Options and Recommendations for Serving Dual Eligibles through Prepaid Health Plans

Dual Eligibles Advisory Committee

December 20, 2016

The Charge

"The Division of Health Benefits, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017."

S.L. 2015-245, Section 5(11)

Discussion Topics

- Brief Background on Medicaid-Medicare Beneficiaries
- Introduction to Proposed Strategy for Dual Eligibles
- Understanding Options on the Medicare Side
- Lessons from Other States on Addressing Dual Eligibles
- NC's Options for Capitated Plan Contracting
- Additional Variables and Considerations
  - Timing and Sequencing
  - Enhancing Medicaid Benefits
  - Quality Measurement and Incentives
  - Supporting Beneficiaries & Providers in Transition

Brief Background on Medicaid-Medicare Beneficiaries

Data Snapshot of North Carolina Dual Eligibles

319,720 duals (Dec 2015), **of which 235,947 receive full Medicaid benefit**

According to CMS State Profile (2011 data)**:**

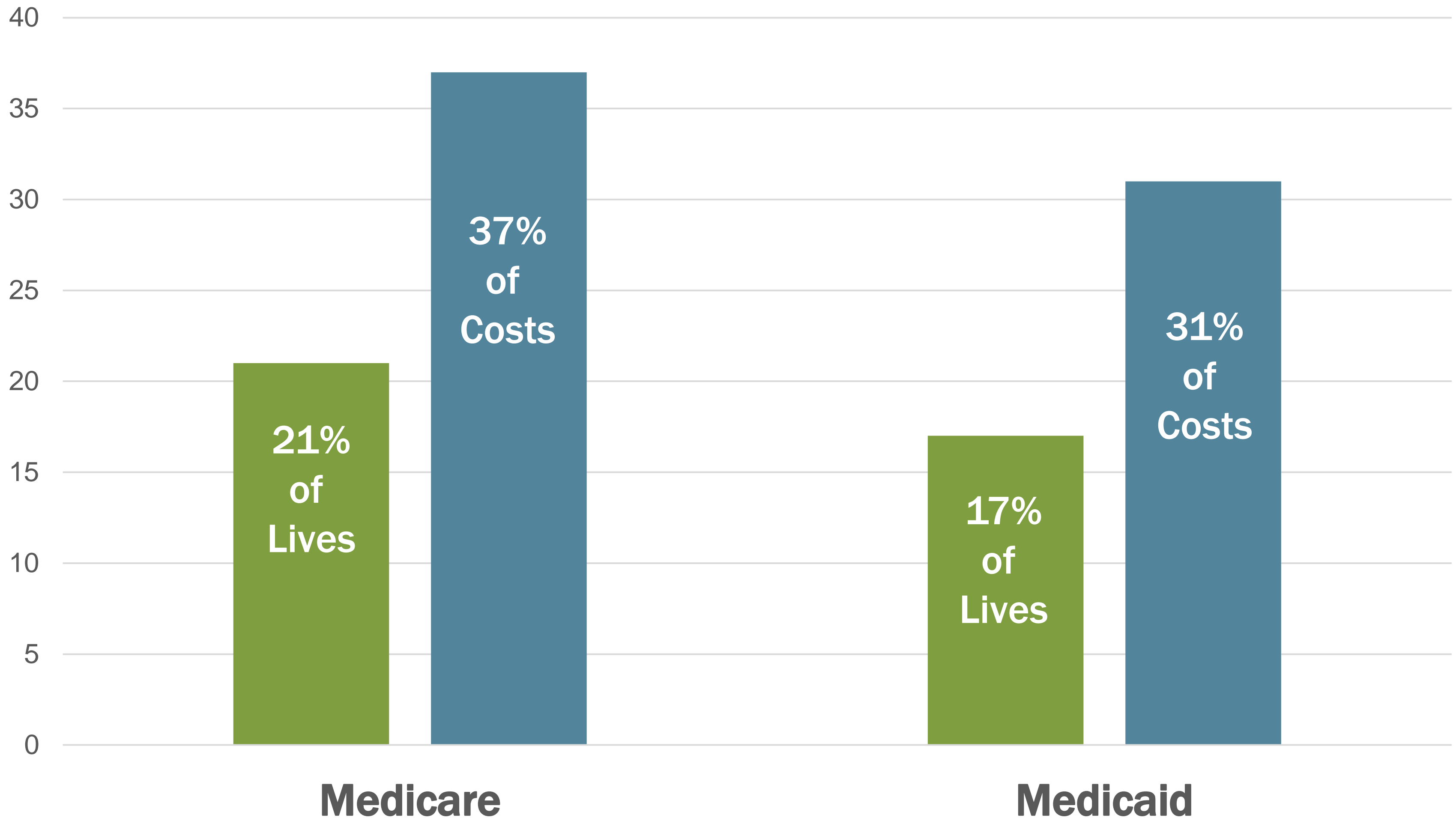
- **52% of NC full duals had 3+ chronic conditions**

