

Mini-Symposium: Integrating Services for Dual Eligibles

Managed Long-Term Services and Supports Intensive
2020 HCBS Conference
December 3, 2020

The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies

Michelle Herman Soper, Vice President of
Integrated Care, CHCS

ADvancing States' Focus on Dual Eligibles

- Strategic direction from Board of Directors
 - First identified in 2019; continued in 2020
- Key priority area for the MLTSS Institute Advisory Council
 - Both MLTSS state leaders as well as health plan MLTSS executives agreed this was one of the most important issues facing LTSS programs

Approach

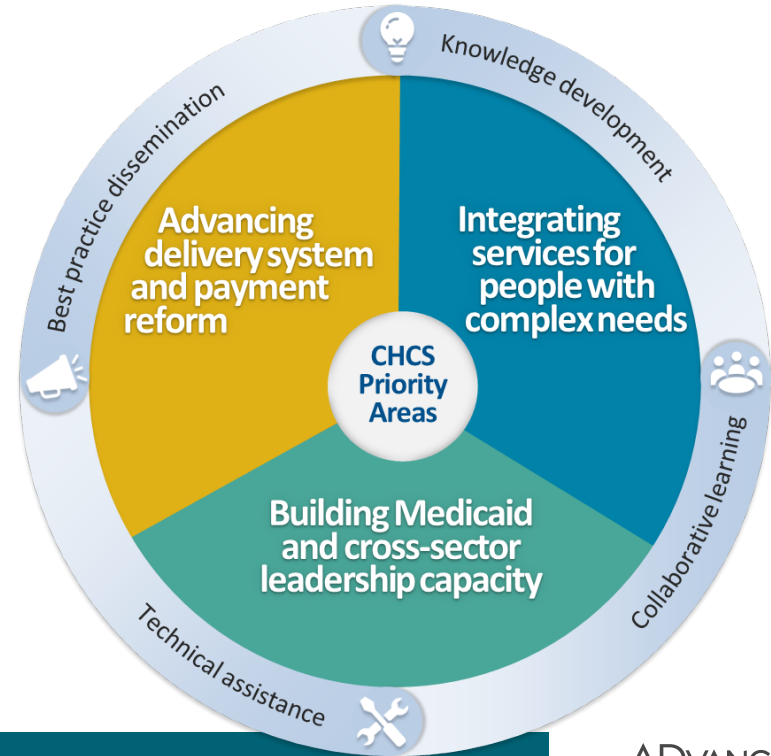
- Do not reinvent the wheel or duplicate existing materials
- Identify key barriers and address them
- Provide complementary assistance to ICRC's State Pathways to Integrated Care tool

Activities to Date

- Collaborate with CHCS on three issue briefs
- Topics identified and informed by focus group of adopter and non-adopter states as well as national health plans
- All issue briefs published and discussed today:
 - The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies, November 2019
 - Starting from Square One: Considerations for States Exploring Medicare-Medicaid Integration, May 2020
 - De-Mystifying Data: How Medicare Data Can Support Medicaid Agencies, October 2020

