



MANAGED LONG-TERM SERVICES AND SUPPORTS

PRE-CONFERENCE INTENSIVE
2019 HCBS CONFERENCE

Camille Dobson
Deputy Executive Director

Welcome to the HCBS Conference



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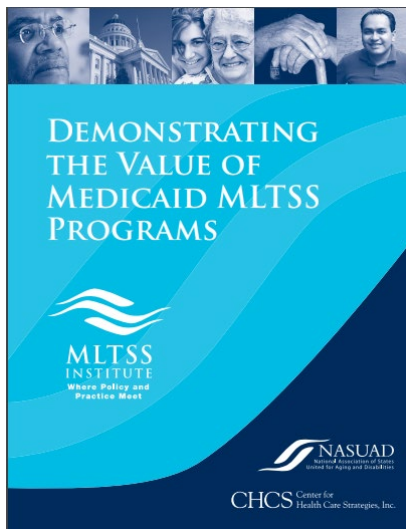
- HCBS is the premiere national conference on LTSS, including Medicaid, the Older Americans Act, and a broad array of programs, services, and supports for older adults and people with disabilities
- Learn more about NASUAD at www.nasuad.org
- Don't forget to sign up for:
 - ▣ NASUAD's Friday Update: a weekly electronic newsletter that consolidates federal and other news on aging and disability policy
 - <http://www.nasuad.org/newsroom/friday-update>
 - ▣ The State Medicaid Integration Tracker: a bi-monthly publication that highlights LTSS activities, including MLTSS, dual eligible programs and other integrated care activities in the states
 - <http://www.nasuad.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker>

NASUAD's MLTSS work

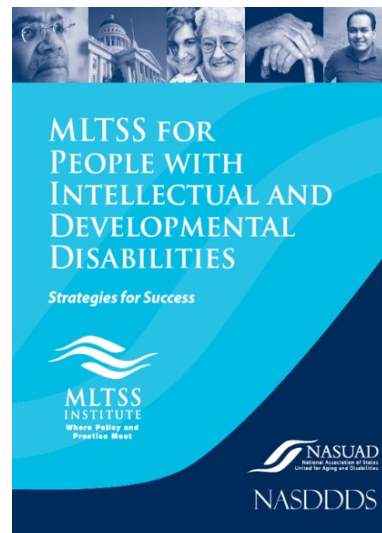
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■ MLTSS Institute

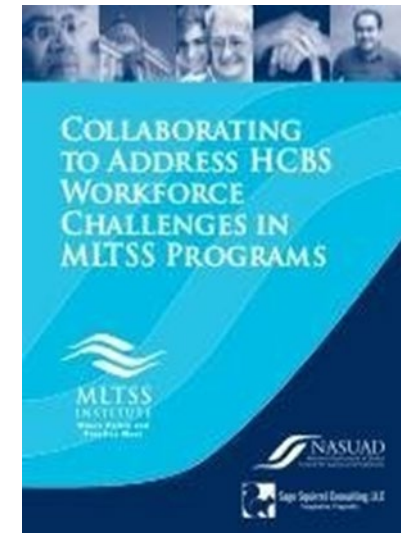
- Provide intensive technical assistance to states
- Bring thought leaders together to discuss policy issues
- Publish research papers (<http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/resources>)



May 2017



May 2018



April 2019

Managed Long-Term Services and Supports (MLTSS)

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- MLTSS is the delivery of long term services and supports (state plan, waiver or both) through capitated Medicaid managed care plans
- Plans can be a managed care organization, pre-paid inpatient health plan, or a pre-paid ambulatory health plan (depending on scope of benefits provided)
- In most states, plans are covering medical services as well, which provides a comprehensive delivery system for consumers

Why MLTSS?

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Accountability & Simplification

- State can drive performance through contracting with few entities
- Eliminates need to contract with/monitor hundreds/thousands of LTSS providers
- Managed care plans take on claims payment, member management, utilization review

Access

- Reduce HCBS waiting lists
- Plans can integrate siloed streams of care (primary/BHI/LTSS) more effectively
- Increased use of primary and preventive care

System Balance

- Increase HCBS options (consistent with consumer desire)
- Plans have incentive to divert NF admissions
- May be less susceptible to political influences on NF downsizing

Innovation and Quality

- Shift to person-centered, integrated care and services
- Plans have more flexibility to deliver services
- Can better measure health and quality of life outcomes

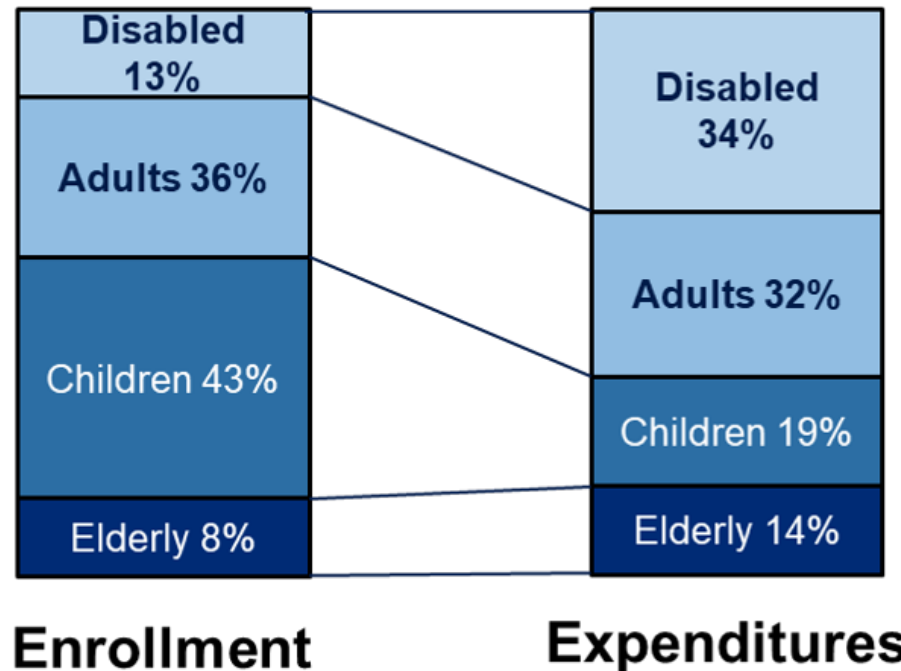
Budget Predictability

- Capitation minimizes unanticipated spending
- LTSS interventions can lower acute care costs
- May slow growth in per-person costs

Why Do States Implement MLTSS?

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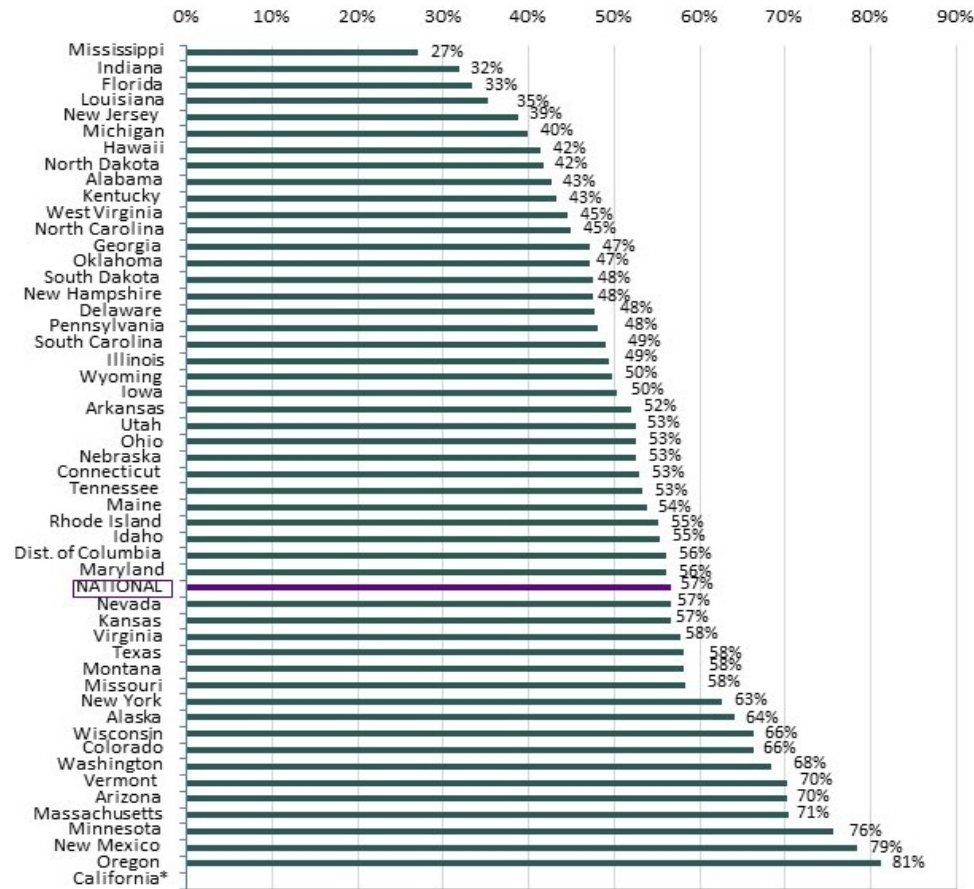
Nearly half of Medicaid spending is for the elderly and people with disabilities, FY2015



Source: Center for Budget and Policy Priorities

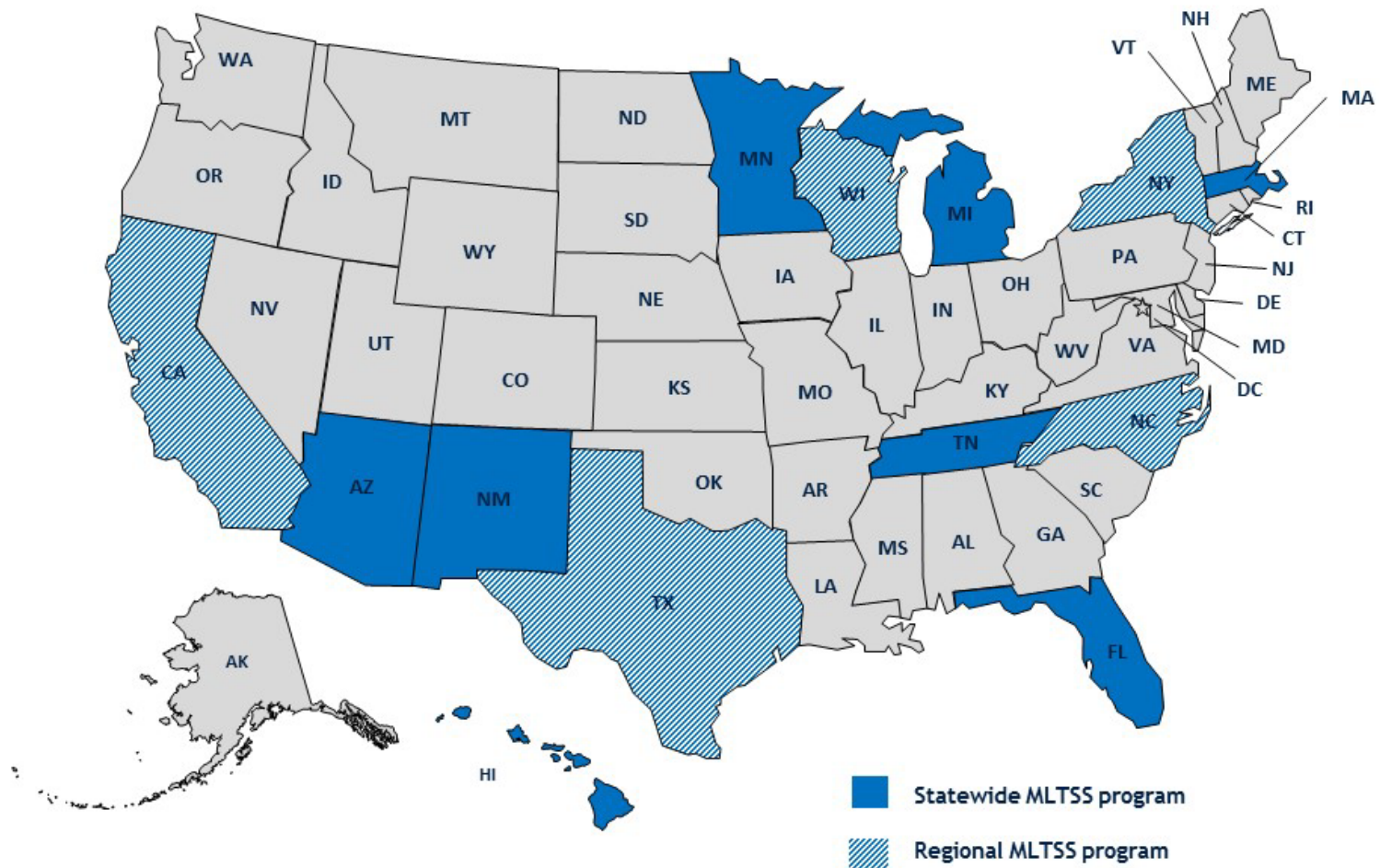
Why Do States Implement MLTSS?

HCBS Expenditures as % of all Medicaid LTSS Expenditures, FFY 2016

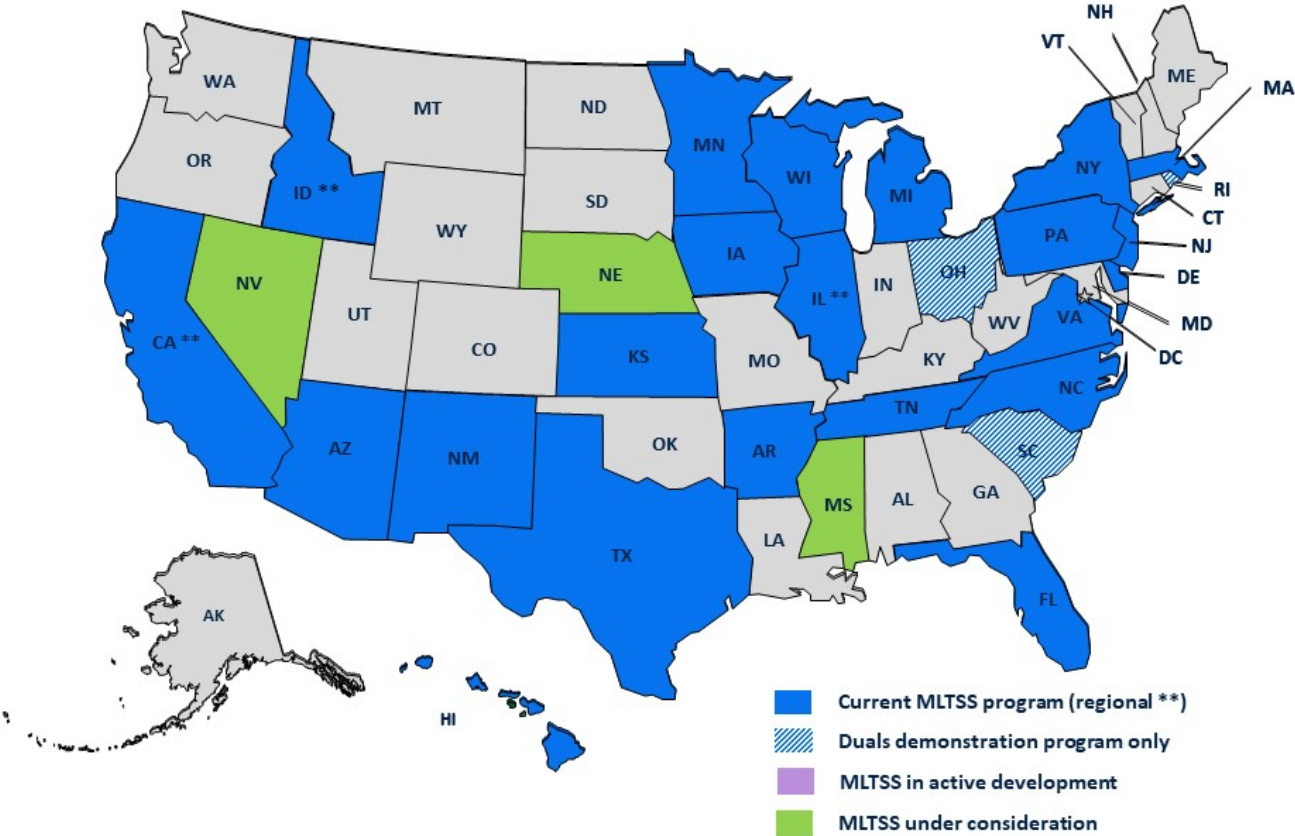


National Avg - 57%

MLTSS Programs - 2010

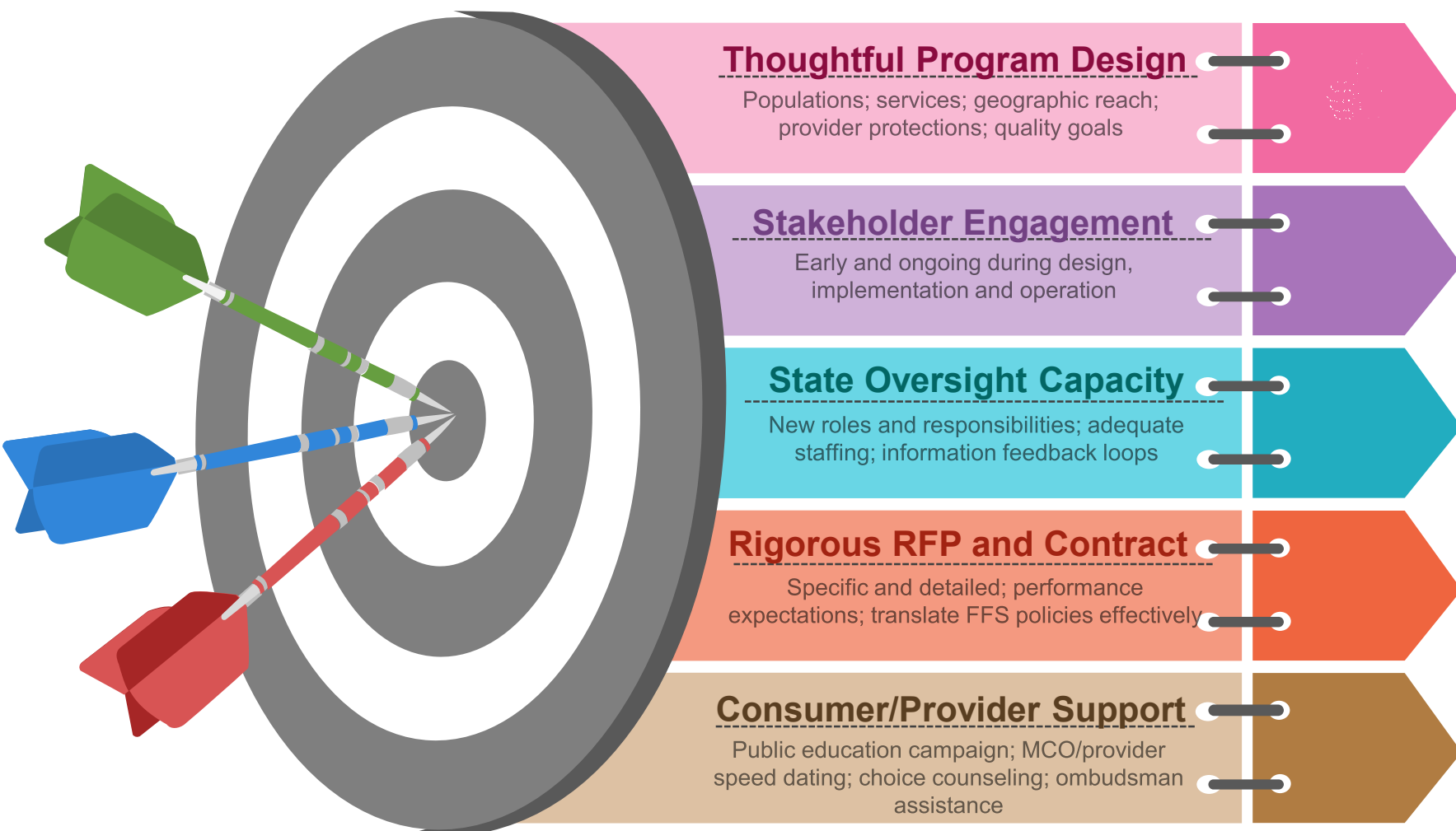


MLTSS Programs - 2019



Note: VT is included in CMS' list of MLTSS states

Key Elements for an Effective MLTSS Program



Trends for 2019 and beyond

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- MLTSS continues to be the biggest trend/opportunity for states to address accountability, cost efficiency and better outcomes for consumers
- However, no new programs implemented since 2017
- Most likely to see expansion of existing programs...
 - ▣ Statewide
 - ▣ To new populations
 - Beyond dual eligibles only
 - Individuals with intellectual/developmental disabilities for HCBS services

Trends for 2019 and beyond

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- Focus on quality - concern about putting plans in charge of service plans has amplified calls for outcome measurement
- States without managed care capacity or unwillingness to implement or expand acute care managed care looking at managed FFS alternatives (i.e. ACOs in MA)
- States also looking at expanding pay-for-performance/value-based purchasing from NFs and other large providers to HCBS providers
- Increasing focus in MCOs on combatting social isolation, addressing workforce shortages and caregiver supports

Context for today's intensive

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- MLTSS programs face challenges in maximizing the benefits of MLTSS in a number of policy areas

- We picked 4 topics to focus on today (among many)
 - HCBS workforce shortages, while not unique to MLTSS programs, pose real challenges to community living but present unique opportunities for MLTSS states
 - Mature MLTSS programs still have concerns to address – the work is never done!
 - Progress is being made in measuring quality in MLTSS but more still remains to be done
 - Dual eligible integration is an area of great interest for states and one where CMS has been very active
 - 75 - 90% of waiver consumers are dual eligibles

Context for today's intensive

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- Goal for intensive: Share learnings on ongoing challenges in MLTSS for states, health plans, providers and consumers
- Outcome of intensive: Leave with greater understanding of each area and how innovations underway in states and plans could improve and/or inform MLTSS programs in your state.



Sage Squirrel Consulting, LLC
Imaginative. Pragmatic.



