HEALTH MANAGEMENT ASSOCIATES

Evolving Integrated Managed Care Models for Medicare-Medicaid Dual Eligible Beneficiaries:

Key Considerations for Health Plans

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Today's Talk

- ❑ INTRODUCTION
- ❑ CURRENT LANDSCAPE AND INTEGRATED MANAGED CARE PROGRAM MODELS
- ❑ HEALTH PLAN INTEGRATED PRODUCTS AND INNOVATIONS
- ❑ EVOLVING REGULATORY ENVIRONMENT AND HEALTH PLAN CONSIDERATIONS

❑INTRODUCTION –

❑CURRENT LANDSCAPE AND INTEGRATED MANAGED CARE PROGRAM MODELS

Medicare-Medicaid Dual Eligible Population – Numbers and Benefits

- Over 12 million people nationwide are dually eligible for Medicare and Medicaid
- Historically, dually eligible beneficiaries account for a disproportionate share of spending for both programs. They represent:
  - 20 percent of the Medicare population and 34 percent of Medicare spending
  - 15 percent of Medicaid beneficiaries and 33 percent of Medicaid spending

- Medicare is the primary payer for their care, mainly covering medical services (e.g. physician, inpatient and outpatient acute care, and post-acute skilled level of care, as well as pharmacy benefits)
- Medicaid wraps around Medicare benefits covering any Medicare premiums and cost-sharing, and for full benefit dually eligible beneficiaries, services not covered by Medicare, primarily long-term services and supports (LTSS) including nursing facility custodial care and home and community-based services (HCBS)

Source: CMS State Medicaid Director Letter #18-012*, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare,* December 2018.

Diversity of Medicare-Medicaid Dual Eligible Population

The dually eligible beneficiary population is diverse in age, gender, race, ethnicity, language, chronic conditions, and disabilities, which include cognitive, behavioral and physical disabilities

- Close to 60% are 65 years of age and older
- Disproportionately female at 61%
- 20% African American/non-Hispanic; 17% Hispanic
- 41% have at least one mental health diagnosis
- 68% have three or more chronic conditions
- Approximately 50% use LTSS
- 45% do not have a high school diploma
- Face many adverse social determinants of health (SDOH) – housing, transportation, food security, employment, health literacy, etc.

Much of this diverse group of consumers access health care and LTSS through fragmented and uncoordinated systems, which can contribute to poor health and quality of life outcomes and higher costs of care

Source: Beneficiaries Dually Eligible for Medicare and Medicaid, *Data Book*, jointly produced by Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), January 2018.

Move to Managed Care for Dually Eligible Beneficiaries

- States are increasingly turning to managed care to deliver and coordinate care and support for Medicaid consumers with higher needs - many are dually eligible beneficiaries
  - 21+ states have Medicaid managed long-term services and supports programs
  - Emphasis on care coordination, person-centered care planning, transitions between care settings, flexibility in services, cost efficiencies and improved quality outcomes
- Dually eligible beneficiaries are increasingly enrolling in Medicare managed care options. Enrollment:

Dually Eligible Beneficiaries	2006	2017
All	11%	35%
Partial benefit	18%	44%
Full benefit	10%	32%

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

Integrated Medicare-Medicaid Managed Care Models

Capitated Financial Alignment Initiatives (aka "dual demos")	Medicaid Managed Long-Term Services and Supports and MA D-SNP	Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP)	Program of All-Inclusive Care for the Elderly (PACE)
9 States (CA, IL, MA, MI, NY (2 FAIs), OH, RI, SC, TX)	10 states require Medicaid MLTSS plans operate a D-SNP (AZ, HA, MA, NM, MN, PA, TN, TX, VA, WI) A few states require D-SNPs operate Medicaid MLTSS health plans (AZ, NJ, *TN)	10 states (AZ, CA, FL, ID, MA, MN, NJ, NY, TN, WI)	120 PACE programs in 31 states

*TN does not allow "new" D-SNP entrants that do not also operate a TennCare plan.