  Most common:
  - Diabetes/ESRD/other endocrine
  - Heart disease/failure and other cardiovascular
  - Psychiatric/mental health

  Only 12% of full duals had no chronic conditions

- **82% of NC full duals used LTSS during a year**
  - 61% institutional
  - 14% State Plan HCBS
  - 7% Waiver HCBS

Dual Eligibles: Small Population, Big Spending



Connecting Medicaid and Medicare

Complementary coverage for full dual eligible beneficiaries

- Medicare primary payer
  - Doctors and hospitals
  - Post-hospitalization short-term skilled nursing
  - Home health care
  - Outpatient prescription drugs
- Medicaid
  - Long-term services and supports, in nursing facilities or home- and community-based services
  - Additional behavioral services and some prescription drugs
  - Medicare premiums and cost sharing

Many Misalignments Between Programs

- Inconsistent authorization procedures and medical necessity rules for overlapping benefits
  - Behavioral health
  - Skilled nursing care
  - Skilled therapies
  - Home health
  - Durable medical equipment
- Different rules/processes to appeal adverse coverage determination
  - Coverage pending appeal
  - Agency responsible
  - Timeline
- Conflicting financial incentives
  - Payment rates for many providers higher in Medicare than in Medicaid
- States allowed to mandate enrollment in capitated plans for Medicaid, but not such mandate is applicable to Medicare benefits

DEAC Recommendations as of November 2016

Main guidance

- Implement capitated plan enrollment for dual eligibles after managed care functions smoothly for the Medicaid-only population
- Integrate dual eligibles into managed care in well planned phases
- Exclude partial dual eligibles (those not receiving full Medicaid benefits) from managed care initially

In addition …

- Ensure adequate funding to support programs and services for dual eligibles
- Examine the PACE model as a possible guide for designing a program for dual eligibles
- Ensure that all services dual eligibles require are addressed in the roll-out plan, along with supporting contracts and readiness reviews

Introduction to Proposed Strategy for Dual Eligibles

Focus Initiative on Full Dual Eligibles

- Partial dual eligibles receive Medicare financial support from Medicaid but no Medicaid services such as LTSS

NC Partial Dual Aid Categories	Medicaid Role
Comprehensive Medicare Aid (MQB-Q)	Pay Medicare premiums + cost sharing
Limited Medicare Aid (MQB-B)	Pay only Medicare Part B premium
Medicaid Working Disabled (MWD)	Pay only Medicare Part A premium
Limited Medicare-Aid Capped Enrollment (MQB-E)	Pay Part B premium but fully federally funded without state financial contribution

- Lacking involvement in a beneficiary's use of services, a Medicaid agency cannot directly influence enrollment of a partial dual eligible into a prepaid plan
- However, many full dual eligibles start as partial dual eligibles, so the State can act – separately from health plan contracting – to improve their conditions and to save the State money

Proposed Strategy for Full Duals – At a High Level

2 companion approaches to capitated plan contracting

- Voluntary enrollment of dual eligibles into capitated Medicaid plans that align with Medicare Advantage plans run by same sponsors
- Mandatory enrollment of dual eligibles into capitated Medicaid plans for Medicaid benefits only, linked with companion Medicare Advantage plans

Phased implementation

- First enrollments effective 2 years after enrollment of Medicaid-only beneficiaries into PHPs (presumed July 2019)
- Possible phasing of start dates by regions or by population cohorts
- Defer to LME-MCOs on behavioral health

Understanding Options on the Medicare Side

Medicare Advantage Plans

Medicare Advantage (MA) plans: private health plans contract with CMS

- All Medicare Part A and B benefits; most add Part D (prescription drugs)
- MA plan capitation from CMS gives plan opportunity to use savings
  - Plans bid against county-level benchmarks, get share of difference as rebate
- Enrollees pay low, possibly zero premiums
- Plans supplement benefits, reduce cost sharing, to attract enrollees
- All enrollment is voluntary – no state waivers available to mandate duals
- Non-dual eligibles, once enrolled, must remain in plan 12 months
- Dual eligibles free to disenroll or change MA plans monthly