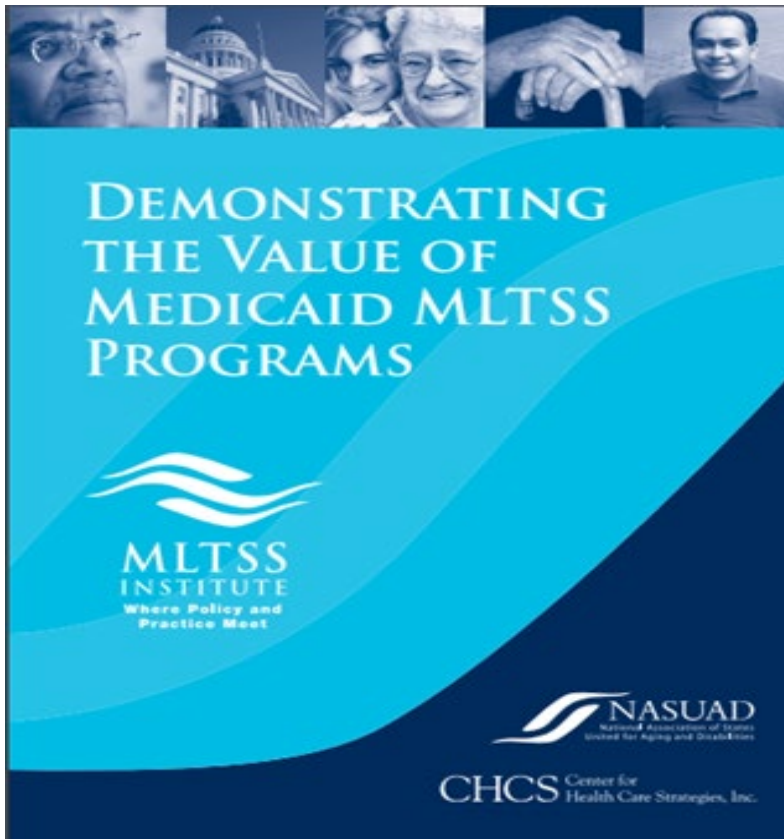
COLLABORATING ON HCBS WORKFORCE CHALLENGES IN MLTSS PROGRAMS

2019 HCBS Conference MLTSS Intensive
August 26, 2019

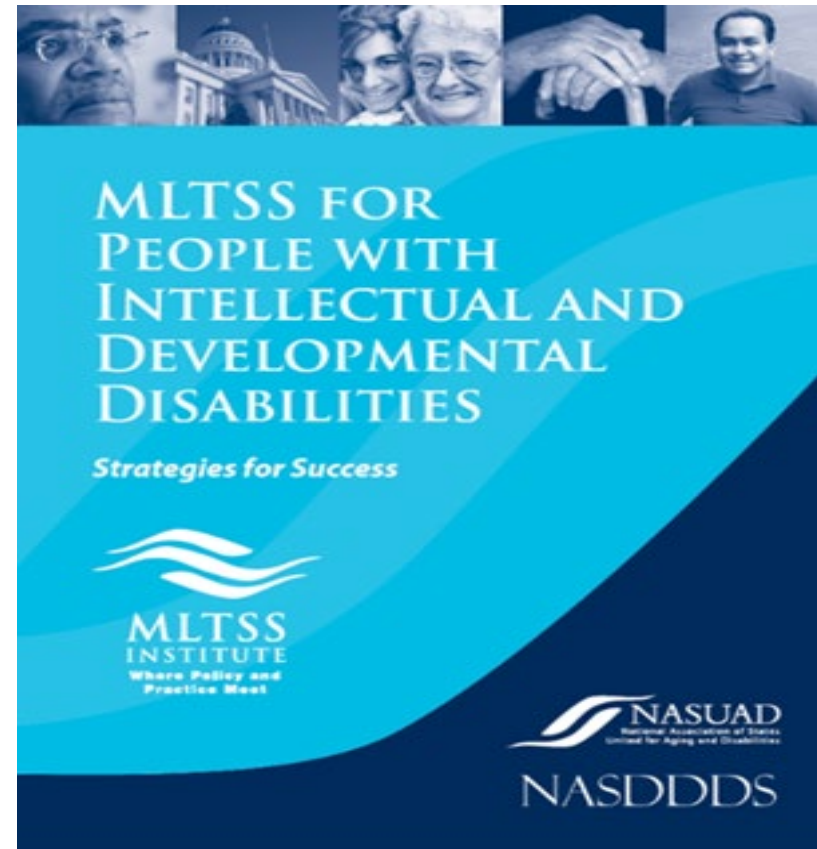
- Created in 2016 to
 - Provide intensive technical assistance to states
 - Bring thought leaders together to discuss policy issues
- Guided by Advisory Council composed of national state and health plan policy experts
- Publish research papers
(<http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/resources>)

MLTSS Institute Papers

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May 2017



May 2018

Need for Paper

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- HCBS workforce shortages affect all states
- Grappling with quality of existing workforce as well
- Little written about opportunities for partnership with MCOs
 - What is state responsibility?
 - What is MCO role?
- Promising practices from state/MCO perspective

Approach

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- Develop outline with Advisory Council
- Partner with Sage Squirrel Consulting, LLC
 - Former IN SUA executives; experience with waivers and HCBS workforce issues
- Gather existing research
- Survey states and health plans
 - Resources included as appendix to report

Methodology

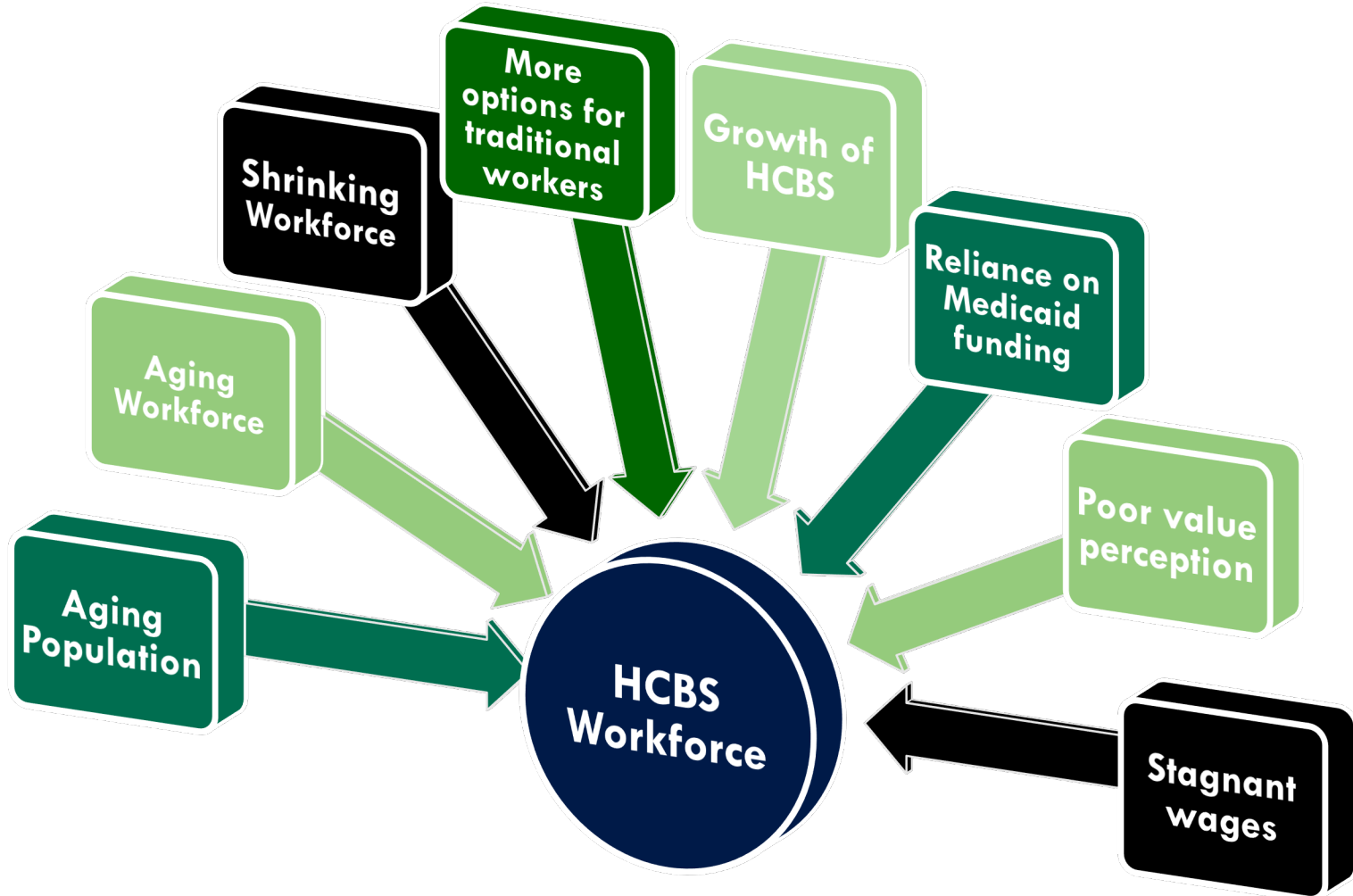
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- States and health plans sent survey with questions on HCBS workforce in December
- Survey in field for 40 days
- Analyze information from respondents
- Follow-up emails and interviews with key respondents
- Highlighted states review prior to publication



Pressures on HCBS Workforce

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DCW Demographics

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HCBS Workforce



- Largely female – nearly 9 out of 10
- Median age is 47
- 6 out of 10 identify as part of a minority group
- Over 25% born outside of the United States

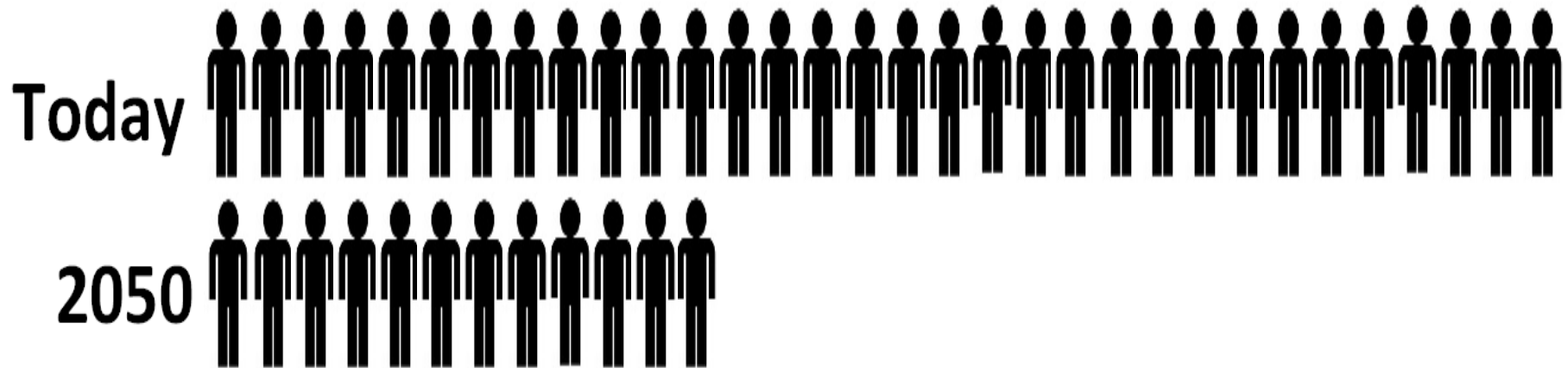
- Includes personal care aides, home health aides, and nursing assistants
- Nearly stagnant wages
- Median hourly wage of \$11.03
- 2 out of every 5 workers work part-time

- Predominantly government funded (Medicaid)
- Nearly 7 out of 10 work for a for-profit company
- More than half receive some form of public assistance themselves
- Of the nearly 4.3 million direct support workers, nearly half now work in home care

U.S. Home Care Workers: Key Facts (2018). Stephen Campbell.
Paraprofessional Healthcare Institute.

The Shrinking Workforce

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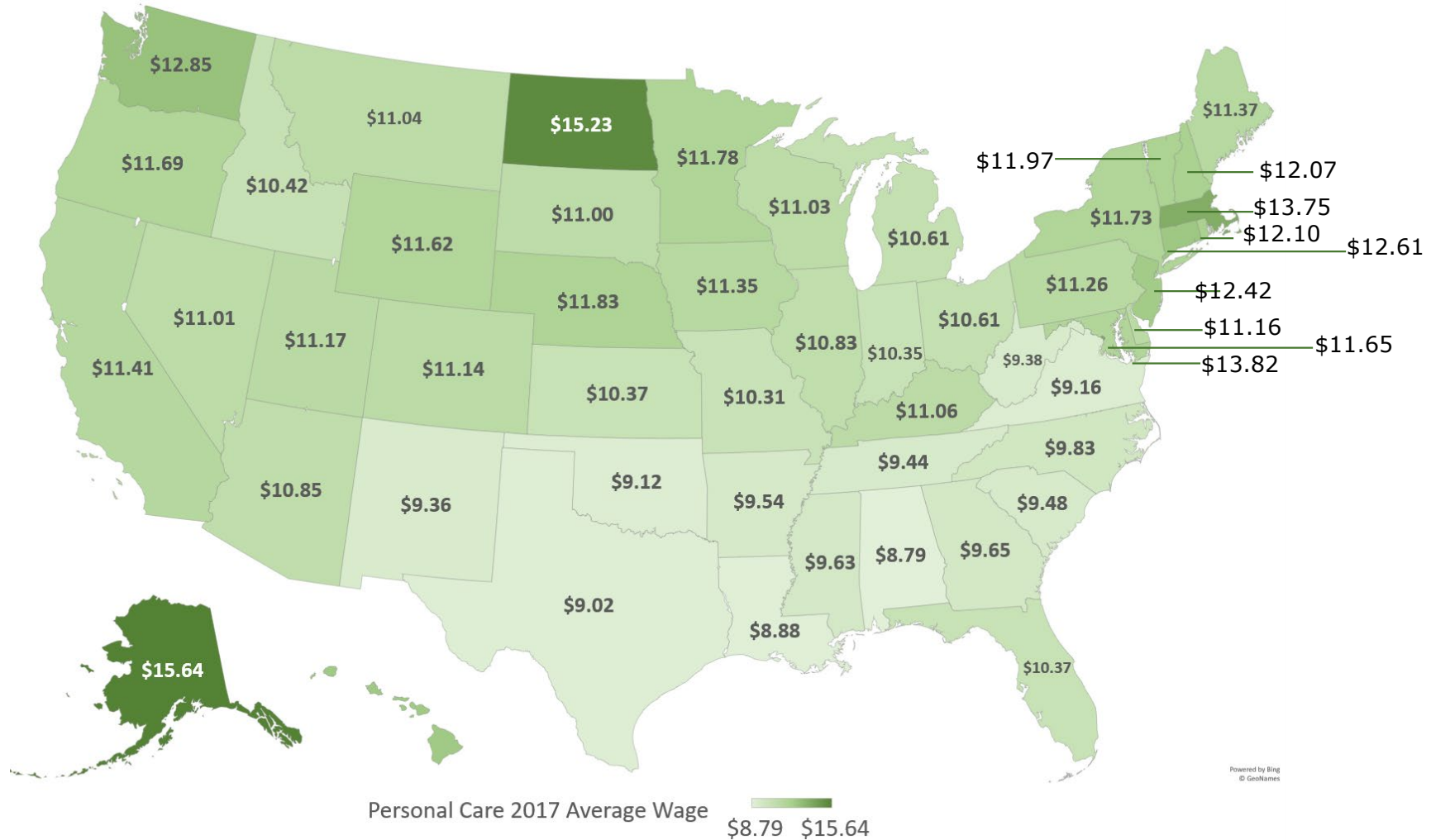


Today there are 32 working age adults per person 85 years old or older. By 2050, there will only be 12.

([https://phinational.org/policy-research/key-facts-\)/faq/](https://phinational.org/policy-research/key-facts-)/faq/))



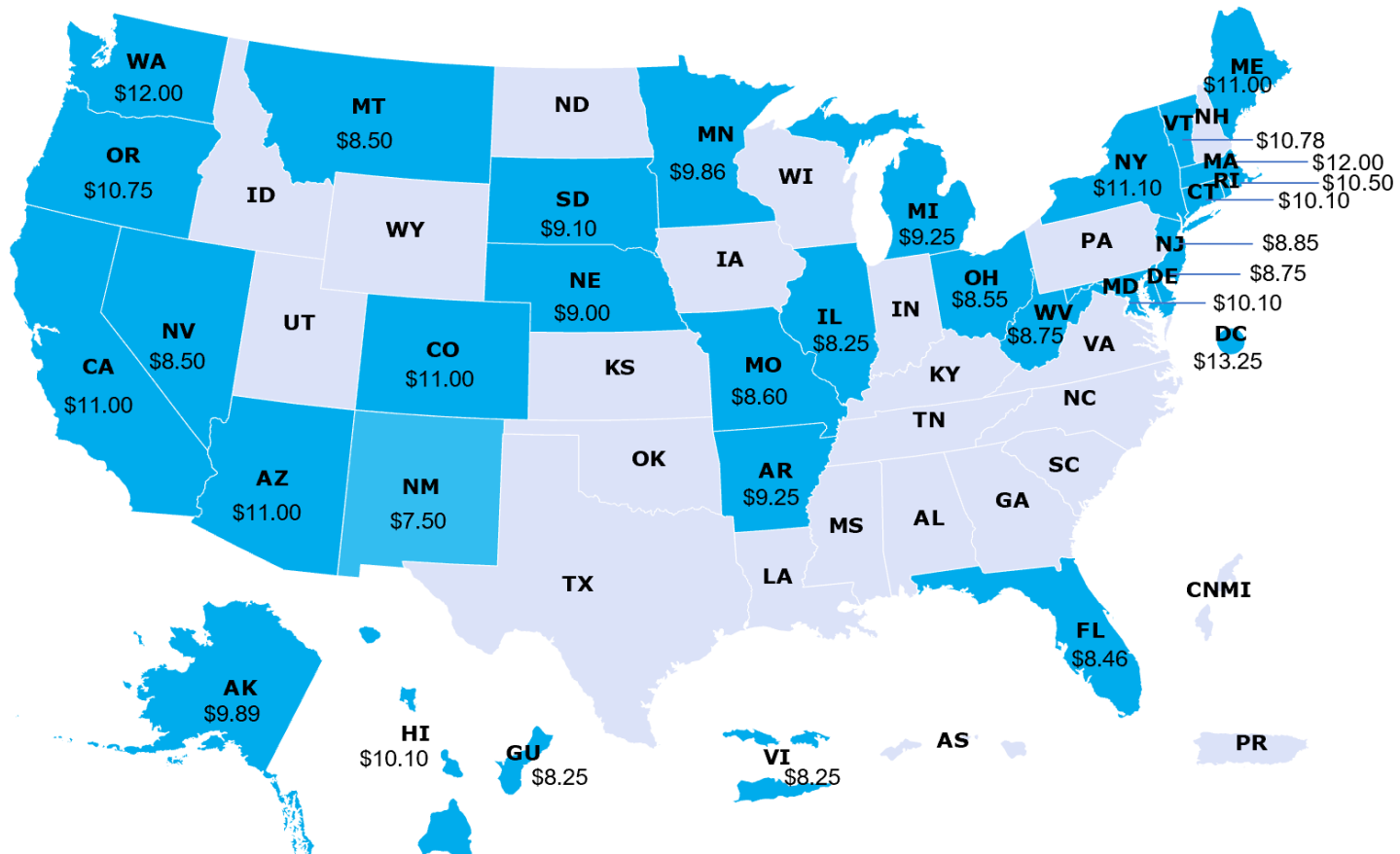
PCA Average Wages





Minimum Wages

States with Minimum Wage Set Higher than the Federal Minimum



U.S. Department of Labor. Updated January 2019. <https://www.dol.gov/whd/minwage/america.htm#stateDetails>



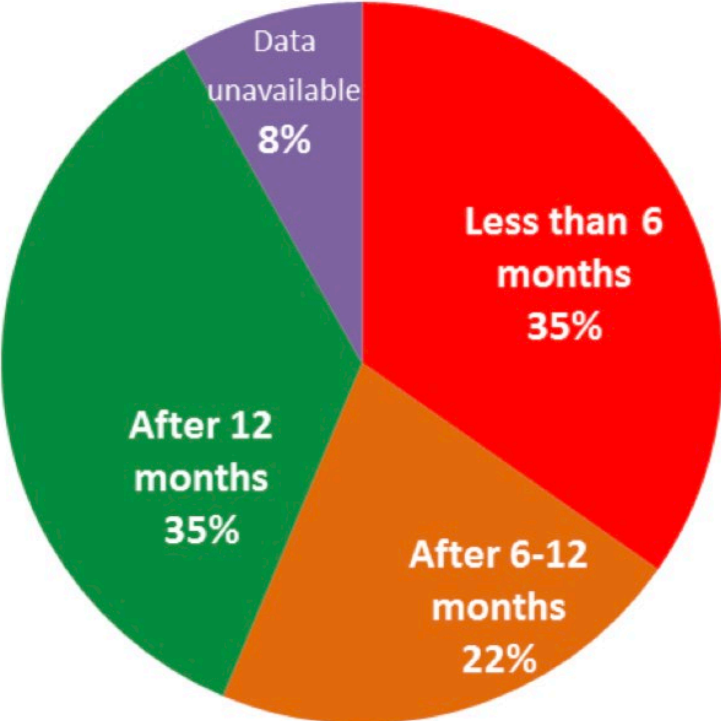
Stagnant Wages

Change in average wage of HCBS workforce from 2006 to 2016:

Personal Care	\$10.33		\$10.49
Home Health	\$12.35		\$12.34
CNA	\$12.10		\$11.62

Workforce Stability

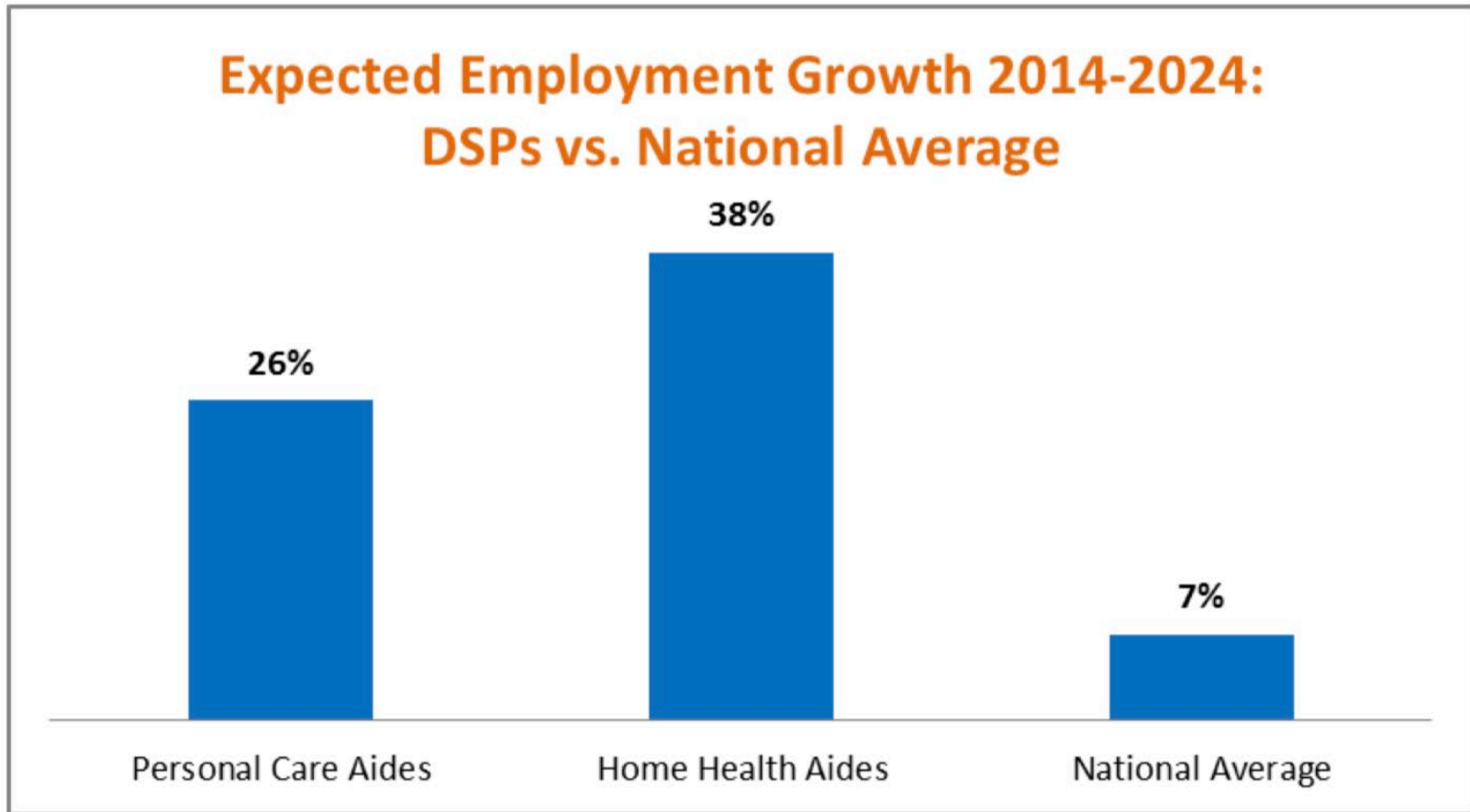
DSP Turnover By Tenure Length



Source: 2016 National Core Indicators study.