Recent Regulatory Support for Integration

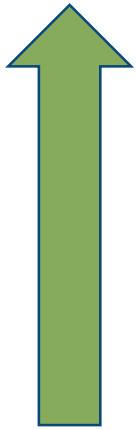
- SNP Provisions in Bi-Partisan Budget Act of 2018
  - Permanent SNP authorization supporting MLTSS+D-SNP as a more "permanent" model/pathway for integration
  - Strengthened authority of CMS Medicare-Medicaid Coordination Office (MMCO) to develop rules and guidance regarding D-SNPs and provide resources to states to support using D-SNPs as integration model
    - Improve integration and coordination for D-SNPs
    - Unify grievances and appeals for services and items provided by D-SNPs
- Default Enrollment - August 2018 CMS guidance
  - Individuals enrolled in a Medicaid managed care plan when they become eligible for Medicare are automatically enrolled in the D-SNP offered by the same organization
  - Plans must have state approval to use default enrollment and state commitment to provide monthly data to identify Medicaid plan members approaching Medicare eligibility

❑HEALTH PLAN INTEGRATED PRODUCTS AND INNOVATIONS

STATUS UPDATE: PLANS AND INTEGRATED PRODUCTS

MARKET TRENDS FOR THREE INTEGRATED PRODUCTS ANTICIPATE GROWTH

Capitated Financial Alignment Initiatives (FAIs): Medicare-Medicaid Plans (MMPs)/"Dual Demo"	D-SNPs Medicaid MLTSS Plan + MA D-SNP	FIDE SNPs



- Health plans are increasingly offering multiple products.
  - Some plans offer an MMP and an MLTSS + D-SNP or a companion plan. This applies to both national and regional plans.
  - FAIs/MMPs. Some states are extending their FAIs. California extended their FAI to 2022. Some states have or will move from FAI to something else. Example: Virginia moved to a MLTSS + D-SNP.
  - MLTSS + MA D-SNPs. Some states are requiring that MLTSS plans operate companion plans. Examples include New Mexico, and Tennessee.
  - FIDE SNPs. Plans in 10 states including Tennessee which is new this year.

PLAN EXPERIENCE: CHALLENGES, SOME EVIDENCE, LEARNINGS, AND POSITIVE SIGNS.

MARKET VIEW: MMPs & FIDE SNPs

STATES THAT HAVE MMPs AND FIDE-SNPs (December 2018)											
			MMPs			FIDE-SNPs			MMPs + FIDE-SNPs		
	State		Total Enrollment	# Contracts in Each State	Avg # Enrollees	Total Enrollment	# Contracts in Each State	Avg # Enrollees	MMPs + FIDE-SNPs	# Contracts in Each State	Avg # Enrollees
STATE MARKETS			9 states with MMPs			10 states with FIDE-SNP plans			16 states in total including states with both MMPs and FIDE-SNPs		
1	AZ *					10,736	3	3,579	10,736	3	3,579
2	CA		115,556	10		13,945	1	13,945	129,501	11	11,773
3	FL					496	1	496	496	1	496
4	ID					4,502	2	2,251	4,502	2	2,251
5	IL		53,676	7	7,668				53,676	7	7,668
6	MA *		22,549	2	11,275	53,373	6	8,896	75,922	8	9,490
7	MI		37,791	7	5,399				37,791	7	5,399
8	MN *					40,202	7	5,743	40,202	7	5,743
9	NJ					41,350	4	10,338	41,350	4	10,338
10	NY		4,693	15	313	12,830	7	1,833	17,523	22	797
11	OH		78,323	5	15,665				78,323	5	15,665
12	RI		15,848	1	15,848				15,848	1	15,848
13	SC		12,497	3	4,166				12,497	3	4,166
14	TN *					1,706	1	1,706	1,706	1	1,706
15	TX *		38,518	5	7,704				38,518	5	7,704
16	WI					2,704	3	901	2,704	3	901
Total			**379,451**	**55**	6,899	**181,844**	**35**	**5,196**	**561,295**	**90**	**6,237**

Note: (*) state requires that Medicaid LTSS plan operates companion MA D-SNP plan.