About the Center for Health Care Strategies

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



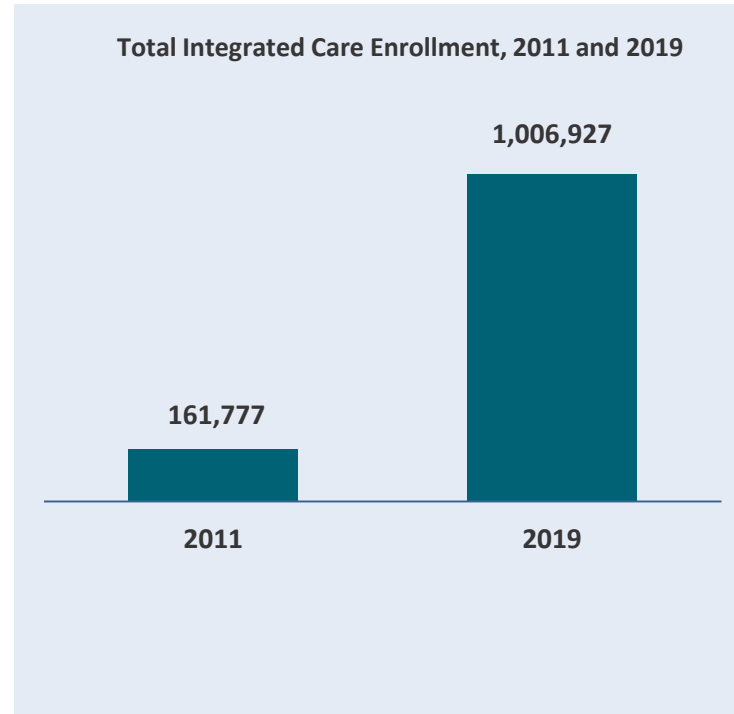
Why Integrate Care for Dually Eligible Beneficiaries?

- What are the current challenges?
 - Complex care needs
 - More than 90 percent receive fragmented care
 - High utilization; high costs
- What are ideal outcomes?
 - Streamlined, coordinated care with improved care experience
 - Higher utilization of preventive and community based care
 - Reduced costs

Integrated Care Landscape

Current Models

- Financial Alignment Initiative (FAI) Demonstrations
- Dual Eligible Special Needs Plans (D-SNPs)
- Programs of All-inclusive Care for the Elderly (PACE)



Early Promising Findings

- Improved beneficiary experience, health outcomes and quality of life
- Increased program efficiencies
- Improved Medicaid program administration and management

Improved Beneficiary Outcomes

- Beneficiary satisfaction is high; tends to steadily improve as programs mature
- High degree of satisfaction with care coordination
- Improved health outcomes are often achieved through better management of Medicare-covered primary or acute care services

Cost Savings

- Washington State's managed fee-for-service model has generated millions of dollars in Medicare savings
 - As of November 2018, WA received more than \$36 million in interim performance payments from CMS
- Mixed results from capitated FAI demonstrations
- Example from Massachusetts: Health plan savings over time

Improvements in Long-Term Services and Supports Utilization

- Integrated care programs promote rebalancing to community-based care
- Several states link integration implementation to rebalancing achievements
- Example from Ohio: Rebalancing savings generated through integration

Program Administration Impacts

- Integrated care infrastructure can support Medicaid program administration and management
 - Increased access and capacity to use Medicare data
 - Joint program oversight with CMS
 - Streamlining of beneficiary, provider and health plan experience

Conclusions

- Evidence is emerging despite some data limitations
 - It takes time for programs to generate positive results and for beneficiaries to reap the benefits
- Continued focus on data collection and analysis is critical to continue to make the case
- Consensus from states: *“These programs are worth it, and you get back what you put in.”*

Reactor: Katherine Rogers, Program
Manager, LTC Operations, District of
Columbia Department of Health Care Finance

Considerations for States Exploring Medicare-Medicaid Integration

Nancy Archibald, Senior Program Officer, CHCS

What Are Your Policy Goals?

Potential policy goals could include:

- Improving health outcomes for dually eligible populations
- Improving beneficiary experience of care
- Reducing the use of institutional long-term care setting
- Bending the cost curve for dually eligible individuals

What Are the Characteristics and Needs of the State's Dually Eligible Population?

- What does the state's dually eligible population look like?
- How are dually eligible individuals in the state currently covered under Medicare and Medicaid?
- Which Medicaid services are carved-in/carved out of Medicaid managed care contracts?
- Does the state allow D-SNPs to provide any Medicaid-covered services?

What is the State's Health Care Landscape?

- Does the state have Medicaid managed care?
- What is the state's Medicare Advantage penetration?
- What types of Medicare Advantage plans are available?
- Are Medicare accountable care organizations or other value-based initiatives operating in the state?
- How willing are providers/provider organizations to engage in an integrated care effort?

Do Stakeholders Support Integration?