Job Growth

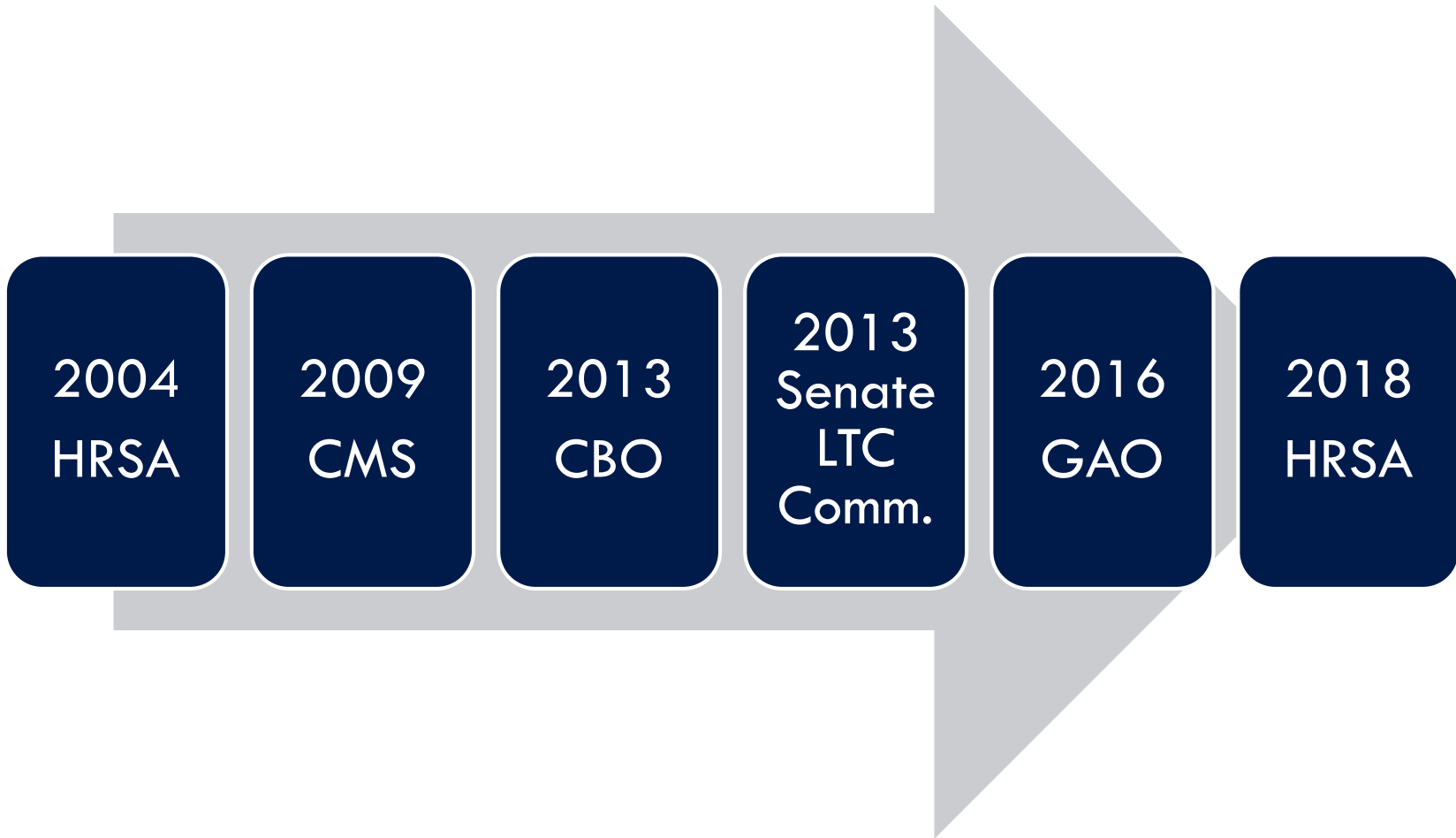
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Source: Bureau of Labor Statistics.

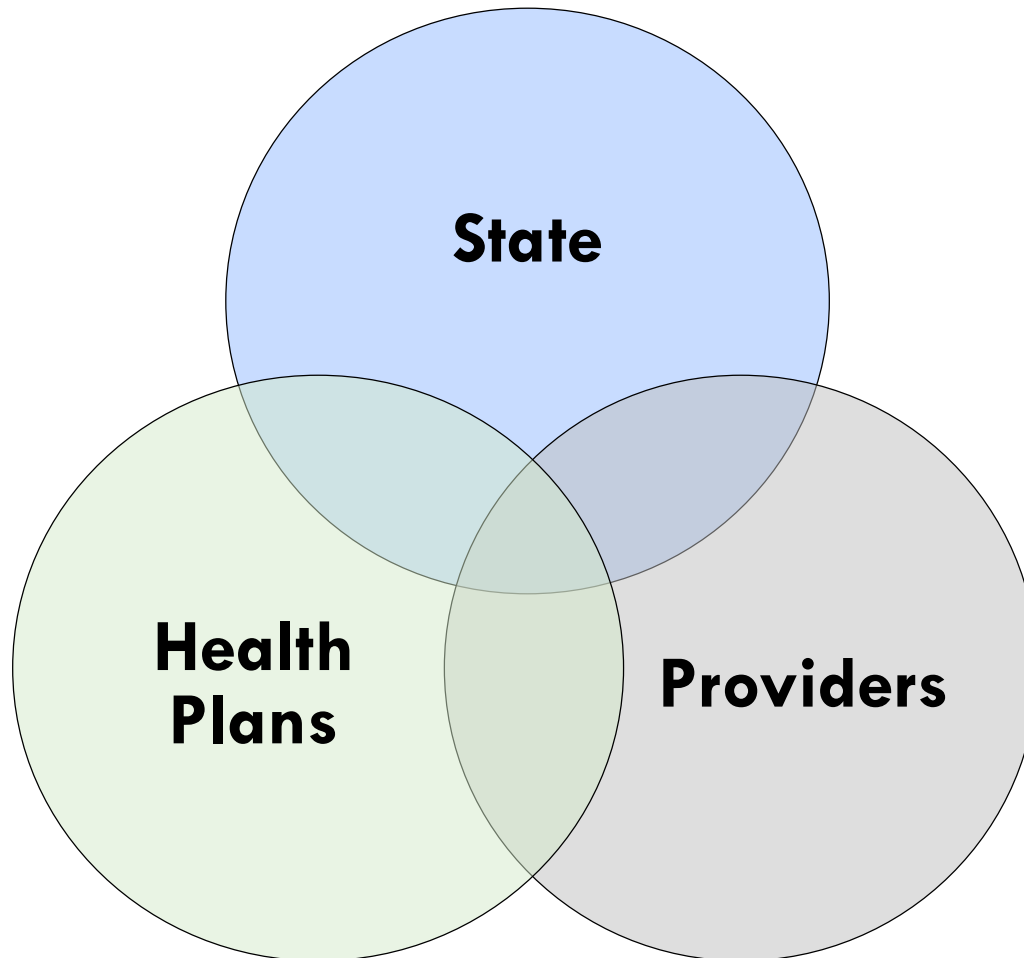
This is NOT a New Problem

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Shared Needs Can Drive Collaboration

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Workforce in MLTSS

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■ Network Adequacy

■ Rates & Reimbursement

■ Quality

Network Adequacy

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Most commonly:

- choice of providers;
- travel distance/travel time; and
- service initiation time.

Preferred by most stakeholders is a gap-in-service measure which requires tracking/reporting instances when authorized services are not provided, either on one or more dates, on time, or at all.

Network Adequacy

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CMS. 2017. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability

Rates & Reimbursement

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Macro level

Raising minimum
wage

Linking wages to
inflation

Living wage laws

Reimbursement strategies

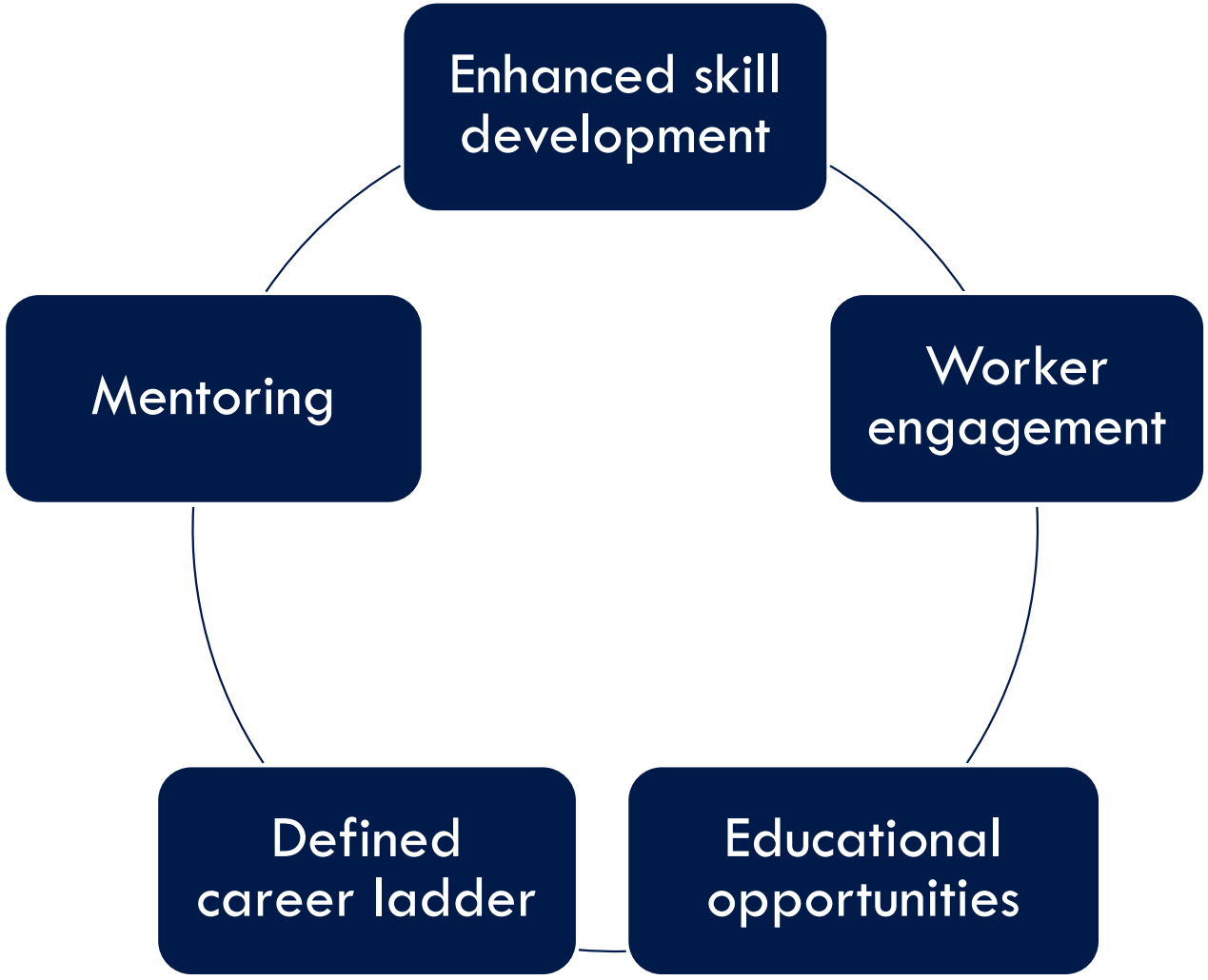
Wage pass-throughs

Setting wage floors

Minimum % of service rates
directed to direct labor costs

Value based purchasing

Quality



Other Promising Practices

- Support for unpaid caregivers
- Technology
- Scope of practice modifications
- Increased use of family and friends as paid caregivers (often through consumer directed care)

Promising Practices

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■ Tennessee

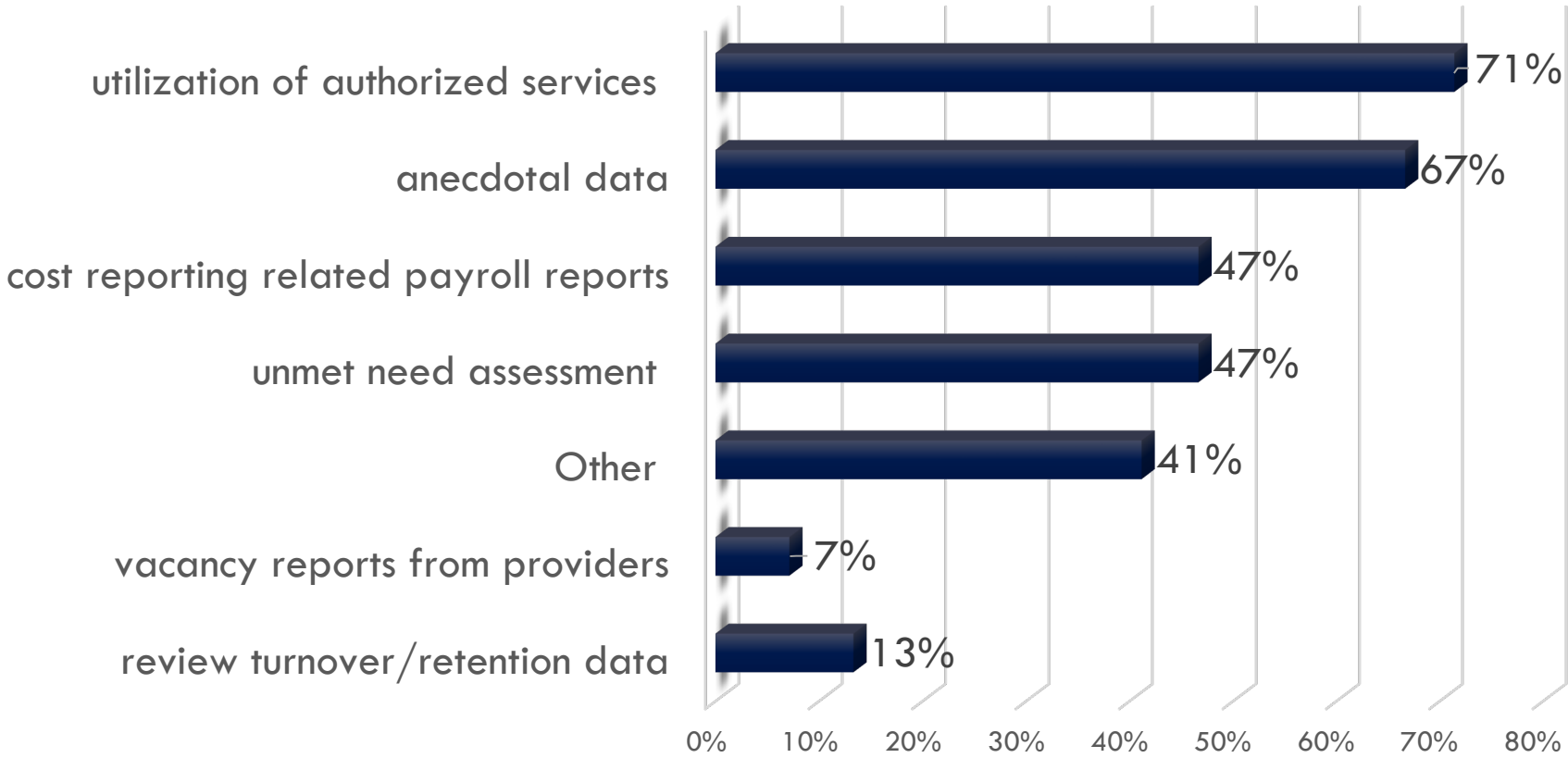
■ Wisconsin

■ Washington

■ Arizona

Good Data is a Challenge

Types of Workforce Data Collected By States





NASUAD

National Association of States
United for Aging and Disabilities



Arizona's ALTCS Workforce Development Alliance

Presented to: 2019 HCBS Conference
National Association of States United for Aging and Disabilities
Medicaid Managed Long Term Services & Supports Intensive

By: *Bill Kennard Healthcare Workforce Development Administrator*
AHCCCS (Arizona Healthcare Cost Containment System)

Why AHCCCS is in the WFD Biz

Mission

Members

Money

Reaching across
Arizona to provide
comprehensive
quality health care
for those in need

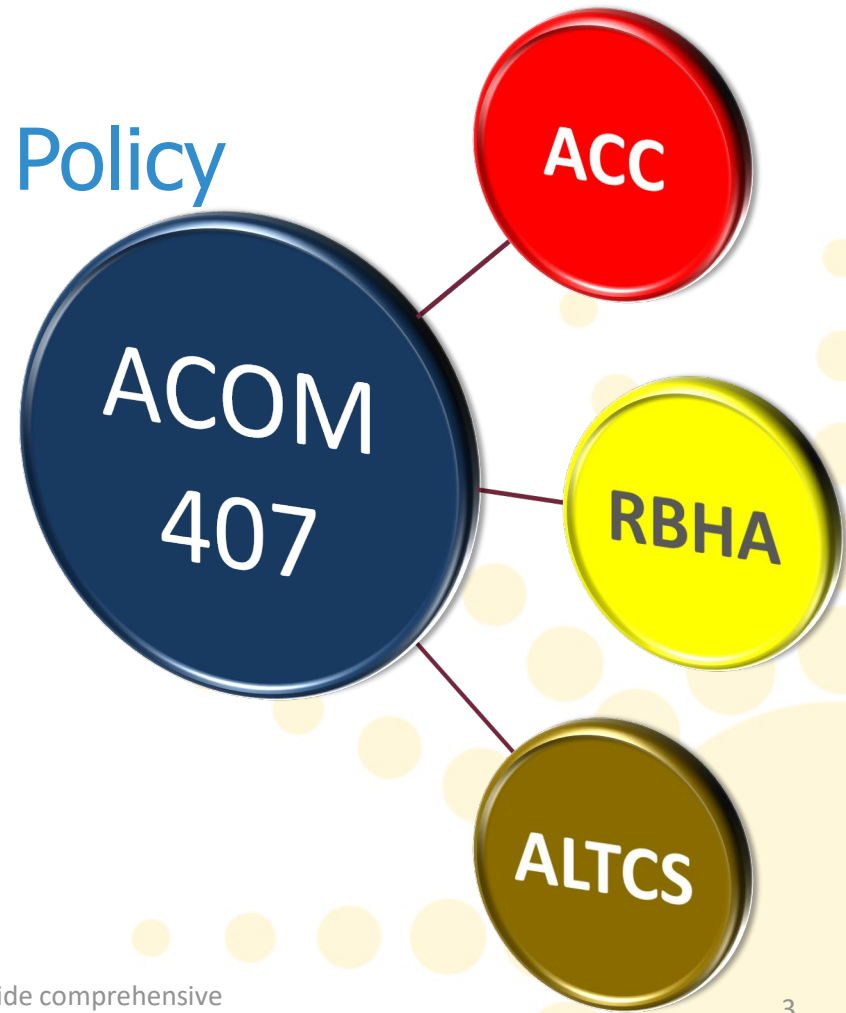
Sufficient
Workforce
Capacity

Capable &
Committed
Workers

Workplace
Culture &
Connectivity

AHCCCS Entered The WFD Biz By...