- 16 states with MMPs and/or FIDE SNPs
  - 3 states with both MMPs and FIDE SNPs
- Contracts/Plans
  - 55 MMP contracts
  - 35 FIDE SNP contracts
- 562,000 enrollees in MMPs and FIDE-SNPs
  - Average plan size was about 6,200 enrollees
  - Plan size for FIDE SNP is lower than for MMP plans
  - Enrollment in FIDE SNPs is voluntary

STATUS: THE TEN STATES THAT REQUIRE COMPANION PLANS

- Ten states that require companion plans: MLTSS + D-SNPs
- HMA "In Focus" (Barth and Breslin)
- https://www.healthmanagement.com/wp-content/uploads/092618-HMA-Roundup.pdf
- The counts represent the universe of all FBDEs in these 10 states

State-Level Counts of Medicare-Medicaid Dual Eligible Enrollees

	QMBs		SLMBs		All Other		Total	Full Medicaid Benefits
State	Qualified Medicare Beneficiaries (QMB)-only	**QMB plus Full Medicaid Benefits**	Specified Low-income Medicare Beneficiaries (SLMB)-only	**SLMB plus Full Medicaid Benefits**	Qualifying Individuals (QI)	**Other Dual Full Medicaid Benefit**	Total for All Dually Eligible Beneficiaries	**Total for Beneficiaries with Full Medicaid Benefits**
Arizona	29,215	53,085	20,817	4,543	10,478	9,887	128,025	67,515
Hawaii	560	29,185	3,514	547	1,623	5,215	40,644	34,947
Massachusetts	1,655	220,650	12,981	7,843	6,820	59,443	309,392	287,936
Minnesota	2,357	74,932	9,734	10,990	5,028	36,185	139,226	122,107
New Mexico	23,172	41,262	6,483	4,500	4,818	17,249	97,484	63,011
Pennsylvania	6,601	286,937	51,375	18,437	30,930	64,246	458,526	369,620
Tennessee	66,419	50,467	58,711	12,086	225	90,148	278,056	152,701
Texas	190,621	315,113	87,116	14,512	37,316	54,290	698,968	383,915
Virginia	28,872	94,958	22,381	6,387	10,967	26,305	189,903	127,650
Wisconsin	10,581	80,869	7,868	13,929	3,669	49,916	166,832	144,714
Total for 10 States	**360,053**	**1,247,458**	**280,980**	**93,774**	**111,874**	**412,884**	**2,507,056**	**1,754,116**
All States	1,511,493	5,503,418	983,350	266,737	528,382	1,864,846	10,658,226	**7,635,001**
10 States as a % of All States	24%	23%	29%	35%	21%	22%	24%	23%

1.7 million FBDEs in these 10 states, or 23% of all FBDEs in the country

Nearly 1 out of 4 FBDEs lives in one of these 10 states

Source: HMA, based on data from the Centers for Medicare and Medicaid Services (CMS).
Data as of March 2017. Data for Qualified Disabled Working Individuals (QDWI) is excluded; Virginia count was 33.
* TX requires MLTSS health plans to have D-SNPs in geographic regions in which the capitated FAI does not operate.