- Is there significant internal support for new programs or efforts, particularly from Agency leadership?
- Are external stakeholders open to considering and collaborating on the design of an integrated care program?
- How will initial integration efforts be funded and then sustained?

What Is the Internal Capacity to Support Integration Efforts?

- Is the state Medicaid agency implementing other initiatives that are taking up bandwidth?
- Is there staff capacity to design and implement the integrated care effort? Or does the state have access to a contractor that can serve as a staff extender?
- Does the state have the needed data analytic capacity and information technology infrastructure?

What Is the State's Approach to Integration?

- What is the scale of the effort the state is willing/able to undertake?
- How would an incremental approach to integration impact beneficiaries and providers?
- Are there strengths of the existing system that should be maintained in a new program?
- Is it possible to use existing Medicaid platforms to support integration efforts?

What Your Answers Tell You

Larger-Scale Efforts

Health plans experienced in both Medicare and LTSS service delivery

Providers experienced with managed care

Clear executive/legislative direction to advance integration and/or strong stakeholder support

Internal staff capacity and resources to design, launch, and sustain a new program

Few health plans or providers with whom you can partner

Limited stakeholder support for large-scale change

Multiple other initiatives that are taking up bandwidth

Few internal staffing resources

Smaller-Scale Efforts

Examples of Smaller-Scale Efforts

- Supporting beneficiary enrollment in Medicare Savings Programs and Extra Help
- Promoting beneficiary enrollment into integrated care models that already exist in the state (e.g., PACE, aligned D-SNPs and Medicaid managed care plans)
- Facilitating development of new PACE organizations for older adults
- Adding requirements to existing D-SNP contracts that increase integration or alignment
- Providing training and resources to Medicaid waiver case managers in order to help them understand and coordinate with Medicare benefits
- Aligning D-SNPs with existing Medicaid managed care organizations to the extent that the state enrolls dually eligible beneficiaries in Medicaid managed care

Examples of Larger-Scale Efforts

- Developing Medicaid health home programs
- Creating MLTSS programs that are aligned with D-SNPs
- Directly capitating Medicaid benefits to create HIDE SNPs or FIDE SNPs
- Developing demonstrations under the Financial Alignment Initiative or new state-specific demonstration models

Reactor: Paul Saucier, Director, Office of
Aging and Disability Services, Maine
Department of Health and Human Services

Starting from Square One in Maine

Paul Saucier, Director

Office of Aging and Disability Services, DHHS

2020 HCBS Conference

MLTSS Intensive ~ 12/03/2020



Maine Landscape

2 Service Coordination Agencies for Waiver and State-funded HCBS

Health Homes/
Accountable
Communities

4 D-SNPs,
with 2
More
Coming in
2021, and
Growing
Enrollment

**No
Medicaid
Managed
Care**

35% Medicare
Advantage
Penetration

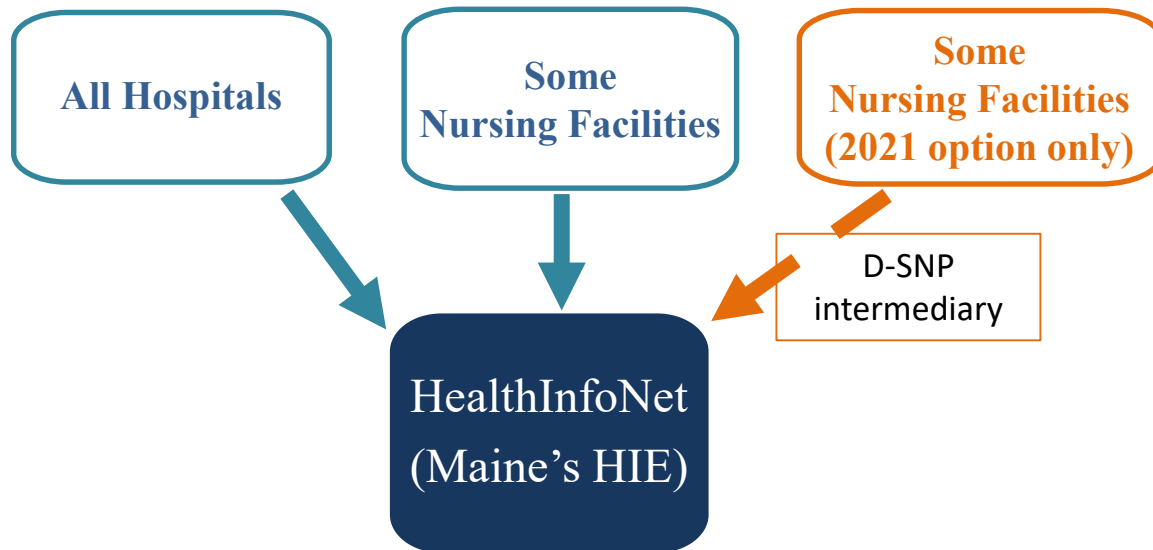
Half of Full Duals
Attributed to
Medicare ACOs