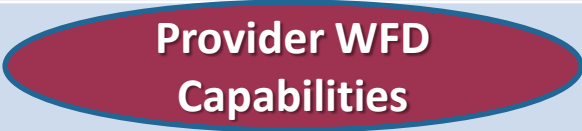

- Creating ACOM 407 – Workforce Development Policy
- Applying 407 to all Health Plans
- Covering all Workforce Segments & Providers



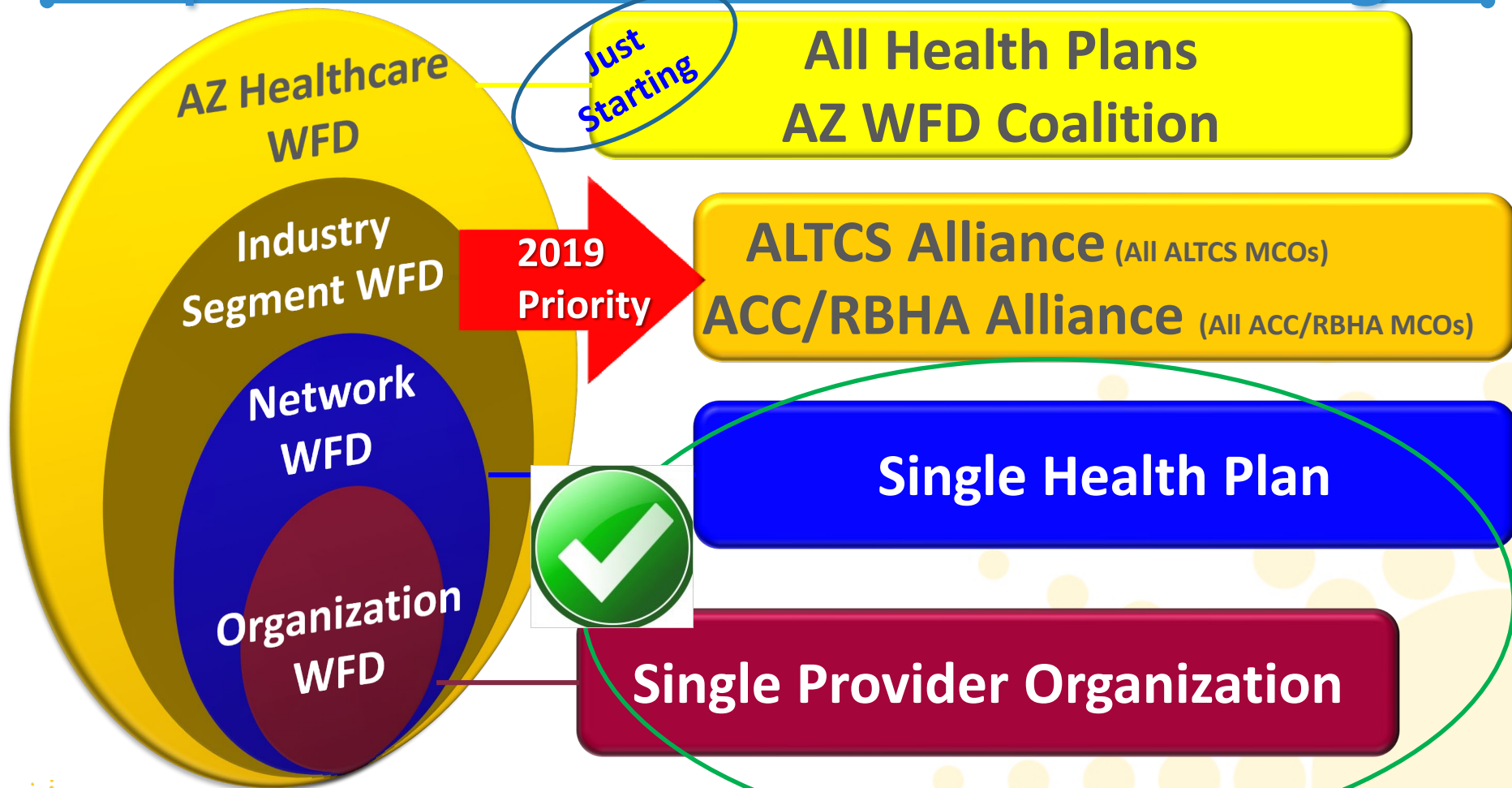
ACOM 407 Requires MCOs Have a...

- WFD Administrator - Leader
- WFD Operation - Capable of Workforce
 - Forecasting
 - Assessing
 - Planning
 - Monitoring &
 - Assisting
- WFD Plan & Annual Progress Report

Plans and Priorities

	ACC / RBHA Alliance		ALTCS Alliance	
5 WFD "C"s	Acute/ Physical Health	Behavioral Health	Developmental Disability	Elderly/Physical Disabilities
Commitment				
Culture				
Capability				
Capacity				
Connectivity				

Improve Co-Orchestrated Planning



Impact of 2019 Health Plan WFD Initiatives

6-10K Workers
Intended Impact Areas

WFD Focus	Initiatives	Capacity	Capability	Culture	Commitment	Compensation
Retention	Provider Identified AHCCCS Members Transition Age Traditional WF Tribal Members DCW Survey WFD Infrastructure Emergency transportation Scholarship Programs CG recruitment incentives					HCBS Rate Increases 10/1/19 • 5% all & • 3.6% most 1/1/20 • 2.6% most
Deployment	WFD Infrastructure NW Mapping Report					
Training	Provider Identified AHCCCS Members Transition Age Traditional WF Tribal Members HCBS DCW Curriculum WFD Infrastructure MHFA, QPR Seeking Safety					
Selection	WFD Infrastructure					
Recruitment	Provider Identified AHCCCS Members Transition Age Traditional WF Tribal Members New labor pools Coordinated recruit Align CHW Coalition Educator Externship WFD Infrastructure NW Mapping Report ASU HC Students – CG's CG recruitment incentives My Connections for Members Underemployed & 2cd Career					<p>Legend</p> <ul style="list-style-type: none"> Banner University Health Care Mercy Care Div. Developmental Disabilities United Healthcare AHCCCS Alliance



Resources & Contacts

- ALTCS Workforce Development Administrators
 - Allison Kjer WFD Administrator - United Healthcare - allison.kjer@uhc.com
 - Debra White WFD Manager - AZ Dept. of Economic Security – Division of Developmental Disabilities - debrawhite@azdes.gov
 - Kate Lemke WFD Administrator – Banner University Health Plans - katherine.lemke@bannerhealth.com
 - Sarah Hauck WFD Administrator – Mercy Care - haucks@mercycaarez.org
- ACOM 407
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/407_Workforce_Development.pdf



Improving Quality in MLTSS

MLTSS Pre-Conference Intensive

August 28-30, 2017

Quality Measurement

- Quality measures provide a framework around which stakeholders can collaborate around shared goals:
 - ▣ Assist in ensuring collective accountability throughout a system, by various stakeholders:
 - Payers (state governments)
 - Providers
 - Purchasers (managed care organizations)
 - Beneficiaries and their informal caregivers
 - Advocacy groups
 - ▣ Used to incentivize quality and reward sustained levels of high performance
 - ▣ Identify progress towards goals

Challenges to Effective MLTSS Quality Measurement

- HCBS does not have widely adopted or evidence-based guidelines, protocols or training standards
 - ▣ There are few professional norms, education, and bodies of knowledge
- State-specific HCBS measures:
 - ▣ Address common HCBS domains
 - ▣ But may be imprecise, poorly specified, or not thoroughly tested
 - ▣ Cannot be used for cross-state comparisons

Challenges to Effective HCBS Quality Measurement

- States typically use predominantly structure and process measures, for example:
 - ▣ # of providers trained
 - ▣ # of assessments completed
 - ▣ % of care plans completed timely
 - ▣ # of critical incidents reported and remediated
- Outcome measures are highly desirable for beneficiaries, but outcomes can vary based on consumer needs and goals
- States must navigate the push and pull between person-level outcomes and system performance

Importance of Quality Frameworks

- They are a useful way to organize thinking about the different aspect of a HCBS program which are a priority for the state and stakeholders

- Several organizations have published HCBS frameworks that states can adopt – wholly or in part – for their HCBS quality measurement program
 - The National Quality Forum (NQF)
 - United Healthcare
 - The National MLTSS Health Plan Association

Frameworks Comparison At-a-Glance



NQF Quality Framework	United Healthcare Quality Framework	National MLTSS Health Plan Association Framework
Service Delivery and Effectiveness	P (Service/Care Coordination)	N
Person-Centered Planning and Coordination	P (Service/Care Coordination)	Y
Choice and Control	P (Living Independently/Choice and Decision-making)	P (Quality of Life)
Community Inclusion	P (Community Integration)	N
Caregiver Support	N	N
Workforce	N	N
Human and Legal Rights *	N	N
Equity *	N	N
Holistic Health and Functioning	P (Health Status/Medical Care)	P (Integration Risk Factors)
System Performance and Accountability *	N	N
Consumer Leadership in System Development *	N	N
	Access #	Transition to Most Integrated Setting #
		Satisfaction #

Key: * NQF domains measure system performance and as such, are elements a health plan cannot measure or be held accountable for; # there are no corresponding domains in NQF Framework; Y – domain is identical to NQF; P – domain shares some of the same elements; N – domain is not addressed

Considerations for MLTSS Measures

- Should be defined relative to the ultimate goals of or outcomes of LTSS
- Must be as applicable as possible to as many populations as possible
- Should be valid and reliable (ie. audited or otherwise vetted)
- Must address waiver assurances (if appropriate) or 1115 requirements
- Should address both quality of life and service delivery
- Need to be 'doable' for health plans, and focus on what the health plans can control
- Minimize case/record review to the maximum extent possible; focus on administrative data

Considerations for MLTSS Measures

- While HCBS waiver PMs are important, they do not necessarily lead to quality/performance improvement
- “Easiest” measures focus on improved health outcomes
 - ↓ ED visits
 - ↓ Inpatient admits
 - ↑ Preventative services
- Consumer and advocacy groups – especially disability communities – want to see outcome measures
- About half of MLTSS states are using quality of life surveys - including NCI-AD™ - to assess quality

State Efforts to Improve Quality

National Core Indicators – Aging and Disability

- Face-to-face survey of older adults and persons with disabilities
- Collaboration among NASUAD, the Human Services Research Institute (HSRI), and participating states
- Parallel to National Core Indicators (NCI) survey – 40% of survey questions are identical
- States get specific results based on sampling approach as well as national report against which to benchmark their performance

Purpose of NCI-AD



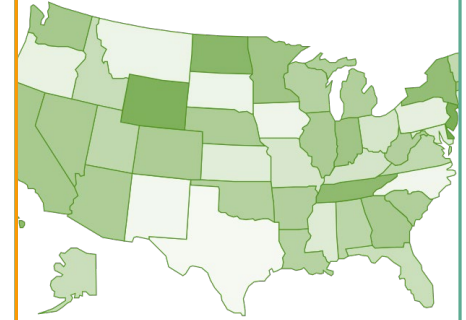
Hear directly from people receiving LTSS



Assess quality of life, service satisfaction, and outcomes of people receiving LTSS

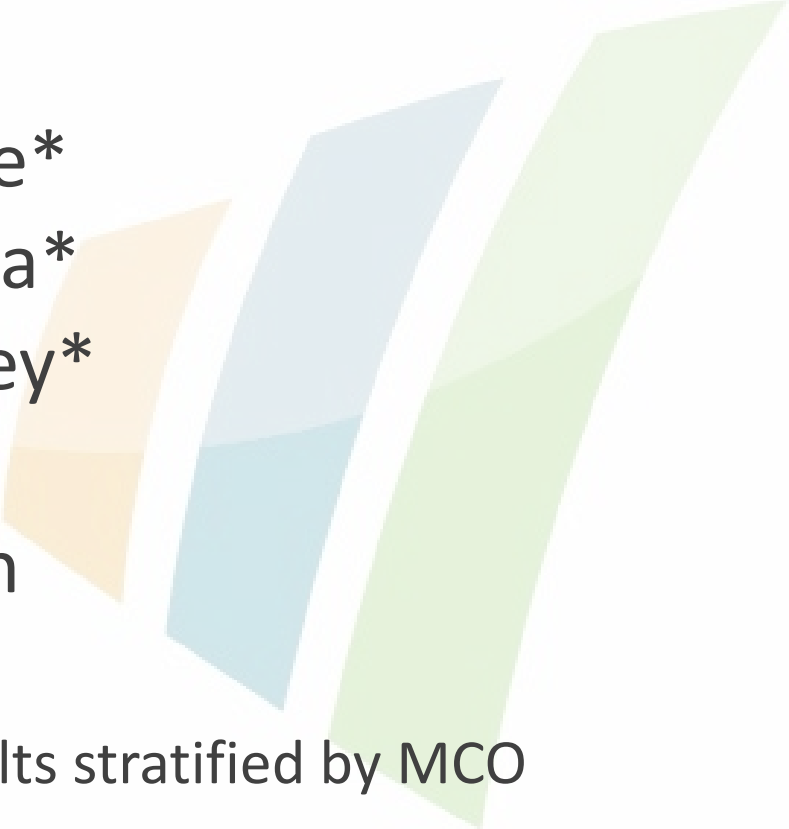


Support state Aging, Disability, and Medicaid agencies in measuring performance of their state LTSS systems



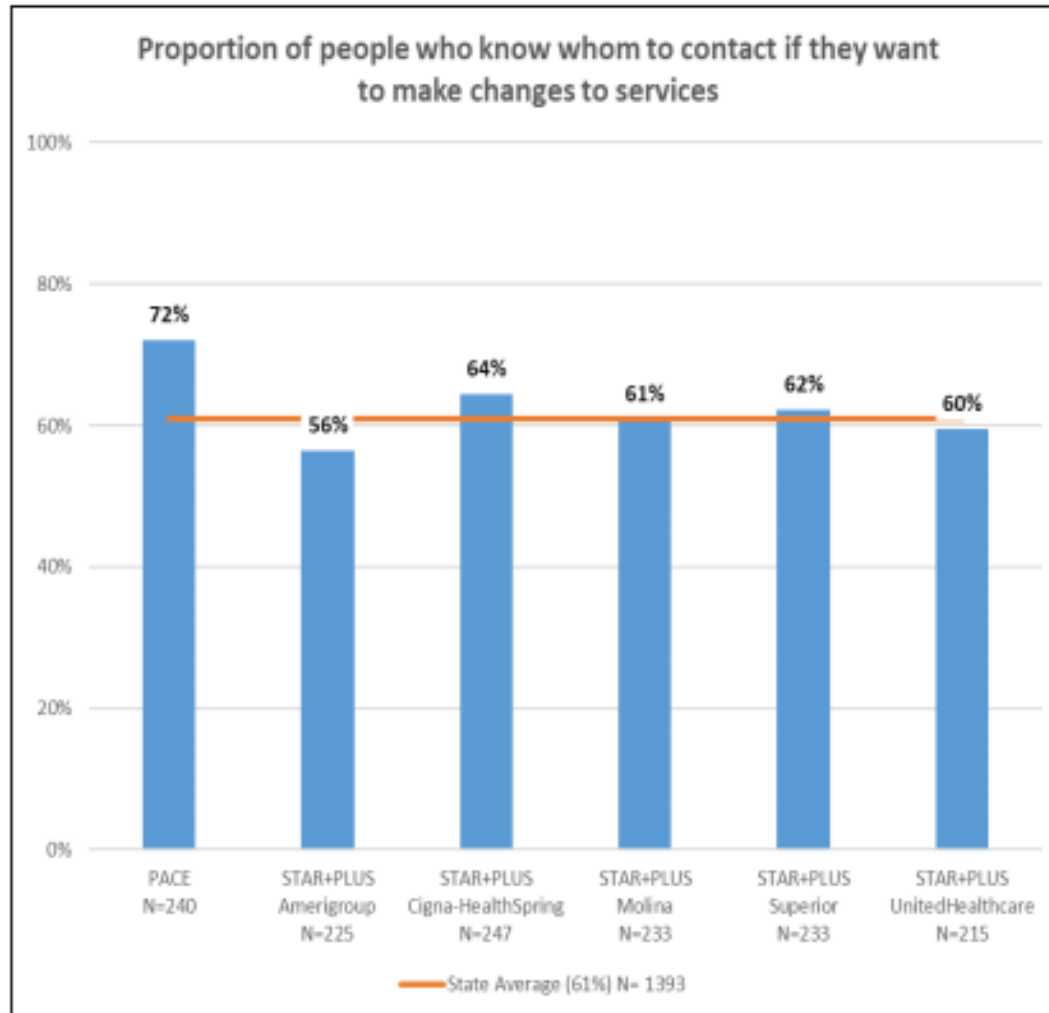
Assist states in improving the quality of services and supports provided

NCI-AD MLTSS States

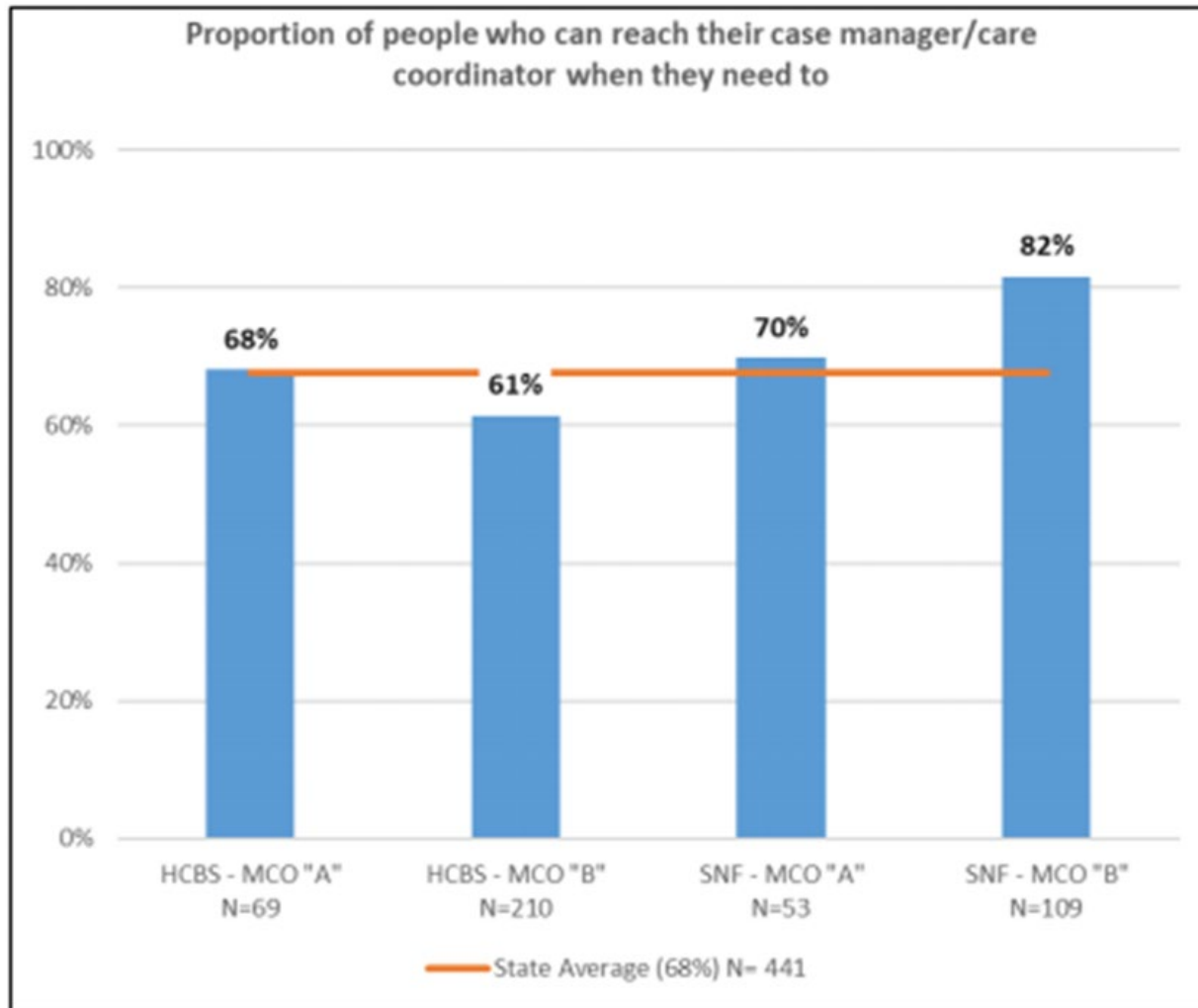
- Delaware*
 - Texas*
 - Tennessee*
 - Minnesota*
 - New Jersey*
 - Ohio
 - Wisconsin
 - Kansas
- 

*indicates results stratified by MCO

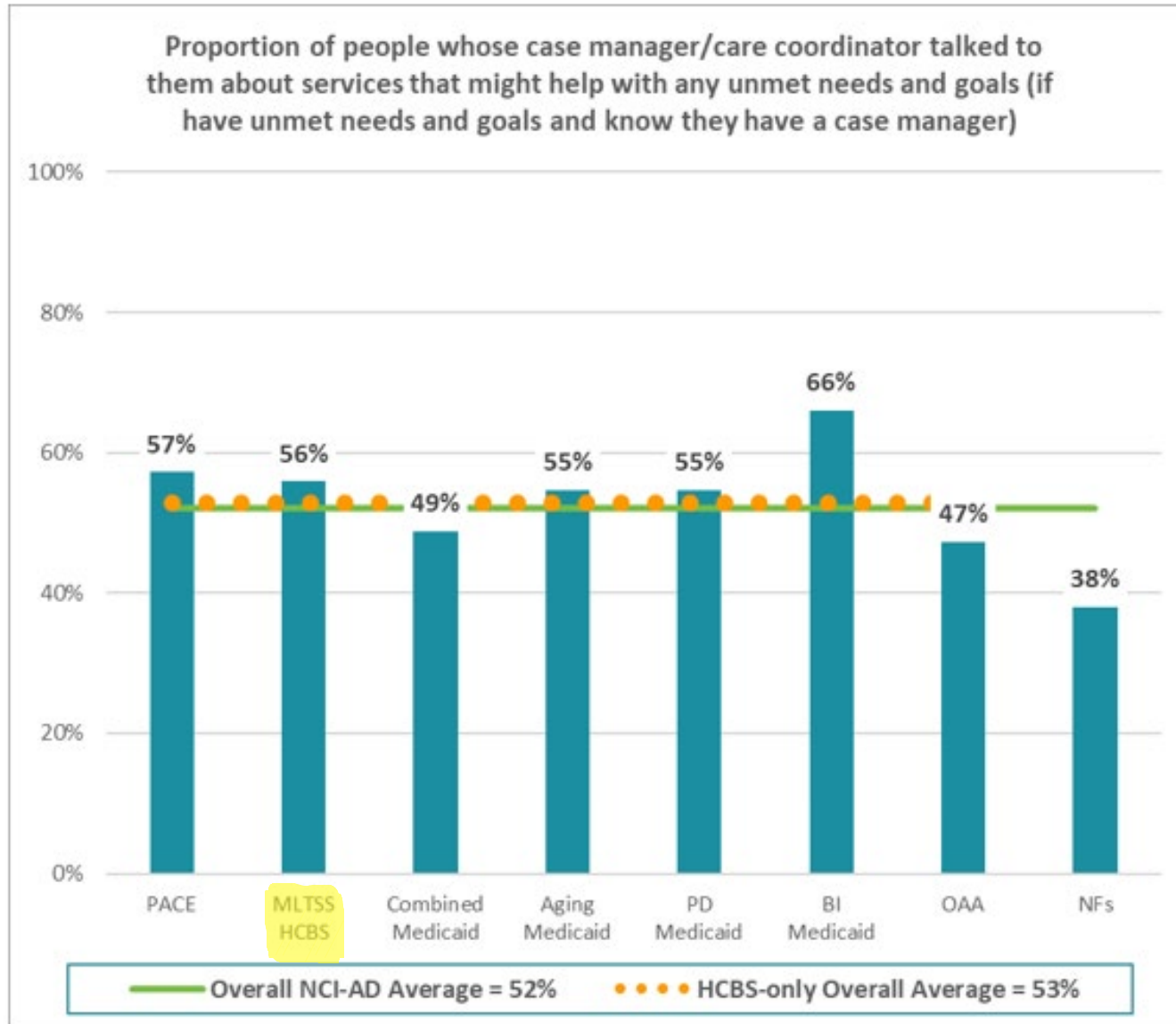
NCI-AD State Data Example: Texas Stratifies Results by MCO



NCI-AD State Data Example: Delaware Stratifies Results by MCO



NCI-AD 2017-18 National Data Results



www.NCI-AD.org

- State-specific and National reports
- Presentations
- Webinars
- Technical guides and resources

The screenshot shows the NCI-AD website. At the top left is the NCI-AD logo: 'NCI-AD NATIONAL CORE INDICATORS Aging and Disabilities™'. To the right are logos for NASUAD (National Association of State Unemployment Agencies) and HSRI (Human Services Research Institute). A green navigation bar contains the links: HOME, ABOUT, NCI-AD STATES, RESOURCES, NEWS, CONTACT.

