefit	TN
Plans required to work with consumers who want to transition	HI, MN, TN, TX
Performance measures require service timelines for sentinel events	AZ,TN, TX
Performance measure with penalty for NF utilization	TX

Source: Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf

New Mexico Coordination of Long Term Services (CoLTS) - Controlling Cost Trends

- CoLTS authorized to operate as an MLTSS program under Section 1915(b)/1915(c) concurrent waivers
- CoLTS goals
  - Address acute physical health and long-term care needs in a coordinated, consumer-centered system
  - Focus service delivery on community-based services rather than institutional care
  - Realize cost-savings from community-based orientation
- CoLTS eligibility
  - Age 21 or older
  - NF level of care
  - Dually eligible for Medicare and Medicaid

New Mexico Coordination of Long Term Services (CoLTS) - Controlling Cost Trends

- CoLTS services delivered by two MCOs paid under full capitation and risk
- Program implemented August 2008 via geographic roll-out
- Independent assessment for period July 1, 2011 to June 30, 2012 showed an operating margin gain of 4.5 percent (operating gain), compared to the national average of -5.0 percent (operating loss)

Source: HealthInsight New Mexico. *Independent Assessment of New Mexico's Medicaid Managed Care Program-Coordination of Long-Term Services, Final Report*, June 28, 2013.

MLTSS Outcomes – Tennessee Experience with Money Follows the Person and MLTSS

- TennCare CHOICES in Long-Term Services and Supports operates under the authority of an 1115 waiver
- MCOs at full risk for all services
- Key objectives for restructuring the LTSS system
  - Reorganize – Decrease fragmentation and improve quality and coordination of care
  - Refocus – Increase options for those who need LTSS and their families, expanding access to HCBS so people can live in the community
  - Rebalance – Serve more people using existing LTSS funds

Source: Patti Killingsworth. CMS MLTSS Foundational Webinar July 11, 2013 Presentation: *Tennessee – How Money Follows the Person Supports Rebalancing Efforts Through MLTSS.*

MLTSS Outcomes – Tennessee Experience with Money Follows the Person and MLTSS

- MCOs required to have a nursing facility diversion and nursing facility-to-community transition program
- Up to $2000 transition allowance
- MFP Program = CHOICES HCBS benefits and is "layered onto" MLTSS
  - Simultaneous enrollment in MFP and CHOICES
  - Member remains in CHOICES MLTSS at conclusion of MFP demonstration period and continues to receive HCBS
- MFP Incentive payments tied to MFP benchmarks
- TN transitioned 610 people under MFP

Source: Patti Killingsworth. CMS MLTSS Foundational Webinar July 11, 2013 Presentation: *Tennessee – How Money Follows the Person Supports Rebalancing Efforts Through MLTSS.*

MLTSS Outcomes – Tennessee Experience with Money Follows the Person and MLTSS

Baseline 2010 program, years 2011 and 2012 results:

- # of HCBS participants at a point in time *more than doubled*
- # of NF residents at a point in time *decreased by more than 9%*
- Unduplicated HCBS participants across a 12-month period *more than doubled*
- % of NF eligible people entering LTSS choosing HCBS increased from 18.66% prior to CHOICES to 37.6% during first two years
- NF length of stay reduced by an average of 37 days
- NF-to-community transitions increased from 129 prior to CHOICES to 567 and 740 in program years 1 and 2, respectively

Source: Patti Killingsworth. CMS MLTSS Foundational Webinar July 11, 2013 Presentation: *Tennessee – How Money Follows the Person Supports Rebalancing Efforts Through MLTSS.*

MLTSS – Vehicles and Considerations

- Using Medicaid MLTSS as a vehicle to better coordinate Medicaid services and provide plan incentives for rebalancing and coordination with Medicare
  - 1915 (b)/(c) combination waiver (NM CoLTS, TX Star+Plus)
  - 1115 waiver – (AZ ALTCS)
- Considerations
  - Access to Medicare data to coordinate benefits/services
  - Extent to which financial incentives can be built into rates to coordinate across programs
  - Beneficiary confusion navigating two programs
  - More housing options are needed to further rebalancing (e.g., supportive housing, assisted living)

Managed Care as a Purchasing Strategy for LTSS

- Managed care can be a tool to reduce fragmented acute and primary care, behavioral health, and LTSS.
- With strong oversight and incentives MLTSS programs can provide high-quality, person-centered and cost-effective care to eligible beneficiaries in the setting of their choice.

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Movement to Integrated Care – Beyond MLTSS

- Financial Alignment Models – Capitated and MFFS
- Administrative Dual Demonstration Model (MN)
- Dual Eligible Special Needs Plan Platforms (AZ)
- Stepped Approach - Medicaid Managed Long-Term Services and Supports (NJ)

Financial Alignment Demonstration Models*

Capitated

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

- Joint procurement of high-performing health plans
- 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

MFFS

CO, CT*, MO*, WA

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

*As of June 2014 do not currently have signed Memorandums of Understanding with CMS

Emerging Best Practices - Communications and Engagement

- Robust communication plans for stakeholder engagement from design and implementation to ongoing program oversight
- Engage sister state agencies, beneficiaries , providers, community organizations and advocacy groups
- Go where stakeholders are – in the community; after office hours for providers; partner with community organizations to get the word out and GET FEEDBACK

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Special Needs Plan (SNP) Basics

- SNPs are Medicare Advantage (MA) plans authorized to target enrollment to three specific vulnerable populations:
  - Beneficiaries who are dually eligible (D-SNPs)
  - Beneficiaries who live in long-term care institutions (or would otherwise require an institutional level of care) (I-SNPs)
  - Beneficiaries who have certain chronic conditions (C-SNPs)
- SNPs focus on care management of their targeted population
  - Health risk assessments (HRA)
  - Model of care (MOC)

Source: Medicare Advantage and D-SNPs: An Introduction to Medicare and Medicare Advantage, Centers for Medicare and Medicaid Services, Division of Medicare Advantage Operations State Resource Center, July 28, 2011.