5 AAAs, with
Collaboration
Through a
Joint Venture

2019 Stakeholder Process

- Aging and LTSS Advisory Committee
- Managed Care Organization RFI
- Recommendations:
 - Continue looking at both MFFS and MLTSS approaches
 - Bring D-SNP Agreement into compliance with new federal integration requirements and increase level of engagement with D-SNPs
 - Maine chose to require notification of all hospital and nursing facility admissions, discharges and transfers via the State's single health information exchange, HealthInfoNet

Plan for 2021



Providers Accessing HIN:

- Primary Care
- Behavioral Health
- Hospitals
- Some Nursing Facilities
- **Service Coordination Agencies**

D-SNP Agreement Improvements

- Revamps reporting requirements:
 - Adds monthly submission of enrollment files
 - Adds submission of Health Risk Assessment results at population level
 - Removes lower value requirements
- Expands ability of DHHS to work with D-SNPs (e.g. Case Coordination Unit)
- Requires D-SNPs to enter into MOUs with Service Coordination Agencies to identify shared members and coordinate their services
- DHHS has held quarterly meetings on new requirements and plans to continue them going forward

Summary

- Maine's new D-SNP Agreement:
 - Provides more targeted reporting that will help the State understand the population enrolled
 - Creates an expectation of more active engagement to strengthen the relationship between the State and the D-SNPs
 - Requires relationships between D-SNPs and key LTSS entities
 - Expands provider participation in HIE, making it useful for coordination of health and LTSS

De-Mystifying Data: How Medicare Data Can Support Medicaid Agencies

Michelle Herman Soper, Vice President Integrated Care, CHCS

Why Is Medicare Data Important for States?

- Provides key demographic, clinical, service utilization and spending information about dually eligible individuals
- Completes the picture of an individual's needs
- Offers value to multiple state staff
 - State Medicaid Directors
 - Medicaid agency teams focused on Medicare-Medicaid integration and related programs
 - Partner agencies such as aging and disability units
- Supports program planning, care coordination and program integrity

Using Medicare Data To Support Program Planning: Examples

- Medicare service use and spending data for people with behavioral health conditions
 - Develop effective, targeted interventions using data on inpatient hospital stays, physician/therapist visits, and prescription drugs
- Diagnostic and assessment data for older adults or individuals with disabilities
 - Identifies most common behavioral health conditions across settings or prevalence of Alzheimer's disease among dually eligible beneficiaries
 - Assessment data from skilled nursing facilities and home health identifies cognitive and functional issues and those who can transition out of facilities

Using Medicare Data for Care Coordination: Examples

- Real-time event data from Dual Eligible Special Needs Plans (D-SNPs)
 - Data sharing on admissions, discharges and other key events with Medicaid MCOs and providers (hospitals, physicians, nursing facilities, home care agencies, etc.)
- COVID-19 related testing, preventive service utilization, admissions
- Monitoring of inappropriate trends in provider opioid prescribing and opportunities to collaborate with or issue corrective actions to high-risk providers