The main content area is titled 'National Core Indicators – Aging and Disabilities (NCI-AD)™'. Below the title is a paragraph: 'NCI-AD™ is a voluntary effort by State Medicaid, aging, and disability agencies to measure and track their own performance.' This is followed by another paragraph: 'The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including service planning, rights, community inclusion, choice, health and care coordination, safety and relationships.' A third paragraph states: 'NCI-AD™ is a collaboration of participating states, NASUAD, and HSRI'. Below this text are two buttons: 'READ MORE' and 'HOW TO PARTICIPATE'.

To the right of the text is a map of the United States titled 'Participating NCI-AD States'. The map shows several states highlighted in dark teal, representing participating states. A dropdown menu labeled 'NCI-AD States' is positioned above the map. Below the map are two buttons: 'READ MORE' and 'HOW TO PARTICIPATE'.

At the bottom of the page, there are three columns of information:

- RELEASED: 2016-2017 National Report**
From June 1, 2016 through May 31, 2017, twelve states - Colorado, Indiana, Kansas, Maine, Minnesota, Mississippi, Nevada, New
- Presentations**
NCI-AD Project staff present data at conferences and meetings and hold a series of introductory webinars each year for states interested in learning more about the project.
- Join NCI-AD**
NCI-AD is open to any State Aging, Disability, or Medicaid Agency and new states are welcome to join the project at any time. First year states are encouraged to begin planning for

National Efforts to “Move the Needle”

- In 2012, CMS began MLTSS quality efforts as a result of expansion of MLTSS programs and new Financial Alignment Demonstrations
- The purpose was to:
 - Fill major gaps in MLTSS measures;
 - Develop and test measures that could be included in an MLTSS quality measure set
 - Enable “apples-to-apples” comparisons of MLTSS plan performance

National Efforts to “Move the Needle”

- In 2018, CMS released specifications* for seven MLTSS-specific measures in areas of care coordination and rebalancing

LTSS Comprehensive Assessment and Update	LTSS Comprehensive Care Plan and Update	LTSS Shared Care Plan with Primary Care Practitioner	Long-Term Services and Supports Reassessment/ Care Plan Update After Inpatient Discharge
LTSS Admission to an Institution from the Community	LTSS Minimizing Institutional Length of Stay	LTSS Successful Transition after Long-Term Institutional Stay	

* <https://www.medicaid.gov/medicaid/managed-care/ltss/index.html>

National Efforts to “Move the Needle”



- Four of the measures were added to HEDIS in 2019 (for optional reporting)
 - ❑ LTSS Comprehensive Assessment and Update (LTSS – CAU)
 - ❑ LTSS Comprehensive Care Plan and Update (LTSS – CPU)
 - ❑ LTSS Shared Care Plan with Primary Care Practitioner (LTSS – SCP)
 - ❑ Long-Term Services and Supports Reassessment/ Care Plan Update After Inpatient Discharge (LTSS – RAC)

- NCQA sponsored a learning collaborative with plans and CBOs reporting these measures
 - ❑ Identify barriers in collection
 - ❑ Make recommendations for measure refinement

National Efforts to “Move the Needle”



- NCQA has also developed a LTSS Distinction status for MLTSS health plans

- 5 MLTSS states require contracted MCOs to achieve LTSS Distinction status:
 - Kansas
 - North Carolina
 - Pennsylvania
 - Tennessee
 - Virginia

- Ten MCOs have thus far achieved LTSS Distinction status

National Efforts to “Move the Needle”



- The Medicaid and CHIP Adult and Child Core Set workgroup has – for the first time – recommended inclusion of LTSS quality measures into the Core Set
 - ▣ National Core Indicators
 - ▣ National Core Indicators – Aging and Disabilities
- CMS will release 2020 final Core Set measures this fall
- LTSS measures are under consideration for Medicaid and CHIP Scorecard
- CMS is working on set of recommended HCBS measures for state and MCO use

Wisconsin's Quality Management Structure



2019 MLTSS Intensive

Curtis J. Cunningham
Assistant Administrator
Long-Term Care Benefits and Programs
August 28, 2019

National Quality Measures



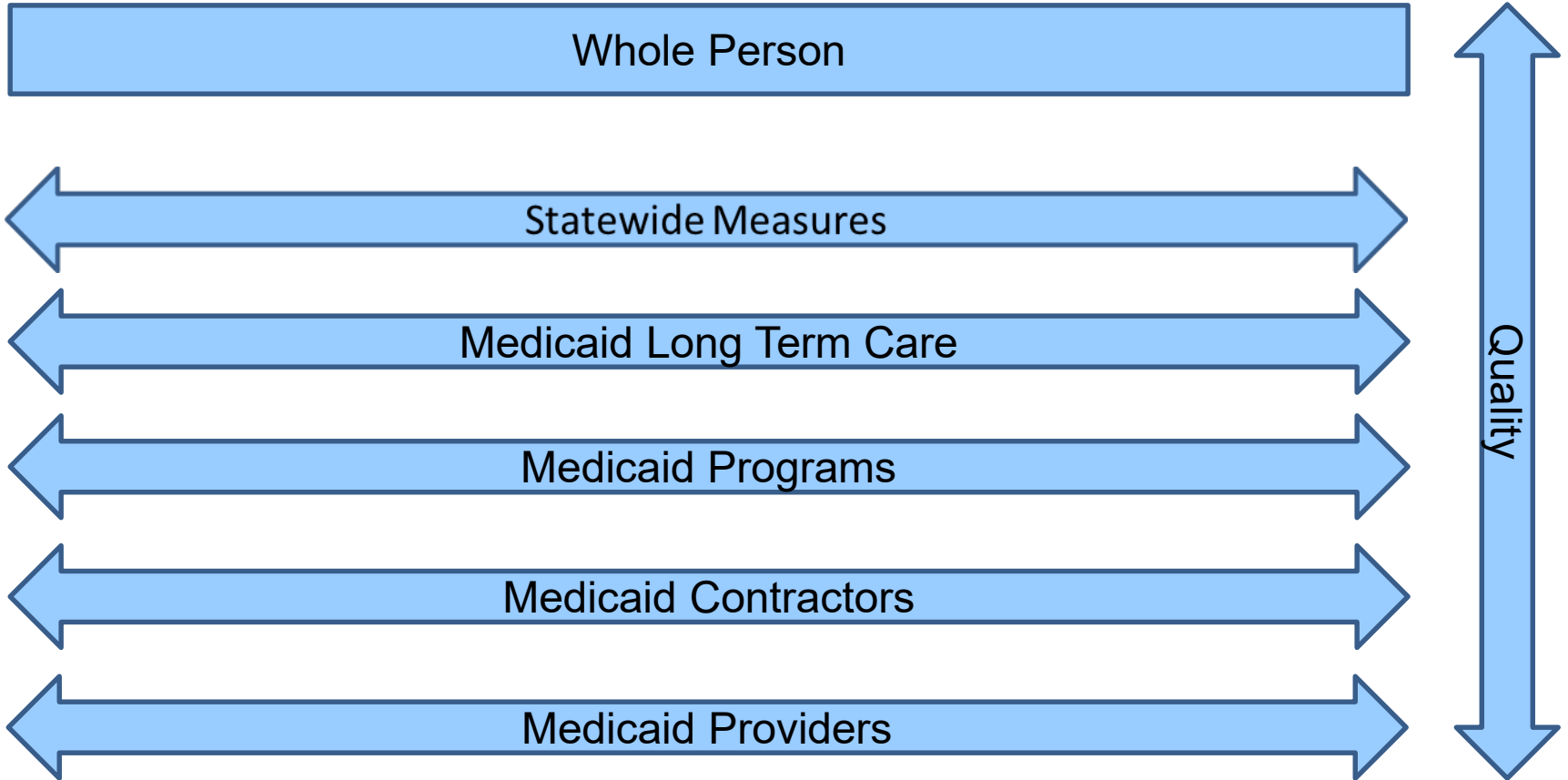
Why Have a Long Term Care Quality Strategy?

The long term care (LTC) quality strategy will allow us to measure what we **value** to meet our mission and achieve our vision.

Vision: People with diverse abilities empowered to realize their potential

Mission: Administer programs that provide people with high quality, person-centered services and supports.

Quality Strategy for People in Long Term Care

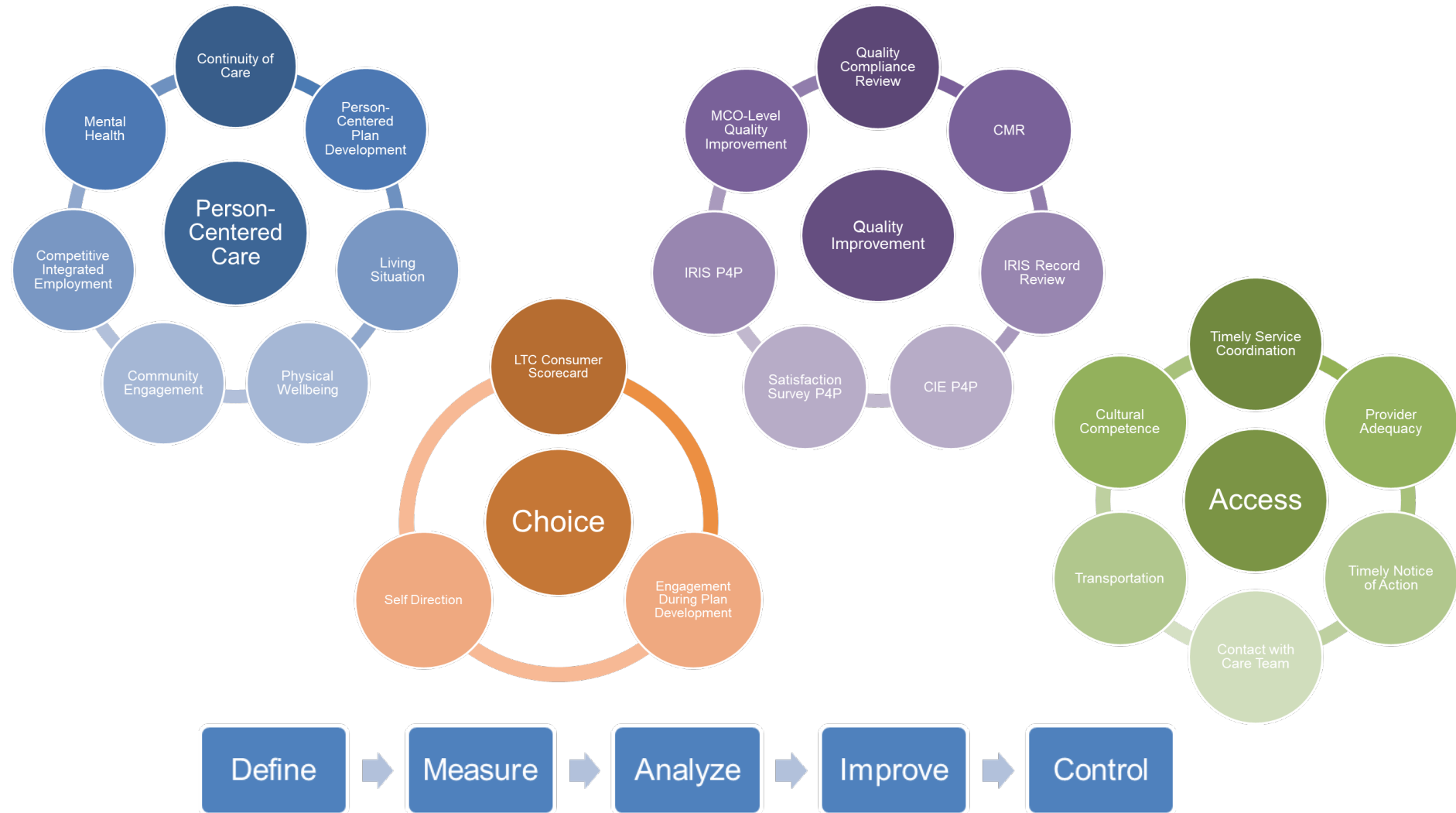


To protect and promote the health and safety of the people of Wisconsin

Statewide and Medicaid LTC Measures

- AARP LTC scorecard
- National core indicators (NCIs) for intellectual or developmental disabilities (I/DD)
- NCIs for elderly and those that are physically disabled
- Wisconsin LTC scorecard

Adult LTC Quality Strategy



A Sample of the Adult LTC Quality Strategy Measurements

<u>Measure</u>	<u>Definition</u>	<u>Data Source</u>
Person-centered plan development	Percentage of records with member centered plan updated for significant changes	Care management review
Person-centered plan development	Percentage of records with an individual support and service plan (ISSP) updated for significant changes	IRIS record review
Person-centered living situation	Percentage of those who currently live in the setting they prefer	NCIs
Access: provider adequacy	Number of MCOs that meet QCR standards for provider selection: credentialing and nondiscrimination	Quality compliance review
Access: contact with care team	Percentage of those able to contact Interdisciplinary Team/ IRIS Consultant when needed	Quality compliance review

A Sample of the Adult LTC Quality Strategy Measurements (cont.)

<u>Measure</u>	<u>Definition</u>	<u>Data Source</u>
Choice: engagement in plan development	Percentage of those who feel they are involved in making decisions about their care plan (MCOs)	Member satisfaction survey
Choice: self direction	Percentage of members/participants with at least two self-directed services	Encounter data
Quality improvement: competitive integrated employment pay for performance (P4P)	Number of MCOs that met the competitive integrated employment (CIE) P4P criteria for withhold, incentive 1, and/or incentive 2	MCO reported results
Satisfaction survey P4P	Number of MCOs that met the satisfaction survey P4P criteria for withhold and incentive	Member satisfaction survey

Satisfaction Survey

- Captures consumer satisfaction with their MCO, IRIS consultant agency (ICA), and/or fiscal employer agent (FEA)
- Results are statistically valid by program and target group
- Developed in partnership with UW Survey Center
- First took place in 2018
- 2019 survey will include same questions to allow for equal comparison over time

% who like their MCO/ICA/FEA overall		
MCOs	ICAs	FEAs
84.9%	92.7%	86.9%

How Quality Data is Utilized

Quality data is only good if it can help to improve programs and outcomes.

Three examples include:

- Consumer options scorecard
- P4P
- Systemic benchmarking and improvement

Consumer Options Score Card

Family Care	MCO 1	MCO 2	MCO 3
MEMBER SURVEY			
Overall Satisfaction	★★★★	★★★★	★★★
Care Team Responsiveness	★★★★	★★★★	★★★
Care Team Quality of Communication	★★★★	★★★★	★★★★
QUALITY & COMPLIANCE			
Meeting Quality Standards	★★★★★	★★★★★	★★★★★
Rights and Protections	★★★★★	★★★★	★★★★
Quality and Timely Services	★★★★★	★★★★	★★★★★
Grievance System	★★★★★	★★★★★	★★★★★
CARE TEAM CHARACTERISTICS			
Care Manager Turnover	★★★★	★★★★	★★★★
Nurse Turnover	★★★★	★★★★	★★★
Care Manager to Member Ratio	1:42	1:40	1:36
Nurse to Member Ratio	1:84	1:80	1:72
ADDITIONAL INFORMATION			
MCO Website	www.MCO.com	www.MCO.com	www.MCO.com
Email	N/A	MCO@MCO.com	MCO@MCO.com
Address of Closest Office	123 MCO Way Suite 123 Madison, WI 12345	124 MCO Way Suite 123 Madison, WI 12345	125 MCO Way Suite 123 Madison, WI 12345
Phone	000-000-0000	000-000-0000	000-000-0000
Provider Directory	www.directory.com	www.directory.com	www.directory.com
Number of Counties the MCO Serves	#	#	#
Type of Agency (For profit or not for profit)	Not for profit / For profit	Not for profit / For profit	Not for profit / For profit

2019 P4P Initiatives

1) Member Satisfaction Survey

- 1) **Withhold criteria:** Selected members must be at least satisfied across four survey questions.
- 2) **Incentive criteria:** Members report very satisfied across the four selected survey questions.

2) Competitive Integrated Employment

- 1) **Withhold criteria:** MCO submits five-year plan to DHS for increasing CIE. Plan must also incorporate collective impact.
- 2) **Incentive consist of two criteria**
 - 1) **Criteria 1:** Care team discusses employment opportunities with 90% of members and identify the percent currently working, percent interested in working, percent may be interested in working, and percent not interested in working.
 - 2) **Criteria 2:** Care team provides and documents follow-up activities and benefits provided to engage members in employment opportunities such as job coaching, Division of Vocational Rehabilitation referral, and job shadowing.

2019 P4P Initiatives (cont.)

3) Incentive: Wisconsin Assisted Living Incentive

1) Tier 1: Number of MCO members living in an assisted living community that meets abbreviated Division of Quality Assurance survey criteria of no substantiated complaints or findings for three years and home and community based services (HCBS) compliant

2) Tier 2: Meet criteria 1 and is part of the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) and in good standing with a fall with injury rate of less than 3 per 1,000 resident days.

Systemic Benchmarking and Improvement

Wisconsin LTC Scorecard

1 Access	2011	2012	2013	2014	Progress
1.1 Percent of eligible adults on waiting list for long-term care programs	6.6%	3.3%	2.9%	2.9%	✓
1.2.1 Percent of total LTSS Medicaid funding spent on the care and support of enrollees in home and community-based waiver (HCBW) - adults	64.6%	65.7%	67.9%	70.2%	✓

Staff Reliability

- NCI-In Person Survey (IPS): 94% of Wisconsin IPS (I/DD) survey participants said staff come and leave when they are supposed to (within range of 92% NCI average; 2016-17 result 91%)
- NCI-IPS 18% said they had been unable to take care of themselves or do every day activities due to lack of staff to help
- NCI-Aging and Disability (AD): 83% of Wisconsin NCI-AD survey participants said staff arrive and leave when they are supposed to
- NCI-AD: 24% had needed help with self care or everyday activities in the past year and did not get it due to lack of staff

NCI Barriers to Community Inclusion

Top Reasons Wisconsin NCI-IPS (I/DD) survey participants answered the question about why they cannot go out or cannot go out as often as they would like:

- Transportation (78%)
- Cost or money (48%)
- Health limitations (46%)
- Lack of staffing or personal assistance (39%)
- Other (24%)

Top reasons Wisconsin NCI-AD survey participants said they were not as active in the community as they would like:

- Health limitations (75%)
- Transportation (29%)
- Cost or money (19%)
- Accessibility or lack of equipment (13%)
- Not enough staffing or assistance (11%)

Contact

Curtis J. Cunningham

Assistant Administrator

Long-Term Care Benefits and Programs

Division of Medicaid Services

Wisconsin Department of Health Services

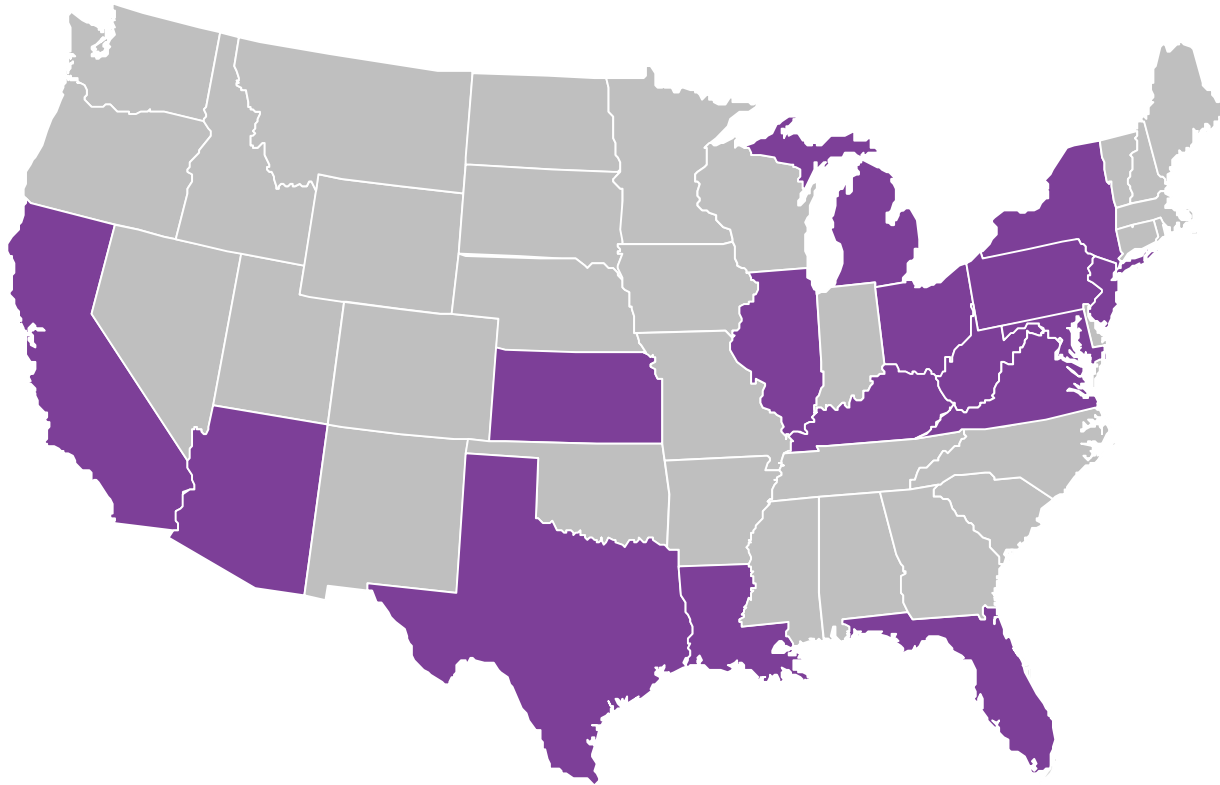
curtis.cunningham@wisconsin.gov

608-261-7810



Health Plan Focus on LTSS Quality

Aetna Medicaid: national presence, local impact



37 contracts across **16** states

Administer Medicaid programs in 16 states across the nation with a varying number of contracts per state managing distinct populations and regions within each state