32% of US Medicare beneficiaries – 31% in NC – are in MA plans
Smaller percentage of NC dual eligibles (~10-15%) in MA plans

Medicare Advantage Special Needs Plans (SNP)

3 types of Special Needs Plans under federal statute:

- Chronic Condition SNP (C-SNP) – for beneficiaries having severe/disabling chronic conditions
- Institutional SNP (I-SNP) – for beneficiaries in nursing facility, ICF/IDD, or inpatient psychiatric facility more than 90 days
- Dual Eligible SNP (D-SNP) – for dual eligible beneficiaries

In 2016, 27,896 NC Medicare beneficiaries are in SNPs
21,219 are in 7 D-SNPs

Medicare’s Requirements of SNPs

- Not optional whether to include Part D outpatient Rx benefit
- Tailor services for population pursuant to a “model of care” (MOC)
  - Provider network suitable to needs of target enrollees
  - Care coordination services
- Tailor plan benefit package (PBP) to special needs of target enrollees
  - Social services
  - Transportation
  - Wellness programs to prevent exacerbation of chronic conditions
- D-SNP must contract with state Medicaid agency setting out how D-SNP will coordinate with Medicaid coverage
  - State may also forbid a D-SNP from operating if it refuses to participate in a Medicaid managed care program for dual eligibles

PACE – Program of All-inclusive Care for Elderly

PACE delivers fully integrated Medicare and Medicaid benefits for persons 55+ who qualify for nursing facility placement

- Virtually all are full dual eligibles, though dual eligibility isn't a pre-condition

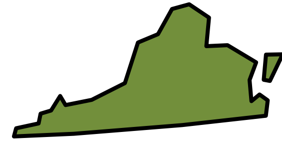
- Intended as community-based alternative to nursing home care
  - Approx. 7% of PACE enrollees do reside in a nursing facility
- Participants remain at home, receive intensive medical care and social supports from an interdisciplinary care team at PACE adult day center
- Beyond social day care, PACE centers must have capacity for
  - Primary care
  - Skilled therapies
  - Transportation
  - Pharmacy

PACE programs receive capitations from both Medicare and Medicaid

In 2015, US had 116 PACE programs in 32 states serving 36,000 people
NC has 11 PACE programs (12 sites) serving 1,900 participants

Lessons from Other States on Addressing Dual Eligibles

Virginia



Commonwealth Coordinated Care Plus

- Mandatory Medicaid managed care for adult Medicaid beneficiaries, including both LTSS users and those not in need of LTSS
  - Excluded groups: those in pre-existing Medicaid managed care plans; residents of ICF-ID facilities, psychiatric residential facilities, Alzheimer specialty assisted living facilities; persons in hospice, Money Follows the Person, or PACE; partial duals
- Medicare plan enrollment optional
  - Medicaid plans must secure Medicare D-SNP contracts
  - Contract contemplates possibility beneficiaries will enroll in D-SNP not sponsored by same organization – requires collaboration
    - Notify Medicaid plan about care transitions
    - Coordinate payment of cost sharing

Florida

Managed Medical Assistance & Managed Long-Term Care

- MMA for all Medicaid beneficiaries not requiring LTSS
- MLTC for elderly and disabled adults meeting nursing facility level of care

- Full duals must enroll in a state-contracted plan unless enrolled in a Medicare Advantage plan having companion contract with Medicaid
  - Partial dual eligibles excluded
- D-SNPs in FL must offer MMA benefit package, *may* offer MLTC
  - If D-SNP doesn't have companion MLTC contract, FL pays wrap-around capitation to plan for primary and acute care services covered by MMA
- Rules aim to promote care coordination across Medicaid, Medicare

Texas

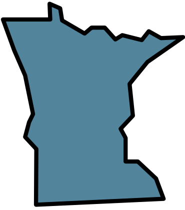
STAR+PLUS

For full duals, optional program layered onto mandatory MLTSS plan

- MLTSS plans in denser areas required to offer companion D-SNPs
- TX allows D-SNPs to operate without offering MLTSS plans
  - State pays these plans only for Medicare cost sharing
- MLTSS plans cover all Medicaid benefits except in some areas where a pre-existing managed behavioral care program operates
- State's contract with D-SNP requires "reasonable efforts" to coordinate with MLTSS

  Key for when beneficiary enrolls in two plans run by different sponsors
  - Identify LTSS providers
  - Coordinate delivery of Medicare and Medicaid covered services
  - Train D-SNP network providers on LTSS