Using Medicare Data for Program Integrity: Examples

- Analysis of how key overlapping benefits such as home health, nursing facility services, and durable medical equipment work together to reduce administrative burden for states and plans
- Service use and spending to identify patterns of fraud or misuse such as aberrant utilization and/or billing patterns for overlapping benefits

Key State Resources for Medicare Data

- Some data is publicly available; other data must be requested
- The State Data Resource Center (SDRC) provides technical assistance to help states receive and learn how to use Medicare data
 - States must request and access some data via assistance from SDRC
- The Medicare-Medicaid Coordination Office (MMCO) compiles reports, data, and other resources to help states and researchers
- States can require D-SNPs to submit data to the state via contract requirements in State Medicaid Agency Contracts (SMACs)
 - States have discretion with data reporting requirements in SMACs, while use of Medicare data provided by CMS is more restricted to certain usages

Reactor: Patti Killingsworth, Assistant
Commissioner and Chief of Long-Term Services
and Supports, Tennessee Bureau of TennCare



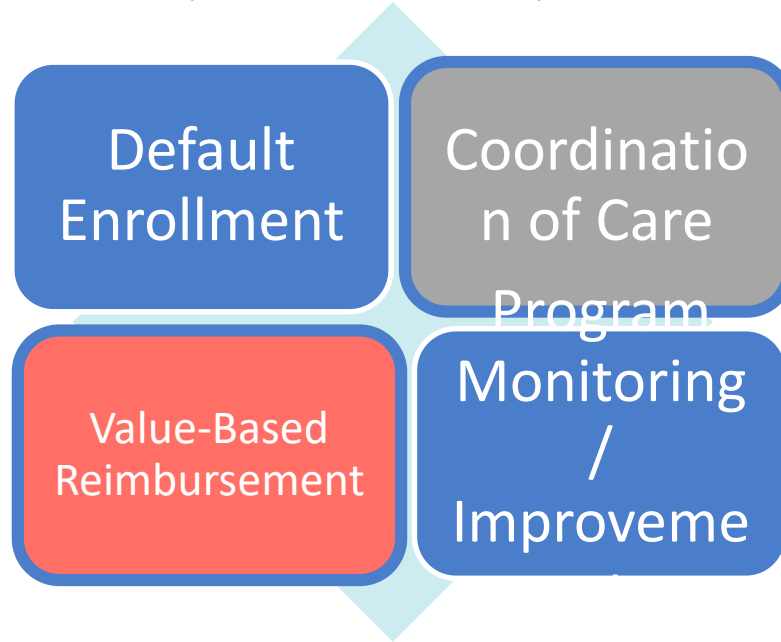
*Using Medicare Data to Advance
Value in Integration*

History of D-SNPs in Tennessee

- Began offering Dual Eligible Special Needs Plans (D-SNPs) in 2006
- *Medicare Improvements for Patients and Providers Act (MIPPA)* compliant contracts implemented in 2010
- Statewide Medicaid MCOs (including mandatory MLTSS) required to offer aligned D-SNPs beginning in 2015
 - No new MIPPA contracting for unaligned plans
- As of 2020, 3 aligned D-SNP contracts and 3 “legacy” unaligned D-SNP contracts
 - Two aligned contracts include a FIDE SNP with the 3rd effective 1/1/21
 - One of the contracts also includes a FIDE-“like” SNP for I/DD
- All 3 aligned D-SNPs approved for default enrollment beginning in 2015, 2016, 2017

Using Medicare Data

- Evolved over time to include (*but not limited to*):



Using Medicare Data for Default Enrollment

- TennCare leverages Medicare Part C authority and the D-SNP platform to align enrollment of full benefit dual eligible (FBDE) members in the same health plan for Medicare and Medicaid benefits
 - More than 50% of Tennessee’s FBDE members now in a D-SNP
 - 101% increase in FBDE enrollment in D-SNPs since Dec 2013
 - 97% increase in FBDE enrollment in aligned D-SNPs
- TennCare encourages/supports, but does not contractually require default enrollment
 - Reviewed plan’s applications prior to CMS submission
 - Upon approval and prior to implementation, conducted extensive readiness review process to ensure plans could satisfy required timelines for beneficiary notification, etc.