30 plus years experience

Across all populations including managing the care of complex, high-risk populations; Best-In-Class winner of the 2017-18 Medicaid Health Plan Association Award

2M Medicaid members

In Aetna Medicaid Administrators and ABH health plans across the nation

6.7k employees

In Aetna Medicaid Administrators and ABH health plans across the nation

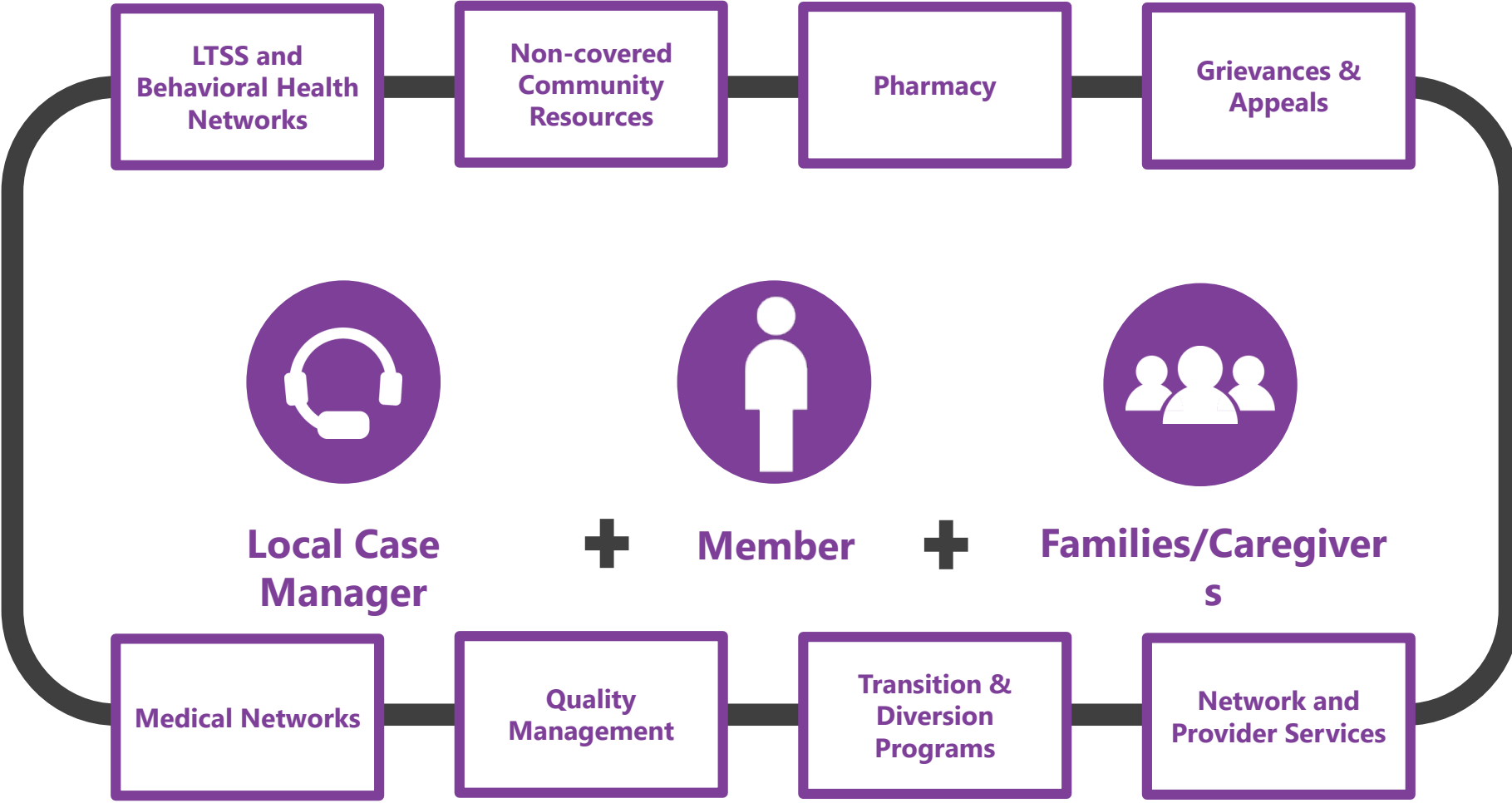
Populations we serve

	Arizona	California	Florida	Illinois	Kansas	Kentucky	Louisiana	Maryland	Michigan	New Jersey	New York	Ohio	Pennsylvania	Texas	Virginia	West Virginia
ABD/SSI	■	■	■		■	■	■	■	■	■	■		■	■	■	■
ACA Expansion	■	■				■	■	■	■	■			■			■
BH Carve-In	■	■	■		■	■	■		■	■		■		■	■	■
CHIP	■	■	■		■	■	■	■	■	■			■	■	■	
Duals*	■	■	■	■	■	■	■		■	■	■	■	■	■	■	
LTSS	■	■	■	■	■				■	■	■	■		■	■	
TANF	■	■	■		■	■	■	■	■	■			■	■	■	■
Foster Children	■	■			■	■	■	■	■	■			■		■	
SPD / I/DD	■	■	■		■				■	■				■	■	

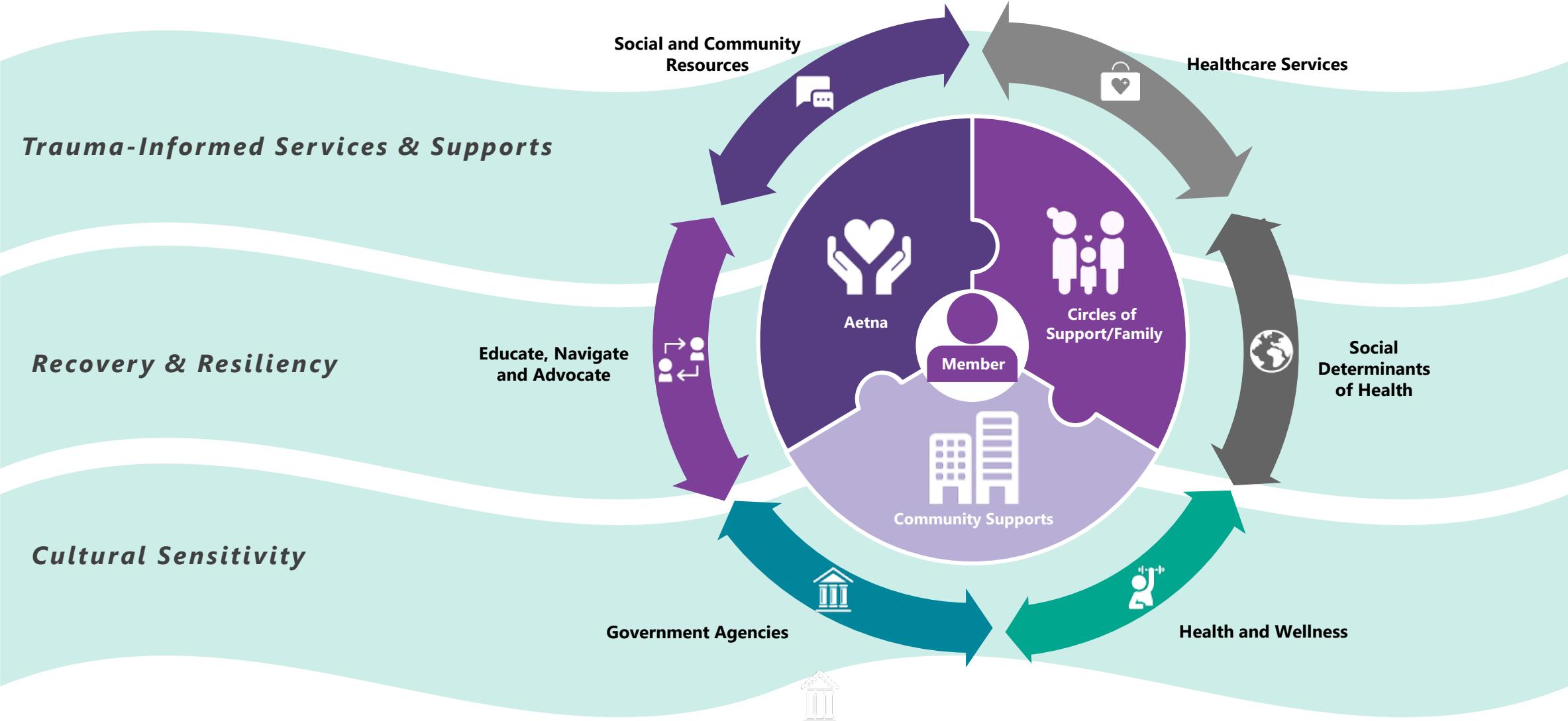
*Includes Dual Demonstration Medicare/Medicaid Plans as well as Dual-Special Needs Plans



Integrated support of members in their community

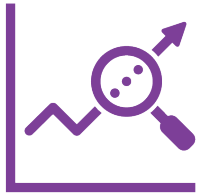


Our System of Care



Focusing on quality and outcomes

We have high member and provider satisfaction rates and are proud to show our strong commitment to quality and transforming care for members:



The National Committee for Quality Assurance (NCQA) has **accredited 11 Aetna Medicaid plans**, three of which are at the Commendable level



Medicaid Health Plans of America honored three Aetna plans with inclusion in the **Medicaid Managed Care Best Practices 2017-2018 Compendium**, including awarding Mercy Maricopa with **“Most Innovative Best Practice”** and **“Innovation in Behavioral Health”**



Aetna Better Health of Florida is the **#1 ranked Medicaid plan** in Florida by the NCQA and consistently above **90% for customer satisfaction**



Aetna Better Health of New York has been recognized for three consecutive years by NYS for implementing initiatives that **drove positive health outcomes**



Aetna Better Health of West Virginia has **scored 100% on state External Quality Review audits** the past three consecutive years

Health Plan Focus on LTSS Quality

- MLTSS Health Plan Association (MLTSS.org)
- NCQA Collaborative
 - HEDIS LTSS
 - LTSS Best Practices Academy
- Medicaid and CHIP Quality Rating Strategy (MAC QRS)
 - Mathematica coordinating
- HP alignment with state contract requirements



MLTSS Health Plan Association



- Model LTSS Performance Measurement and Network Adequacy Standards for States
 - Quality of Life
 - Transition to Most Integrated Setting
 - Integration Risk Factors
 - Person-Centered Planning and Coordination
 - Satisfaction
- 36 Measures – Initial focus on 11 measures
- Based on measures from other entities or new

HEDIS LTSS Learning Collaborative

- NCQA with support from SCAN Foundation
- Invited Community Based Organizations and HPs
- Measures
 - LTSS Comprehensive Assessment and Update
 - LTSS Comprehensive Care Plan and Update
 - LTSS Shared Care Plan with Primary Care Provider
 - LTSS Re-Assessment/Care Plan Update After Inpatient Discharge
- Focus of measures
 - File review
 - Evaluates quality of the assessment, care planning and care coordination
 - Factors in how medical needs are addressed



NCQA LTSS Best Practices Academy

- Discuss strategies for quality LTSS programs
- Share and discuss improvement ideas and strategies with peers and partners



Medicaid and CHIP Quality Rating Strategy (MAC QRS)



- Enhance transparency in Medicaid & CHIP managed care
- Assist members to select a HP
- Mathematica Workgroup
 - To support CMS in developing the MAC QRS
 - MLTSS Association / Aetna Medicaid participating

Challenges Collecting and Reporting Quality Measures

- Developing national benchmarks comparison across states
- State modifications to national measure specifications
- Member fatigue
 - Length of NCI-AD and CAHPS HCBS surveys
 - Frequent surveys
 - Frequent F2F with case manager
- Who are the LTSS members (e.g., LOC, State Plan personal care, Community First Choice)?
- Do not address members under age 18
- Dual eligible – access to Medicare data
- Variation of LTSS benefit package may impact outcome







Better Care for Dually Eligible Beneficiaries

Lindsay Barnette and Kerry Branick,
CMS Medicare-Medicaid Coordination Office



Dually eligible beneficiaries

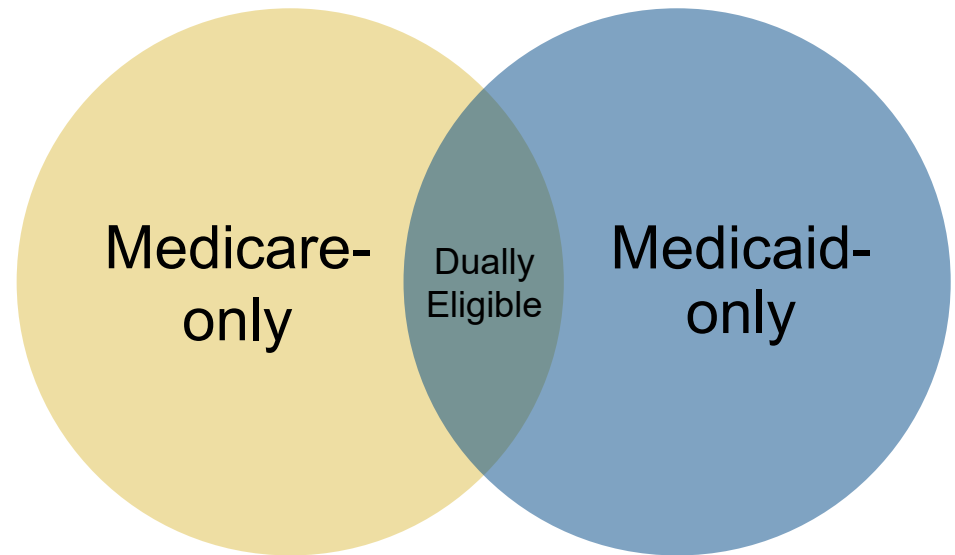
The dually eligible population

- Higher incidence of chronic conditions, disability
 - 41% have at least one mental health dx
 - 41% eligible for Medicare due to disability (vs. 8% for non-dual Medicare beneficiaries)
 - About half use long term services and supports
 - 19% have Alzheimer's or related dementia

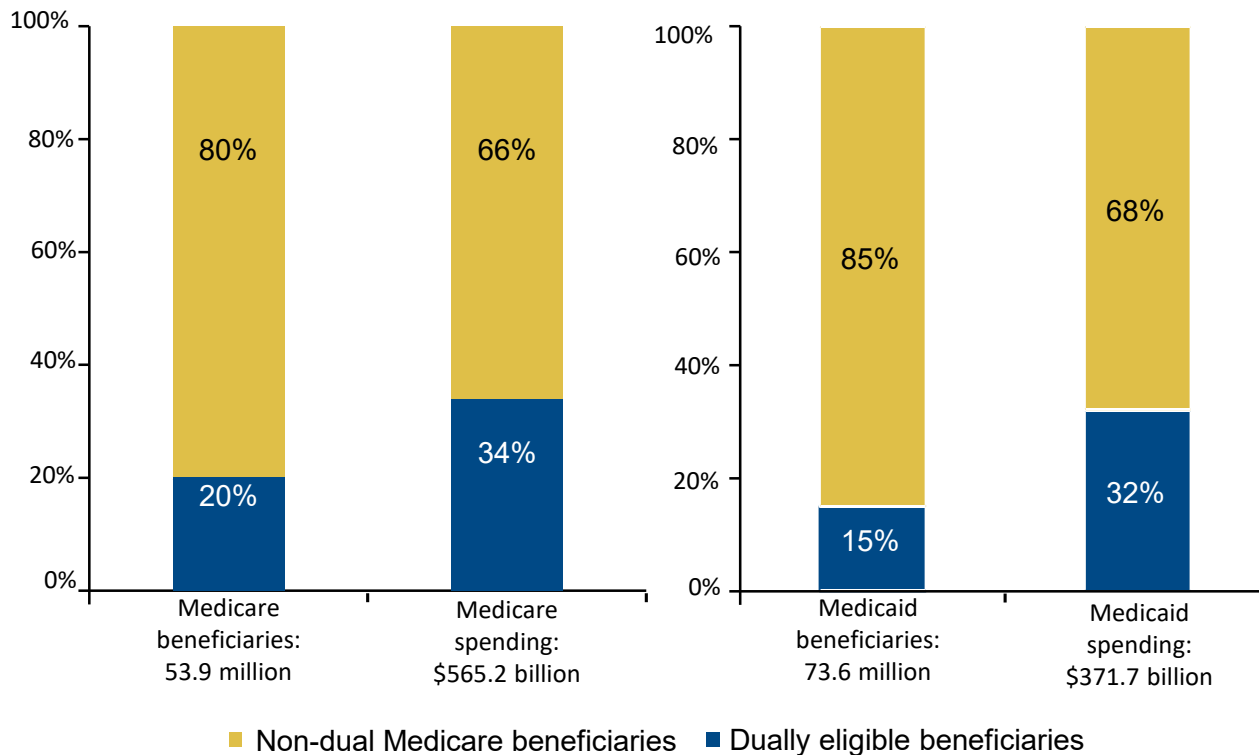
How it works

- Duals navigate two separate programs:
 - Medicare for the coverage of most preventive, primary, and acute health care services and drugs.
 - Medicaid for the coverage of long-term care supports and services, certain behavioral health services, and for help with Medicare premiums and cost-sharing.
 - Where benefits overlap, Medicare is primary payer.

12 million individuals are simultaneously enrolled in Medicare and Medicaid



Dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending



Note: Data are from CY 2013. Charts include all dually eligible beneficiaries (FFS, managed care, and ESRD). Medicaid spending amounts exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Source: MedPAC-MACPAC Data Book 2018

Looking from a Medicare perspective: dual eligibility correlates to poorer outcomes in Medicare programs

Program	ASPE findings for dually-enrolled vs. non-dually-enrolled beneficiaries
Hospital Readmissions Reduction Program	- 10-31% higher risk-adjusted odds of readmission
Hospital-Acquired Conditions Reduction Program	- Higher safety event rates for 4/8 individual events; lower for 2/8
Hospital Value-Based Purchasing Program	- 5-14% lower risk-adjusted odds of mortality - 4% higher risk-adjusted spending per episode
Medicare Advantage	- Performance worse on 17/20 quality measures
Medicare Shared Savings Program	- 18% higher risk-adjusted odds of readmission - 16% higher age/gender-adjusted odds of COPD admission - 14% lower age/gender-adjusted odds of HF admission
Physician Value-Based Payment Modifier	- 11-20% higher risk-adjusted odds of readmission - 80-230% higher risk-adjusted odds of preventable admission - \$725-\$2,979 higher risk-adjusted costs
ESRD Quality Incentive Program	- Performance worse on 5/5 quality measures
Skilled Nursing Facility Readmissions	- 4% lower risk-adjusted odds of readmission
Home Health Readmissions and ED Use	- 9% higher risk-adjusted readmission rates - 18% higher risk-adjusted ED use rates

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. December 2016.

<https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.

CMS' Better Care for Dual Eligible Individuals Strategic Initiative

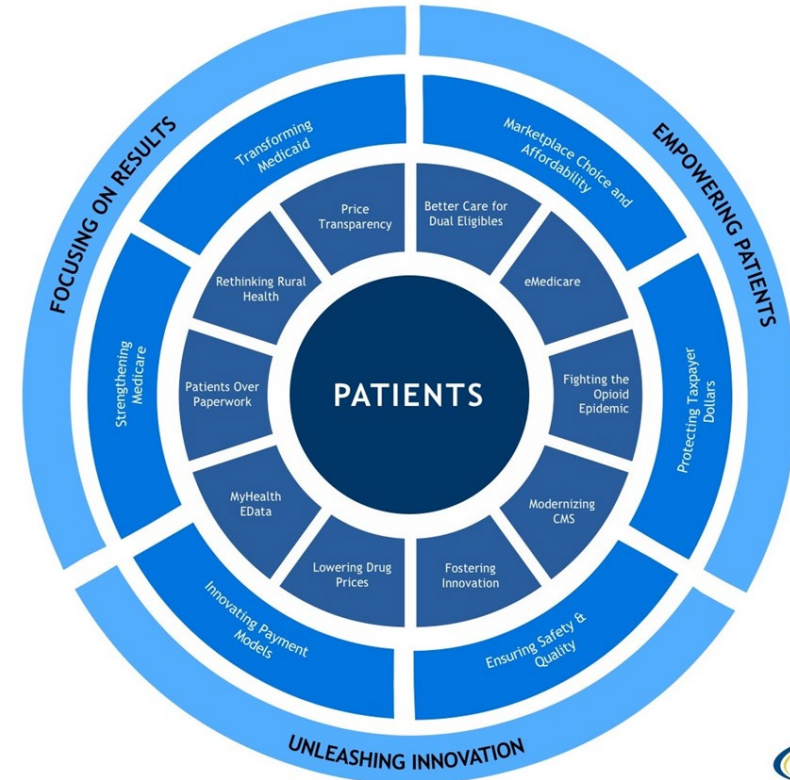
Initiative Goal: Improve quality, reduce costs, and improve the customer experience for people dually eligible for the Medicare and Medicaid programs.

Modernizing the Medicare Savings Programs (MSPs)

- CMS–state data exchange
- Crossover payments
- Reducing burden in eligibility processes

Promoting integrated care to achieve better outcomes

- Strengthening Medicare Advantage and Medicaid alignment in the final 2020 Medicare Advantage rulemaking
- Modernizing requirements for the Programs of All-Inclusive Care for the Elderly
- Inviting states to partner to test approaches in serving dually eligible individuals that work best for the unique needs of their state.