INTEGRATED PRODUCTS

- Alignment between Medicare and Medicaid varies from full alignment to no alignment
- Full alignment is widely recognized as needed for FBDE population

#	Illustrative Continuum: The role that MMPs and D-SNPs play in driving integration and alignment.	ALIGNMENT		Degree of Integration Based on Medicaid Coverage		
			Requirements: care coordination data sharing	Medicare Cost Sharing	Some Medicaid services	All Medicaid services
1	Medicare-Medicaid Plans (MMPs)	Full	x	x		x
	D-SNP-Based Integration					
2	FIDE SNPs	Full	x	x		x
3	D-SNP Contract	Less than Full	x	x	x	
4	D-SNP Contract	Modest	x	x		

HIGH

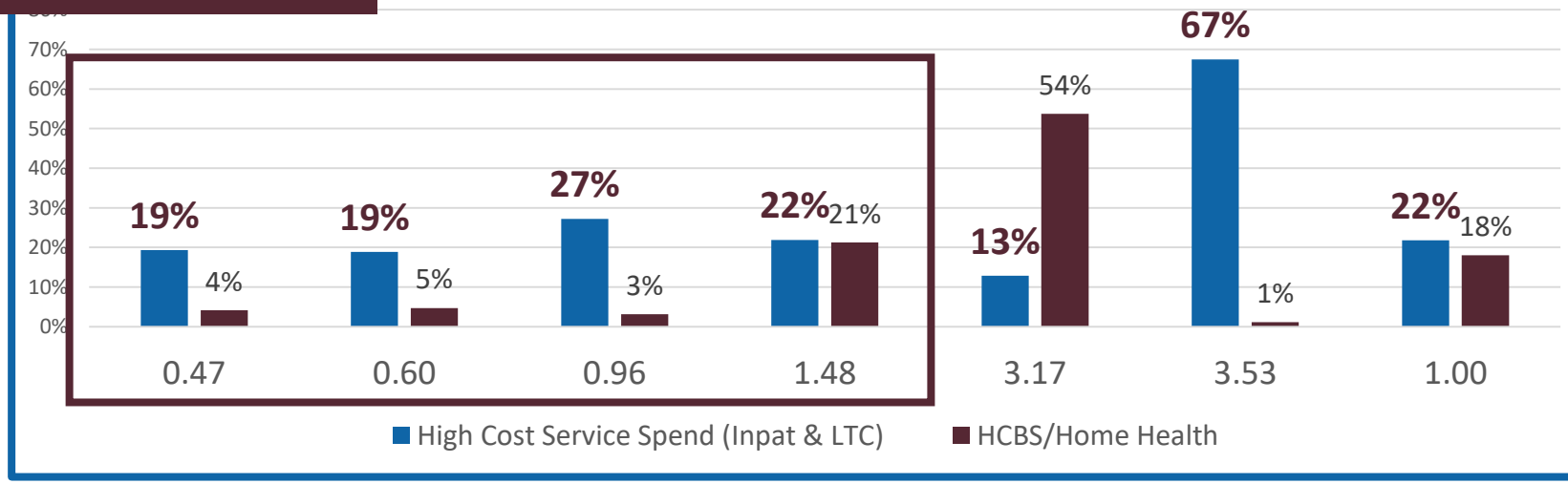
Note: PACE is not included on this chart, since the chart focuses on plans.

EVOLUTION: "FRESH EYES" ON THE MEDICARE-MEDICAID RELATIONSHIP

- FULL ALIGNMENT PROVIDES PLANS WITH THE OPPORTUNITY TO REDUCE INPATIENT AND REBALANCE.
- BEING ABLE TO SEE SPENDING ON MEDICARE AND MEDICAID SERVICES TOGETHER IS VERY IMPORTANT. HOWEVER, IT IS STILL HARD TO ANSWER THE QUESTIONS: (1) WHAT IS THE APPROPRIATE LEVEL OF SPENDING ON INPATIENT & NURSING FACILITY CARE, AND HCBS? AND, (2) ARE WE RE-BALANCING AS MUCH AS WE COULD?
- The graph below shows how MMPs in Mass spent the total service per member per month (PMPM) amounts. The box shows a series of two columns of numbers. Take the first set of numbers: 19% and 4%. MMPs spent 19% of the total service PMPM on inpatient services & NF care, and only 4% on HCBS for the population of enrollees with the lowest risk relative to the average.