Using Medicare Data for Default Enrollment

- **TennCare uses Medicare enrollment data to support D-SNPs' default enrollment processes**
 - Obtain prospective Medicare enrollment dates for FBDEs from CMS
 - Provide prospective Medicare enrollment dates for FBDEs to Medicaid MCOs/D-SNPs
 - Send a letter to prospective duals advising of default enrollment, benefits of alignment, ability to opt out (prior to enrollment or at any time)
 - Send an education letter if default enrollment cannot be effectuated timely

Using Medicare Data for Default Enrollment

TennCare uses Medicare D-SNP provider enrollment data to support continuity of care upon default enrollment

- Requirement to develop a provider network that specifically targets substantial overlap of D-SNP providers with its TennCare MCO to ensure seamless access to care for FBDE members who are seamlessly enrolled in the D-SNP plan
- Ongoing monitoring of network provider files by TennCare
 - High degree of network overlap, especially among PCPs

Using Medicare Data for Default Enrollment *and* Care Coordination

- 30-day continuity of care period for all FBDEs seamlessly enrolled (regardless of providers' network participation), extended as necessary to allow time for completion of Health Risk Assessment, network contracting, or seamless transition to network providers
- Required reporting of continuity of care for PCPs and certain Specialists
- Ongoing monitoring by TennCare
 - 98%+ continuity of PCPs at expiration of COC period
 - Continuity of care for specialty providers also high (after targeted network enrollment, single case agreements, etc.)

Using Medicare Data for Care Coordination

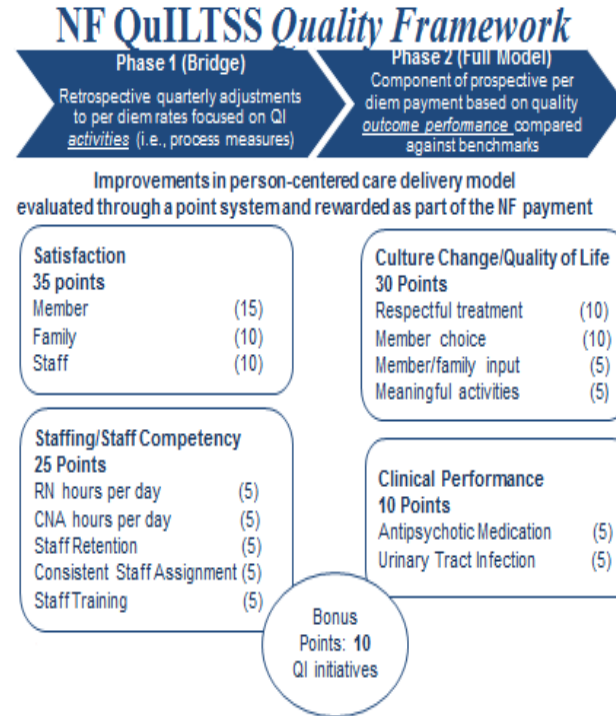
- For Unaligned Members – D-SNPs must submit daily Care Coordination Reports to Medicaid MCOs
 - Within 2 business days
 - All inpatient admissions (planned and unplanned, hospital or SNF), observation days, ED visits
- All D-SNPs (Medicaid/non-Medicaid contractors) required to submit full Medicare electronic crossover claims and encounter files
 - At least weekly or within 2 business days of completion of payment cycle
 - Must meet state and federal data quality standards

Using Medicare Data for Care Coordination

- TennCare provides secure Medicare encounter files to all Medicaid MCOs
- Medicaid MCOs contractually required to load all available Medicare claims data, including data from the MCO's D-SNP and Medicare claims data made available by TennCare into case management systems for purposes of care coordination