Opportunities for states

CMS has released two recent State Medicaid Director Letters outlining opportunities for states to improve care for dually eligible individuals:

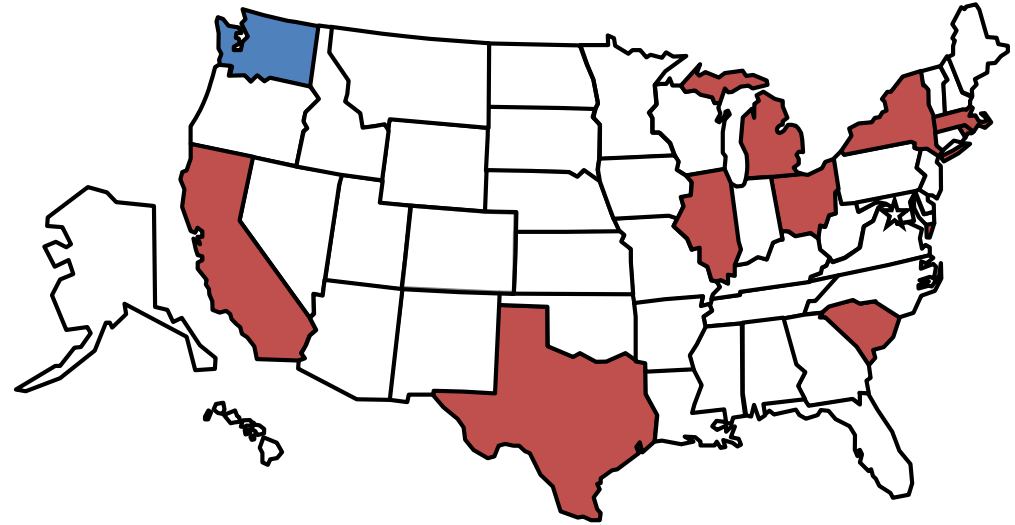
- December 19, 2018: describes 10 opportunities that do not require complex waivers or demonstrations
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>
- April 24, 2019: invites states to partner with CMS to test innovative approaches to better serve those who are dually eligible for Medicare and Medicaid
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>

Demonstration opportunities

- Integrating care through the capitated financial alignment model
 - Extensions of time and geographic scope available for existing states
 - Option for new states to participate in model test
- Integrating care through managed FFS financial alignment model
 - Option for new states to participate in model test
- States may also propose other state-specific models

Overview of the Financial Alignment Initiative

- **Background**
 - A longstanding barrier to coordinating care for the dually eligible population is the financial misalignment between Medicare and Medicaid. That is, investments or disinvestments in one program may result in savings or costs to the other program.
 - CMS is testing models to integrate the service delivery and financing of both Medicare and Medicaid through federal-state demonstrations to better serve the population.
- **Goal**
 - Reduce expenditures while preserving or enhancing quality of care
 - Increase access to quality, seamlessly integrated services for the dually eligible population.



- **Capitated financial alignment demonstration (9 states)**
- **Managed FFS financial alignment demonstration (1 state)**

¹ CMS and NY operate two separate capitated demonstrations, both in the New York City area.

Early evaluation results show promise in key cost, utilization and quality metrics

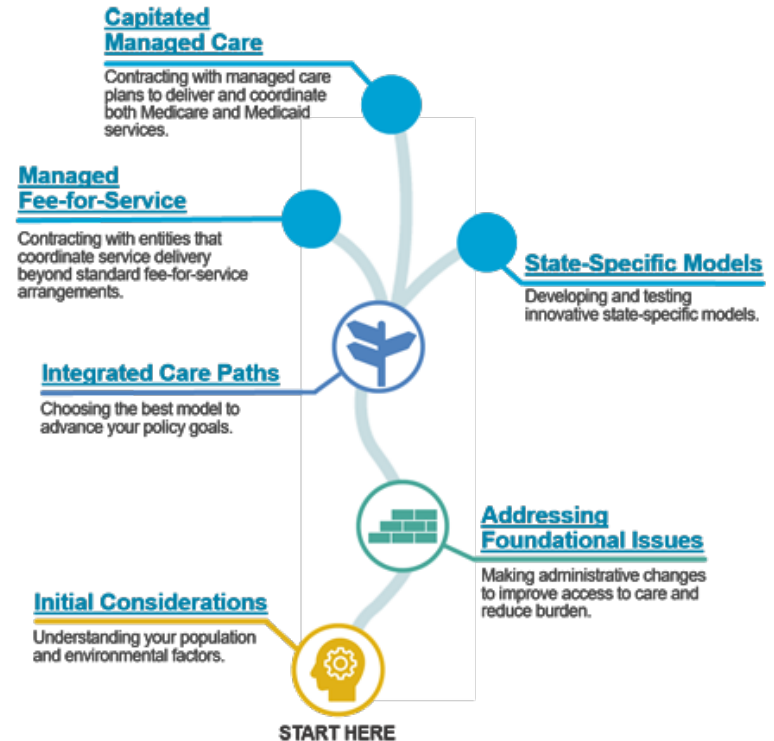
Cumulative results for evaluation reports released to date			
	Statistically significant reductions (desired effect)	Results not statistically significant (suggesting no effect)	Statistically significant increases (undesired effect)
Inpatient	3	0	1
SNF	3	1	0
Long-stay NF	3	0	1
Medicare costs	3	3	0
Medicaid costs	TBD	TBD	TBD

- MMP enrollees report high levels of satisfaction with their MMPs
 - 90% of demo respondents to CAHPS rated their health plan a 7 or higher in 2018 (scale of 0-10)
 - 65% of respondents rated their MMP 9 or 10 in 2018 (up from 59% in 2016)

Resources for states: where to start

- Integrated Care Resource Center (ICRC) developed State Pathways to Integrated Care tool
- States can use the tool to explore their options which includes both demonstration and non-demonstration options
- MMCO and ICRC are available to help walk through various options and considerations in more detail

https://www.integratedcareresourcecenter.com/sites/default/files/pdfs/ICRC_Pathways_to_Integration_04.15.19.pdf



Other resources for states

- **ICRC has a number of other FAI related resources, including:**
 - WA Managed FFS Model Case Study:
<https://www.integratedcareresourcecenter.com/resource/using-health-homes-integrate-care-dually-eligible-individuals-washington-state's>
 - OH Capitated Model Case Study:
<https://www.integratedcareresourcecenter.com/resource/mycare-ohio-demonstration-early-successes-and-stakeholder-insights-integrating-care-dually>
 - A variety of TA tools, issue briefs, and tip sheets related to capitated model demonstrations
<https://www.integratedcareresourcecenter.com/>
- **MMCO website includes links to a variety of FAI foundational documents including MOUs, three-way contracts, rate-setting FAQs, etc.**
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html>

Dual Eligible Special Needs Plans: Opportunities to Integrate Care and Improve Care Transitions

August 26, 2019

NASUAD HCBS Conference

Managed Long-Term Services and Supports Intensive

Speakers



Paul Precht

Senior Advisor

Centers for Medicare and Medicaid Services (CMS)

Medicare-Medicaid Coordination Office (MMCO)



Erin Weir Lakhmani

Health Researcher

Mathematica



Alexandra Kruse

Associate Director, Medicare-Medicaid Alignment

Center for Health Care Strategies

Agenda

- **Introduction**
 - History and purpose of Dual Eligible Special Needs Plans (D-SNPs)
 - Benefits covered through D-SNPs
- **Current D-SNP Enrollment and Landscape**
- **Using D-SNPs to Achieve Integrated Care**
 - Key Components of Medicare and Medicaid Integration
 - Fully and Highly Integrated Dual Eligible Special Needs Plans (FIDE and HIDE SNPs)
 - Aligned Enrollment and State Approaches
- **Using D-SNPs to Improve Care Transitions**
 - New Admission Notification Requirements and State Approaches
 - Benefits of Information Sharing to Support Care Transitions
- **Timeline for Implementing New Standards**

Introduction

What are Dual Eligible Special Needs Plans (D-SNPs)?

- A type of Medicare Advantage (MA) managed care plan
- Authorized in 2003 and began operating in 2006
 - Required to have contracts with states as of 2013
 - Made permanent by Bipartisan Budget Act of 2018
- Enroll only dually eligible beneficiaries
- D-SNPs must have an approved Model of Care (MOC) detailing how the plan will meet the needs of the enrolled population

D-SNP Contracts with States

- While all MA plans must have contracts with CMS, D-SNPs must also have a contract with the state Medicaid agency in each state where they operate
- Enables state Medicaid agencies to implement requirements that enhance coordination and integration of Medicare and Medicaid benefits
 - For example, requiring D-SNPs to incorporate Medicaid managed long-term services and supports (MLTSS) elements into MOCs
 - *See ICRC tip sheet on this topic in the Resources section at the end of the slides*

How are D-SNPs Different from Other MA Plans?

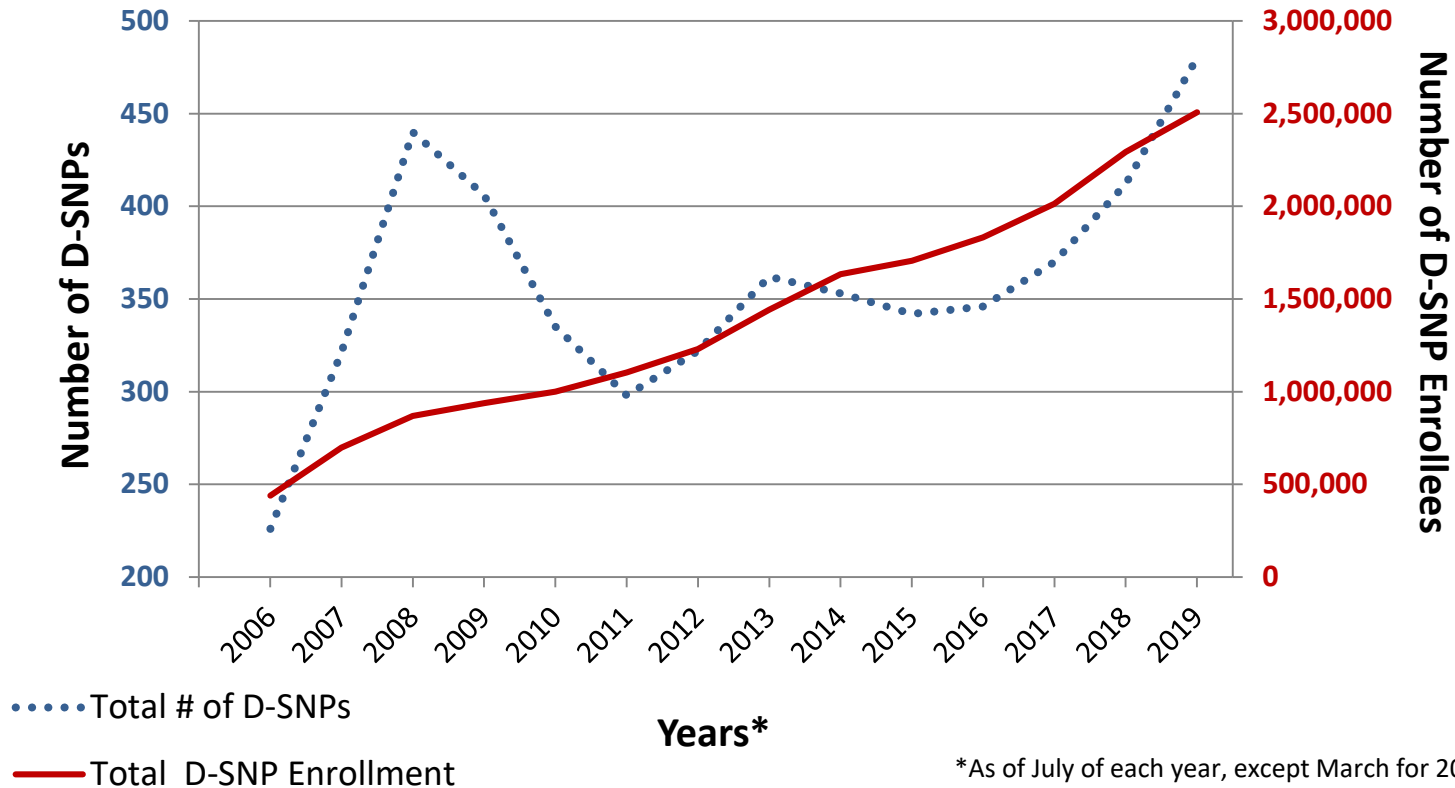
Feature	Non-SNP MA	D-SNP
State Contracting	None	Must have a contract with the state that includes at least certain minimum elements
Coverage of Medicaid Benefits	None	Depends on state contract; ranges from no covered Medicaid benefits, to coverage of Medicare cost-sharing and/or wrap-around Medicaid benefits, to all Medicaid covered benefits including long-term services and supports (LTSS) and behavioral health (BH)
Level of Medicare and Medicaid Alignment and Coordination	None	<ul style="list-style-type: none"> • Responsibility to at least coordinate delivery of Medicare and Medicaid services • May include option for beneficiaries to enroll in affiliated D-SNPs and Medicaid plans operated by the same company (“aligned enrollment”) • Plans with aligned enrollment may also integrate Medicare and Medicaid enrollment, beneficiary materials, appeals, etc.

Medicare-Medicaid Benefit Integration

- States can require D-SNPs to cover any or all Medicaid benefits, including:
 - Medicare beneficiary cost sharing for Qualified Medicare Beneficiaries (QMBs) and Full Benefit Dually Eligible Beneficiaries (FBDEs)
 - Drugs excluded from coverage by Medicare Part D
 - Medicaid services that overlap with Medicare (for example, home health and durable medical equipment)
 - Behavioral health (BH) services
 - Long-term services and supports (custodial nursing facility care, home- and community-based services (HCBS))
 - Services that may be provided through Medicaid, but are not covered by Medicare, such as transportation, vision, dental, or hearing benefits

D-SNP Enrollment and Landscape

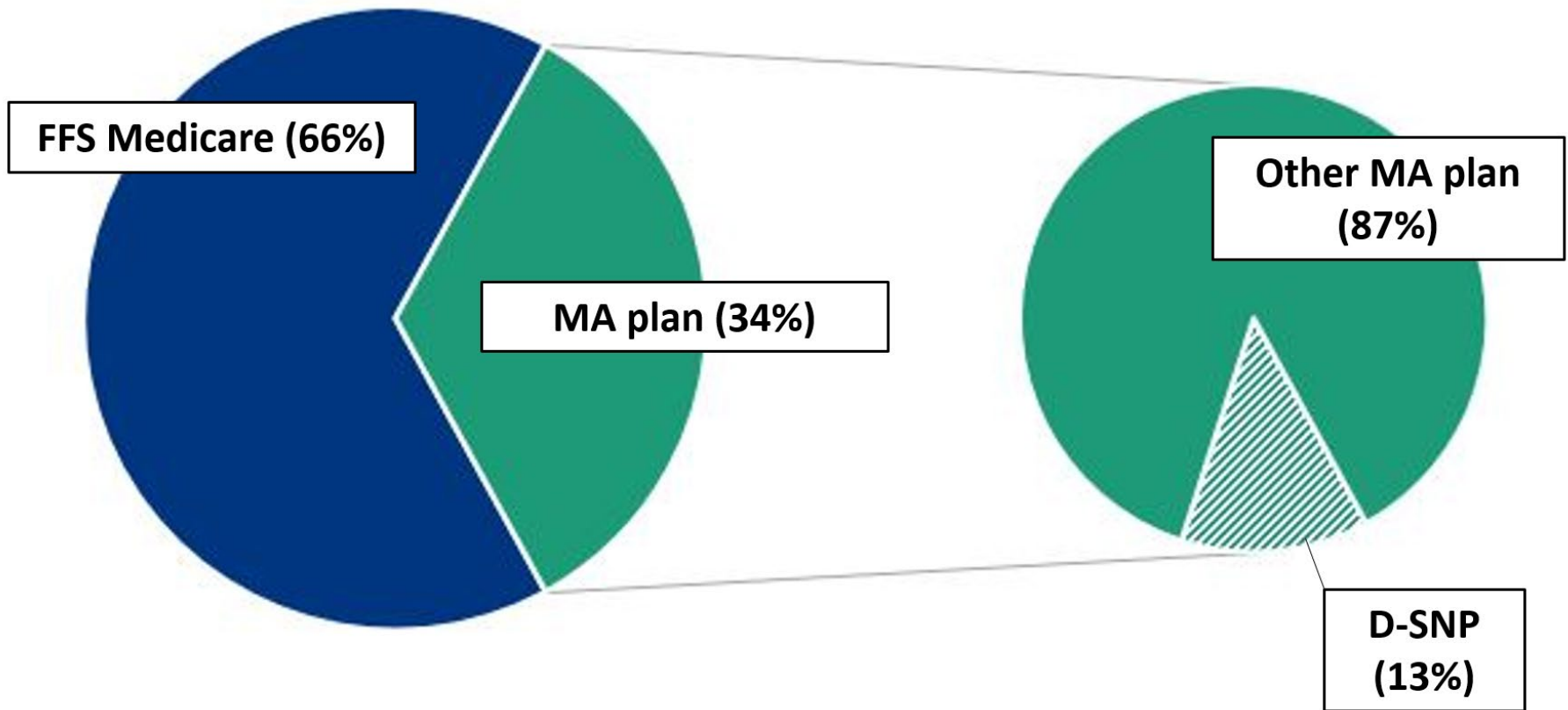
Growth in D-SNPs and Enrollment



*As of July of each year, except March for 2019
 Source: CMS SNP Comprehensive Reports

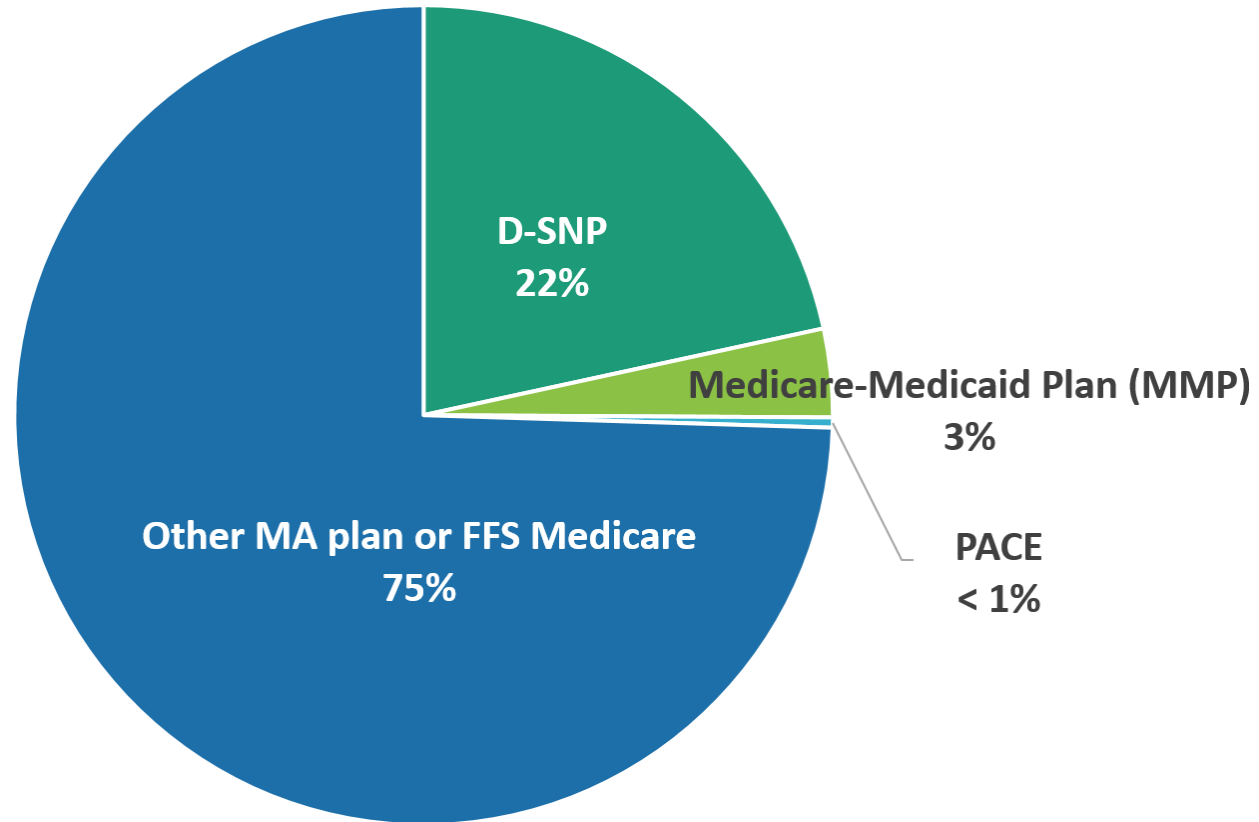
Source: CMS Special Needs Plan (SNP) Comprehensive Reports. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data.html>

D-SNP Enrollment Among All Medicare Beneficiaries



Source: Kaiser Family Foundation. "A Dozen Facts About Medicare Advantage in 2019." June 2019. Available at: <http://files.kff.org/attachment/Data-Note-A-Dozen-Facts-About-Medicare-Advantage-in-2019>

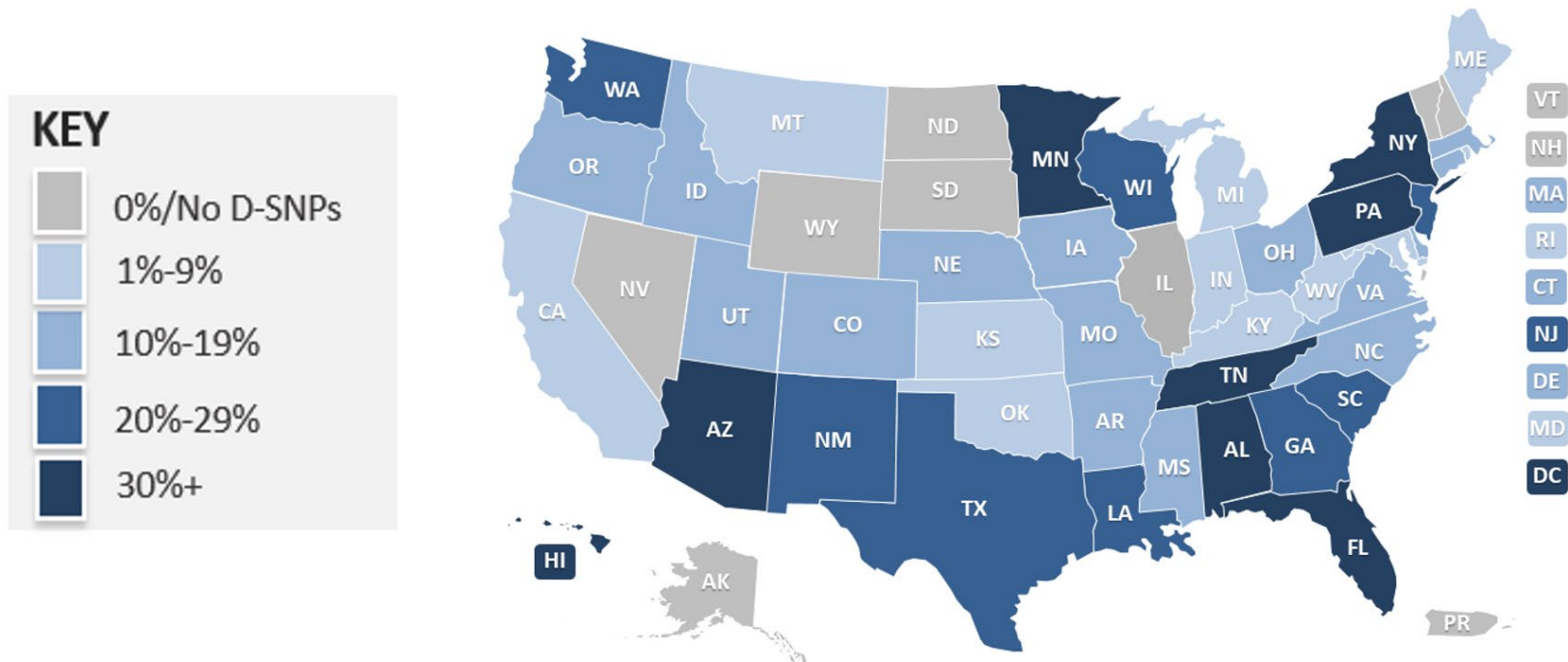
D-SNP Enrollment Among All Dually Eligible Beneficiaries, September 2018



Note: PACE programs may enroll non-dually eligible individuals in some states. PACE Enrollment in September 2018 was 43,303 – less than 1% of the total number of dually eligible enrollees in that month.