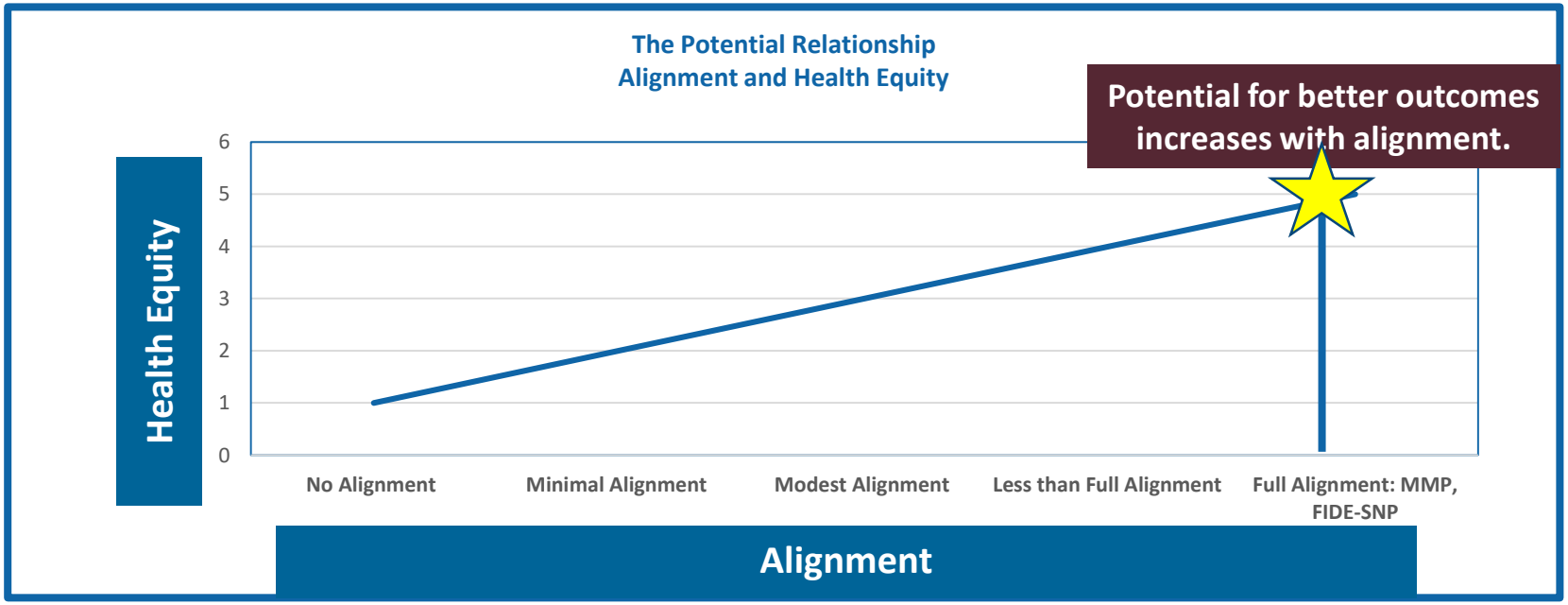
CY 2017 financial experience for MMP for enrollees who are FBDEs under 65
Numbers represent the % of total service PMPM spent on high-cost services v. HCBS by risk group
(Continuum runs from low to high (L to R), with low risk < 1.0 and high risk > 1.0)

Reflection on MMPs



EVOLUTION: AMBITIOUS GOALS FOR HEALTH EQUITY-WELLNESS

FULL ALIGNMENT provides plans with the opportunity to advance health equity and improve outcomes by introducing alternative payment models that promote person-centered models of care, and expanding provider networks to include non-traditional providers and services that address social determinants of health. Plans may advance innovative arrangements to address the continuum of needs including needs that stem from adverse social risk factors and develop robust networks of providers that include community based organizations (CBOs).