D-SNPs as a Platform for Integration

- Coordinating care is the main purpose of D-SNPs
  - D-SNP models of care must outline how Medicare and Medicaid covered benefits will be coordinated
  - Benefit integration under D-SNP contracts varies by state
- Some states were early leaders in contracting with D-SNPs to further integration (MA, MN, WI)

State Contracting with D-SNPs

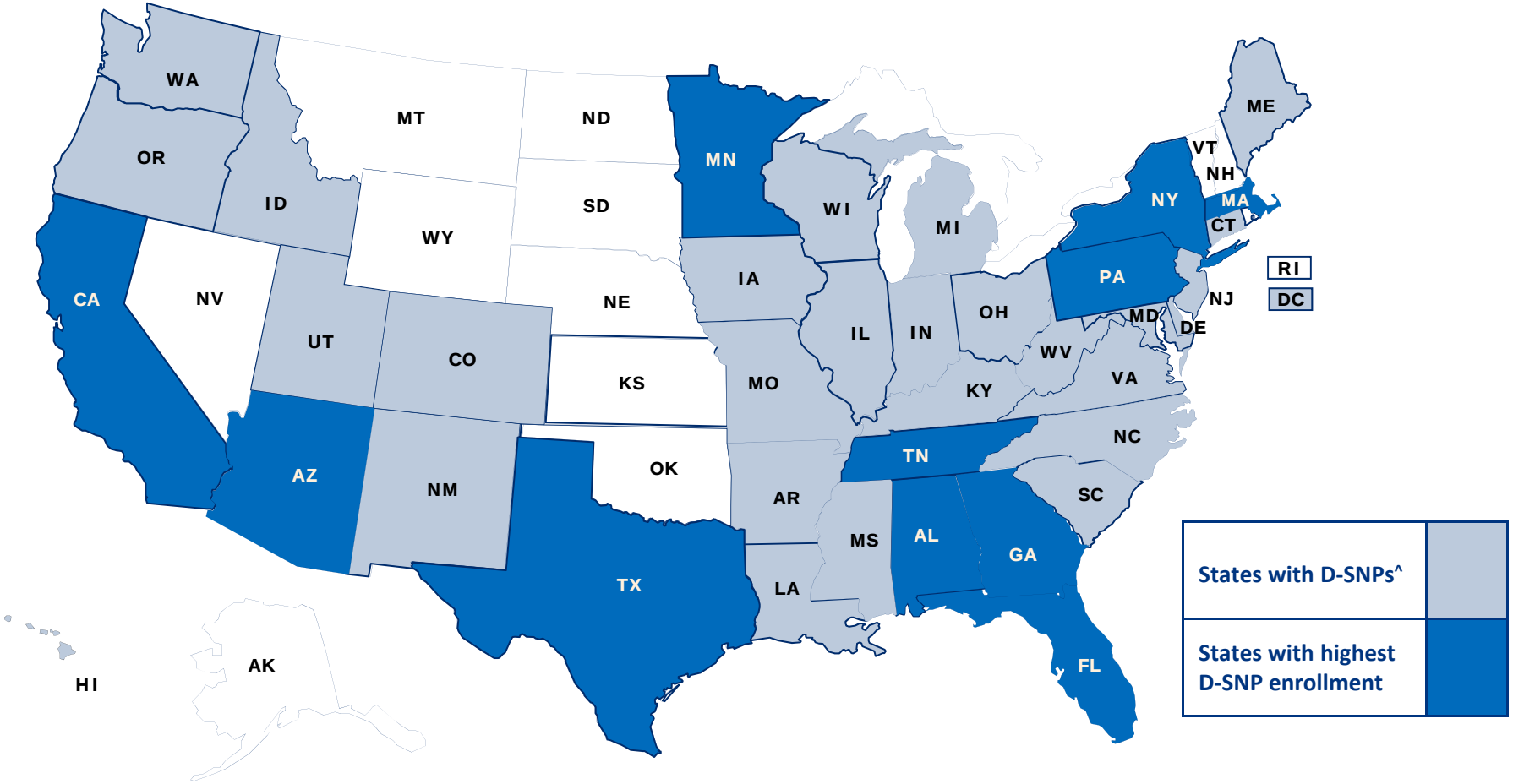
- As of January 2013, D-SNPs must have a contract with state Medicaid agency for coordination of Medicare and Medicaid benefits
  - D-SNP (at a minimum) agrees to provide or arrange for integrated and coordinated Medicare and Medicaid benefit package
  - State Medicaid Agency (at a minimum) agrees to allow the D-SNP to serve and coordinate care for its dual eligible population

Note: Section 164 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 as amended by the Affordable Care Act of 2010 mandates that D-SNPs have such a contract by CY 2013 and each subsequent year to continue to operate as a D-SNP.

D-SNP Opportunities – State Innovations

- States have developed D-SNP contracting approaches that incorporate comprehensive state objectives
- A few examples include:
  - Alignment of D-SNP contracts with Medicaid managed care contractors (AZ, MN)
  - Coverage of Medicaid benefits to reduce fragmentation of care (long-term services and supports and/or behavioral health) (AZ, MA, NM)
  - Alignment of D-SNP program with statewide delivery system reforms to improve overall performance and care outcomes (MN)

Where is D-SNP enrollment concentrated today?



^ D-SNP contracts for Puerto Rico as well as those with no enrollment as of February 2014 where excluded.
Source: CMS SNP Comprehensive Report for February 2014 – Found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

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Thank you!