Sources: CMS Quarterly Enrollment Snapshot, September 2018. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>; CMS Monthly Enrollment by Contract Report, September 2018. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html>; and CMS Special Needs Plan Comprehensive Report, September 2018. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html>

Percentage of All Dually Eligible Beneficiaries Served by D-SNPs, Jan 2019

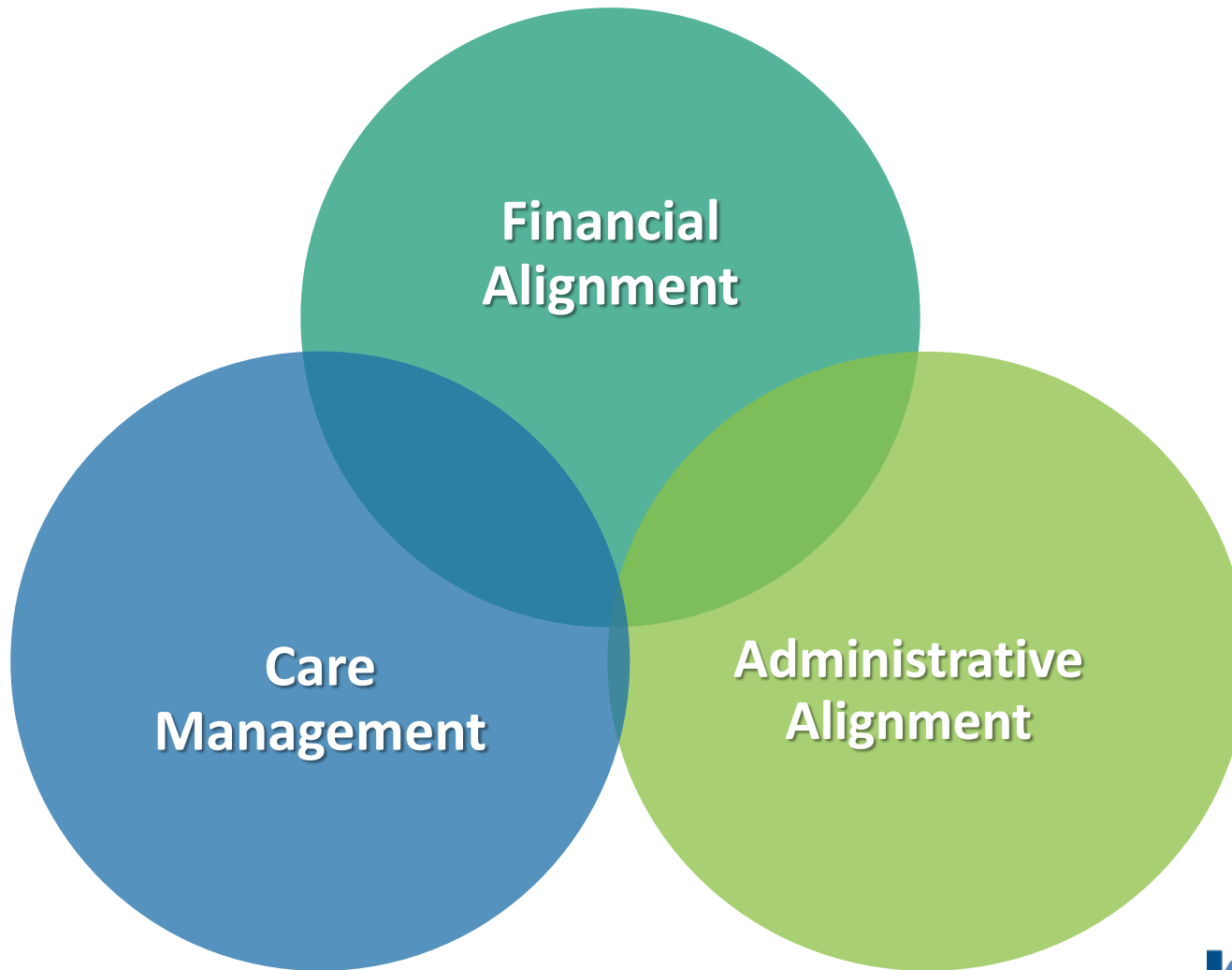


Notes: Five plans spanned multiple states. For this map, enrollment in those five plans was divided equally among states served. Some states allow partial benefit duals in D-SNPs, which are also captured in this map. Total D-SNP enrollment reflects January 2019 data, while the total number of dually eligible beneficiaries reflects December 2017 data, per the sources below. Data for Puerto Rico (PR) are not included in the monthly enrollment snapshot, so PR enrollment data is not reflected in this map.

Sources: CMS. *SNP Comprehensive Report*. January 2019. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2019-1.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=descending>; and CMS. *CMS Monthly Enrollment Snapshots*, December 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html>.

Using D-SNPs to Achieve Integrated Care

Key Components to Medicare-Medicaid Integration



GOAL

Create one accountable entity that delivers person-centered primary/preventive, acute, and behavioral health care, and long-term services and supports (LTSS).

Benefits of Enrollment in Fully or Highly Integrated D-SNPs

- If all/substantially all Medicare and Medicaid benefits are delivered through one plan, or through plans operated by the same parent company:
 - One entity will have a financial stake in ensuring that enrollees receive high quality, cost-effective care
 - Can be simpler for beneficiaries and providers to navigate
 - Provider payments administered by a single entity
 - Beneficiary communication materials can be integrated, making them easier to understand
 - Greater potential for care coordination
 - Information about services needed and received (for example, inpatient stays, care transitions) can be shared more efficiently and effectively

Minnesota Senior Health Options

- Minnesota operates two long-standing managed care delivery systems that enroll dually eligible individuals aged 65 and older:
 - Minnesota Senior Care Plus (MSC+) – Medicaid only MLTSS program
 - Minnesota Senior Health Options (MSHO) – Fully integrated Medicare-Medicaid program on D-SNP platform
- A 2016 analysis found that MSHO enrollees in fully integrated plans, compared MSC+ enrollees in non-integrated plans, 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.

Source: U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. “Minnesota Managed Care Longitudinal Data Analysis.” March 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/204996/MNmclida.pdf>

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)
 - 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

Sources: CMS. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register*, April 16, 2019, pp.15710-15718 and 42 CFR 422.107(d)) p. 15828. Available at: <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>
Bipartisan Budget Act of 2018 (P.L. 115-123). Section 50311: Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations. Available at: <https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf>

Aligned Enrollment

- “Aligned enrollment” means that an individual receives substantially all of their Medicare and Medicaid benefits through one plan, or through plans operated by the same parent company
- Examples of aligned enrollment:
 - Beneficiary enrolls in a FIDE SNP that is contracted with CMS to cover Medicare benefits, and with the state to cover Medicaid benefits, including LTSS
 - Beneficiary enrolls in a D-SNP for Medicare benefits, and a Medicaid managed care plan through the same parent company for Medicaid benefits

State Policies Promoting Aligned Enrollment

- **Influence market participation** by requiring contracted Medicaid managed care plans to offer affiliated D-SNPs in the same service area (and/or requiring D-SNPs to offer Medicaid managed care plans in the same service area)
 - State examples: AZ, HI, ID, MN, NJ, PA, TN
- **Limit D-SNP enrollment** to only full-benefit dually eligible beneficiaries (FBDEs)
 - State examples: AZ, ID, MA, MN, NJ, VA
- **Limit D-SNP enrollment** to only beneficiaries enrolled in affiliated Medicaid managed care plans
 - State examples: ID, MA, MN, NJ

State Policies Promoting Aligned Enrollment

- **Use Medicaid automatic assignment** to enroll D-SNP enrollees into affiliated Medicaid managed care plans (and/or periodically re-assign beneficiaries to Medicaid plans that align with their D-SNP enrollment)
 - State examples: ID, MA, MN, NJ
- **Allow or require D-SNPs to seek approval for default enrollment** of enrollees in affiliated Medicaid managed care plans when they become Medicare-eligible
 - State examples: AZ, OR, PA, TN
- **Encourage or require D-SNPs to target D-SNP marketing** to only enrollees in their affiliated Medicaid managed care plans
 - State examples: AZ, VA

Other State Efforts to Promote Aligned Enrollment

- **Conduct outreach** (for example, via letters, phone calls) to dually eligible enrollees regarding the benefits of aligned enrollment and steps to enroll in affiliated plans
 - State examples: AZ
- **Engage and train enrollment counselors and other benefits counselors** to ensure they can explain integrated options clearly to beneficiaries (e.g., Medicaid enrollment broker staff, State Health Insurance Assistance Program volunteers, and Aging and Disability Resource Center staff)
 - State examples: AZ, PA

Using D-SNPs to Improve Care Transitions

Hospital and SNF Admission Notification Requirement

- **Goal:** Improve coordination of Medicare and Medicaid services between settings of care for at least one group of high-risk full-benefit dual eligible individuals
 - D-SNPs (or a designated entity) must notify the state (and/or individuals/entities designated by the state)
 - State determines:
 - Who is “high risk”
 - Who will be notified
 - The timeframe for the notification
 - The notification method
- Requirement does not apply if D-SNP is a HIDE or FIDE SNP

Source: 42 CFR §422.107(d), as amended by the Final Rule entitled “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published at 84 FR 15828.

Approaches to Information Sharing

- **Potential populations.** States have broad flexibility to define a target population, including all D-SNP enrollees or a targeted subset, such as:
 - Home- and community-based services waiver participants
 - Medicaid health home program participants
 - Individuals with serious mental illness enrolled in a Medicaid behavioral health organization or targeted case management waiver
 - Another group defined through the state Medicaid agency's use of claims or encounter data to target high utilizers of acute care or other services
- In identifying a high-risk population states should consider whether care management infrastructure is available to respond to the notifications

Approaches to Information Sharing

- **Potential recipients.** Entities to be notified can be the state or the state's designee, such as:
 - Partner state agencies, including the state unit on aging or state agencies serving individuals with physical, intellectual, or development disabilities
 - Medicaid managed care plans (e.g., MLTSS plans, behavioral health organizations, or other Medicaid plans)
 - FFS HCBS provider and case management agencies (e.g., Aging and Disability Resource Centers, Centers for Independent Living)

Benefits of Information Sharing for Entities Involved in FFS LTSS Delivery

- Medicaid LTSS providers and/or care management agencies can be designated by a state to receive hospital and SNF admission notifications (i.e., Area Agencies on Aging, Aging and Disability Resource Centers, Centers for Independent Living)
 - Can be direct from D-SNPs, via pass-through information from state, or via a designated health information exchange platform
 - Notifications can be used to coordinate home and community-based service assessments, re-assessments, and transition case management prior to or upon discharge
 - States can also require that D-SNPs offer enhanced care management during transitions to align with state goals for Medicaid nursing facility diversion
 - Data on repeated hospital and SNF service use can be used to identify individuals for targeted case management or other long-term interventions

State Information Sharing Examples

Parameter	Tennessee	Pennsylvania	Oregon
Target Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs		
Entity Notified	TennCare MCO	Community Health Choices-MCO service coordination staff	Medicaid MCO or state care management (CM) staff and providers
Timeframe for Notification	Within 2 business day of the “anchor date” ¹	Within 48 hours of specified events	Timely
Notification Mechanism	Daily reports via state-developed portal	D-SNP to Medicaid MCOs/MLTSS plans	Event notification system (ENS) and web portal
Linkage to LTSS Goals or HCBS Waiver Operations	MCOs work with D-SNP to facilitate timely HCBS, and ensure services are provided in the preferred and least restrictive setting	Linked to MLTSS requirements for timely post-discharge re-assessment and care plan updates and NF transition efforts	State pays subscription for HCBS waiver care management agencies to receive alerts and populates web portal with HCBS contacts

¹ TennCare defines the anchor date as, “The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action.”

High Quality Care Transition Supports and Information Sharing

- High quality care transition support can lead to:
 - Discharge planning that takes all care settings and services into account;
 - Reduction in avoidable hospital and SNF admissions/readmissions;
 - Increase in appropriate follow-up care upon discharge;
 - Increased use of Medicaid HCBS (versus institutional care); and
 - Improved quality outcomes including satisfaction and quality of life.
- Community-based Care Transitions Program (CCTP)
 - CCTP extended sites operating for more than one year showed that **targeted transition services that include information sharing on admissions** could significantly lower hospital readmission rates and reduce Medicare Part A and Part B expenditures for high-risk Medicare beneficiaries.

Source: Ruiz, D., McNealy, K., Corey, K., et al. "Final Evaluation Report Evaluation of the Community-based Care Transitions Program." Econometrica and Mathematica Policy Research, November 2017. Available at: <https://downloads.cms.gov/files/cmmti/cctp-final-eval-rpt.pdf>

Timeline for Implementation of New Standards

- **July 1, 2020:** MA organizations submit signed state Medicaid agency D-SNP contracts to CMS
 - D-SNP contracts must either document Medicaid benefit integration that meets HIDE or FIDE bar, or a hospital and SNF admission notification process for a group of high-risk D-SNP enrollees that will be in place for CY 2021
- **January 1, 2021:** New integration standards must be in place

About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit <http://www.integratedcareresourcecenter.com> to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org

Additional Resources

Fully Integrated Dual Eligible SNPs (FIDE SNPs)

- Provide Medicare and Medicaid benefits under a single entity
- Provide coverage, consistent with state policy of Medicaid benefits, including long-term services and supports
 - Must cover at least 180 days of nursing facility services per plan year
- Promote alignment through:
 - Integrated Medicare and Medicaid care management model, and
 - D-SNP policies and procedures that coordinate or integrate enrollment, member materials, communications, grievance and appeals and quality improvement
- May be eligible for the frailty factor payment adjustment if their risk scores indicate a “similar average level of frailty” as the PACE program
 - For details see CMS April 2016 Call Letter, pp. 60, at this link:
<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>

Source: 42 CFR §422.2, as amended by the Final Rule entitled “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published at 84 FR 15827.

Highly Integrated Dual Eligible SNPs (HIDE SNPs)

- Provides coverage, consistent with state policy, of:
 - LTSS; **and/or**
 - Behavioral health services
- Provides LTSS and/or BH services under a capitated contract between the Medicaid agency and:
 - The MA organization; **or**
 - The MA organization's parent organization; **or**
 - Another entity owned and controlled by the MA organization's parent organization.

Source: 42 CFR §422.2, as amended by the Final Rule entitled "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021," published at 84 FR 15827.

FIDE SNP vs HIDE SNP Comparison

Feature	FIDE SNP	HIDE SNP
Must have a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Social Security Act.	Yes	No
May provide coverage of Medicaid services via a PIHP or a PAHP.	No	Yes
Must provide coverage of applicable Medicaid benefits through the same entity that contracts with CMS to operate as an MA plan.	Yes	No
Must have a capitated contract with the state Medicaid agency to provide coverage of long-term services and supports (LTSS), consistent with state policy	Yes	No
Must have a capitated contract with the state Medicaid agency to provide coverage of behavioral health services, consistent with state policy.	No	No
Must have a capitated contract with the state Medicaid agency to provide coverage of a minimum of 180 days of nursing facility services during the plan year.	Yes	No

Source: 42 CFR §422.2, as amended by the Final Rule entitled “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” published at 84 FR 15707 and 15827.

ICRC Resources

- For information about who qualifies as “dually eligible,” see “Dually Eligible Individuals – Categories” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>
- “Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment”, ICRC Tip Sheet (April 2018): <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-promoting-aligned-enrollment>
- “Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations”, ICRC Brief (August 2019): https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF.pdf
- “Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021”, ICRC Working with Medicare Webinar (July 2019): <https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021>
- “Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long Term Services and Supports into D-SNP Models of Care”, ICRC Tip Sheet (June 2019): <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-integrating-medicaid-managed-longVisit>

CHCS-NASUAD Partnership to Support States with Integrated Care

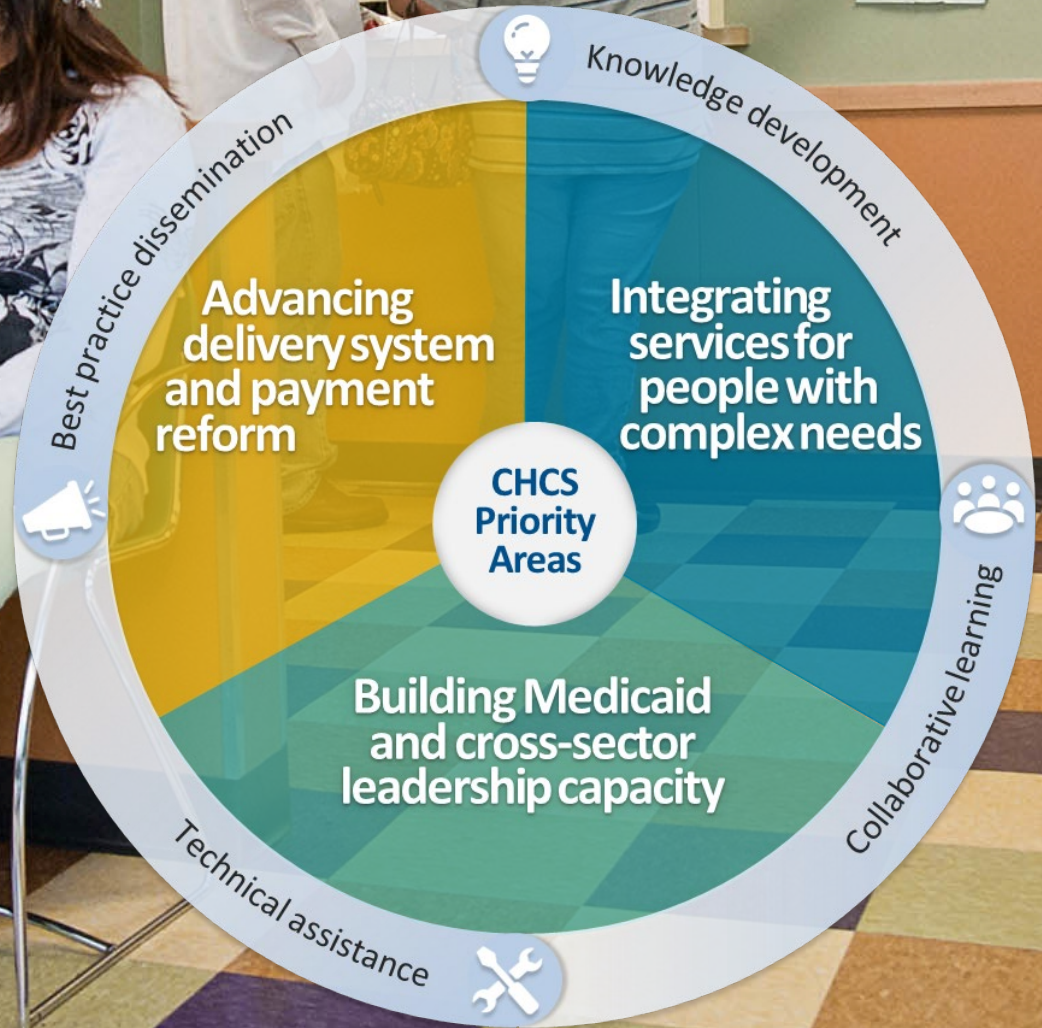
Michelle Herman Soper

Vice President, Integrated Care, Center for Health Care Strategies

August 26, 2019

About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans



Context and Current Action Brief Project

CHCS: Following many years of partnering with states and plans to advance integrated care, conducting targeted research to assess what comes next and what is needed to support new investments.

NASUAD: Embarking on Board-directed effort to support state pathways toward integration and adoption of policies and programs that improve care for dually eligible beneficiaries.

- ***Brief #1: The value of pursuing Medicare-Medicaid integration for Medicaid agencies.*** What is the return on investment from integrated care programs for State Medicaid Agencies?
- ***Brief #2: State considerations for embarking upon a Medicare-Medicaid integration initiative.*** How can states that have not yet determined how or if to proceed with an integration strategy move forward?
- ***Brief #3: Using data to manage dually eligible beneficiaries.*** What are the various data sources—including states' own data—that can be better utilized to understand and support the dually eligible population?

The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies

■ Methodology

- » Literature review (e.g., existing program evaluations and other related information, etc.)
- » Anecdotal insights from interviews with state leaders and stakeholders

■ Elements for Consideration

- » Beneficiary satisfaction and experience
- » LTSS utilization and rebalancing
- » Health indicators
- » Cost savings: actual and expected
- » Program administration

■ Next Steps and Request for Input

- » Email: msoper@chcs.org