Using Medicare Data for Value-Based Payment

- Medicare/Medicaid Minimum Data Set used to establish acuity-related adjustments to direct care components of new acuity- and quality-adjusted payment methodology for nursing facilities
- Specified CMS-required *Nursing Home Compare (Care Compare)* staffing and clinical measures used as part of VBP approach, encompassing a quality-incentive pool and quality-informed rate components



Using Medicare Data for Monitoring *and* Improvement

- **Quarterly Reports**

- MIPPA Coordination Report

- Inpatient admissions, disposition of the admission, readmissions, discharge notifications, Psychiatric inpatient stays, and referrals—both received and sent to all D-SNP plans

- Medicare Provider Enrollment File

- Medicare Appeals

- Total # of appeals (medical and pharmacy), # fully or partially favorable, withdrawn, dismissed, and revised decisions for any reason

- Medicare Grievances

- Total # of grievances by program, timely notification, expedited review, timely decisions, dismissed grievances, and type of grievance (medical and pharmacy)

- Default Enrollment (aligned plans only)

- Individual identified by the plan through state file and identified as eligible by CMS, # noticed at least 60 days prior to enrollment, # enrolled outside of default process, opt outs prior and post enrollment, complaints, and continuity of providers at transition

Using Medicare Data for Improvement

- **Annual Monitoring Reports**

- HEDIS
- CAHPS
- Upon Request
 - Medicare Advantage Star Quality ratings, including poor performing icons, notices of non-compliance, audit findings, corrective action plans
- DNPs must conduct quality improvement activities as requested by TennCare based on performance or opportunities for improved quality and cost efficiency
- All reports subject to audit
- Readmission Audit twice per calendar year
 - Appropriate discharge planning, contacts, education, referral, follow up

Using Medicare Data for Improvement

- **Additional Requirements for FIDE SNP**

- Quality outcomes monitoring including:

- Reduction in avoidable inpatient (hospital/SNF) admissions/readmissions
 - Reduction in Emergency Department utilization
 - Reduction in inappropriate use of antipsychotic medications
 - Increased use of primary and preventive care
 - Increased use of Medicaid HCBS (versus institutional care)
 - Improved performance in specified HEDIS measures and in beneficiary satisfaction and quality of life
 - Additional baseline measures for I/DD FIDE-“Like” Plan, including competitive integrated employment, behavioral health utilization, psychiatric inpatient admissions/readmissions

Recommendations for Using Medicare Data

- Get started
- Set your policy goals
- Examine how Medicare data can help you achieve those goals
- Ask questions
- Be patient
- ***Be relentless...***keep going, one step at a time



Resources

MLTSS Institute Resources

- Soper, M., Kruse, A., and Dobson, C. “The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies.” MLTSS Institute, November 2019.
 - <http://www.advancingstates.org/hcbs/article/value-pursuing-medicare-medicaid-integration-medicaid-agencies>
- Archibald, N., Soper, M., and Dobson, C. “Starting from Square One: Considerations for States Exploring Medicare-Medicaid Integration.” MLTSS Institute, May 2020.
 - <https://www.chcs.org/resource/starting-from-square-one-considerations-for-states-exploring-medicare-medicaid-integration/>
- Ensslin, B. and Soper, M. “Demystifying Data: Medicare Data Can Support Medicaid Agencies.” MLTSS Institute, October 2020.
 - <https://www.chcs.org/resource/de-mystifying-data-how-medicare-data-can-support-medicaid-agencies/>

ICRC Resources

- Request ICRC State TA: ICRC@chcs.org
- ICRC. “State Pathways to Integrated Care.” May 2019.
 - <https://www.integratedcareresourcecenter.com/resource/state-pathways-integrated-care>
- ICRC. “Using Medicare Data to Support Integrated Care for Dually Eligible Beneficiaries.” May 2019.
 - <https://www.integratedcareresourcecenter.com/webinar/using-medicare-data-support-integrated-care-dually-eligible-beneficiaries>
- ICRC. “How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources.” November 2018.
 - <https://www.integratedcareresourcecenter.com/resource/how-states-can-better-understand-their-dually-eligible-beneficiaries-guide-using-cms-data-0>