AT THE SAME TIME … PLANS FACE SOME KEY CHALLENGES

PLAN CHALLENGES

- Enrolling beneficiaries
- Locating & engaging enrollees
- Building networks, negotiating rates, and handling cross-over payments and potential limitations
- Making upfront investments
- Creating service capacity, such as the full continuum of behavioral health services needed
- Partnering with community-based organizations (CBOs)
- Understanding what lived experience can truly offer

SPOTLIGHT:

Commonwealth Care Alliance (CCA)

- **Crisis Stabilization Units (CSUs) that provide short-term psychiatric care including detox services**

BUT PLANS ARE HEADING IN THE RIGHT DIRECTION

SOME EVIDENCE, LEARNINGS, PLAN EXPERTISE DEVELOPING, POSITIVE SIGNS

+ Locating enrollees
+ Improving beneficiary experience
+ Driving more appropriate utilization by decreasing hospital admissions and emergency room visits
+ Advancing health equity is emerging as the goal
+ Addressing the Social Determinants of Health (SDOH) in partnership with CBOs is starting to happen

LOOKING AHEAD: WHAT TO FOCUS ON

+ Financing matters
+ More innovations to translate goals into reality
+ More evaluation, better data to support whole-plan evaluation
+ More emphasis on health equity goals to reduce health disparities
+ More emphasis on SDOH and partnerships with CBOs

SPOTLIGHT:

SDOH: Food & Nutrition

- **Partnerships with food banks to provide groceries that have been tailored to address chronic health needs**
- **Partnerships with CBOs to provide medically-tailored meals**

❑EVOLVING REGULATORY ENVIRONMENT AND HEALTH PLAN CONSIDERATIONS

Future Regulatory Support for Integration

- State Medicaid Director Letter "Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare"
  - Announced MMCO will be outlining new Medicare-Medicaid Financial Alignment Initiative-related opportunities for current demonstration states "and others in the coming months"
- Contract Year (CY) 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P) implementing provisions of the Bipartisan Budget Act of 2019 establishing new D-SNP requirements
  - Proposed integration activities for D-SNPs
  - Proposed integrated grievance and appeals

CY 2020 MA Proposed Rule D-SNP Category Overview

Dual Eligible Special Needs Plan (D-SNP) that is not a HIDE or FIDE SNP

A D-SNP that meets additional state Medicaid agency contracting requirements listed in proposed rule.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP)

A type of D-SNP that has, or whose parent organization or another entity owned and controlled by parent, a capitated contract with state Medicaid agency in state it operates that includes LTSS, BH or both

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

(Updated elements of the definition) Primary distinction remains - Provides access to Medicare and Medicaid benefits under a single Managed Care Organization (MCO);

Health Plan Considerations for Serving Dually Eligible Beneficiaries (Slide 1 of 2)

Highlights of Health Plan Considerations
✓ Understand the unique characteristics of the population and related needs
✓ Use effective, tailored, continuous ways of communicating with consumers and their family/caregivers at all stages of enrollment, assessment, coordination and delivery of services, and ongoing quality improvement
✓ Tailor models of care to populations' needs, including addressing loneliness and isolation and supporting community engagement
✓ Support consumers' family/caregivers
✓ Use approaches to support care coordination across all providers and services including medical, behavioral health, LTSS and SDOH
✓ Develop provider networks that know and understand dually eligible beneficiaries and their needs
✓ Develop tailored and untraditional approaches to locating and engaging dually eligible beneficiaries in their communities

Health Plan Considerations for Serving Dually Eligible Beneficiaries (Slide 2 of 2)

Highlights of Health Plan Considerations
✓ Use of electronic health records/care management systems
✓ Break down silos of internal plan business operations for Medicare and Medicaid lines of business
✓ Develop data capabilities that can combine Medicare and Medicaid member level information
✓ Understand Medicare Advantage Stars rating system and implications of serving full benefit dually eligible beneficiaries
✓ Measure quality and outcomes for the population that captures goal achievement and quality of life
✓ Ensure capitation rates reflect the characteristics and changing acuity of the population

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