Minnesota

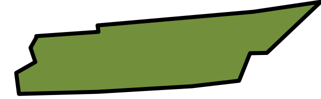


MN Senior Care Plus & MN Senior Health Options

- MSC+ - mandatory Medicaid MLTSS program
- MSHO - voluntary plan linking Medicaid and Medicare plans

- MSC+ covers Medicaid acute care and LTSS for dual eligibles and Medicaid-only beneficiaries
  - Medicare-covered services either fee-for-service or through MA plan
- Full duals 65+ may choose MSHO
  - Enrollment limited to beneficiaries who agree to one-plan arrangement
  - Plans must be Medicare D-SNPs
- All MSHO plans are Fully Integrated Dual Eligible SNPs (FIDE-SNP)
  - Deliver all Medicaid and Medicare benefits through one plan
  - State contract sets D-SNP Model of Care requirements
    - Unified care coordination
    - LTSS and acute/behavioral care integration

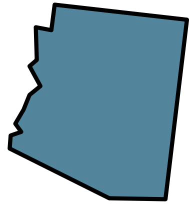
Tennessee



TennCare CHOICES

- Medicaid MLTSS plans required to offer companion Medicare D-SNPs
- 3 statewide plan contractors
- To ensure coordination, even if beneficiary enrolls in non-companion Medicaid and Medicare plans, TN requires D-SNPs to:
  - Notify Medicaid plan of inpatient admissions, coordinate discharge planning
  - Ensure LTSS are in most appropriate, cost-effective, integrated setting
  - Work with Medicaid plans on needs assessments and care plans
  - Train staff on coordinating benefits for dual eligibles
- Population stratified by level of care need
  - All ages, in nursing facilities
  - Adults 21+ qualified for NF LOC but living at home
  - Other not meeting NF LOC but need home care (capped at $15,000/yr.) to delay/prevent NF need

Arizona



Arizona Long-Term Care System

- MLTSS program for seniors and disabled (including I/DD) covering nursing facility and HCBS
- Contracted plans must have companion D-SNPs
- Enrollment in ALTCS plans is mandatory for Medicaid, enrollment in companion D-SNPs is encouraged for Medicare
  - More than 1/3 of full duals needing LTSS are in companion plans
  - Remainder in other Medicare Advantage plans or Medicare fee-for-service

Oldest Medicaid MLTSS program in US
Arizona never had a fee-for-service Medicaid program, launched Medicaid in 1982 using all capitated plans

NC's Options for Capitated Plan Contracting

Capitated Plan Program Design Options Arrayed

Mandatory Medicaid Capitation Plans for Dual Eligibles*

- All Medicaid Benefits Included
- Behavioral Care Benefits Carved Out to LME-MCOs
- All Full Dual Eligibles Enrolled
- Only LTSS Users Enrolled
- Prior Nursing Facility Residents Exempted

Voluntary Enrollment Program Linking Medicaid & Medicare

- Fully Integrated D-SNP
- Aligned D-SNP
- Non-Aligned D-SNP
- Other Medicare Advantage Plan
- PACE

* Choices shown not exhaustive; select other services and/or types of Medicaid beneficiaries could be taken out

Medicaid Plan Options

- Medicaid benefits included
  - All benefits
    - Best choice for integrated, whole-person care
    - Easier exchange of information related to substance use disorder treatment under 42 CFR Part 2
  - Behavioral health care remains with LME-MCOs
    - LME-MCOs already managing behavioral care
    - Statute guarantees LME-MCO role at least 4 years post-PHP start-up
- Populations included
  - All dual eligibles
  - All full dual eligible beneficiaries (partial duals excluded)
  - Limit enrollment to LTSS users, making plans pure MLTSS
    - Place some others into same PHPs as for Medicaid-only beneficiaries
    - Some may remain in fee-for-service
  - Exempt persons residing in nursing facilities at time of program start
    - Minimize disruption
    - Lose opportunity for fuller integration of care

Medicare Plan Options

- Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)
  - Characteristics
    - Single managed care organization
    - Required to perform coordinated Medicaid & Medicare assessments
    - Aligned care management and specialized networks
    - Unify enrollment, member communications, grievances, quality impr.
  - Advantages
    - Best administrative alignment and care integration
    - More flexible than regular D-SNPs
    - Incentives for plans: frailty adjuster in capitation rate for LTSS users
  - Disadvantages
    - Greater burden on plan operators
    - Limitations on which services can be carved out
    - State agency needs strong knowledge of Medicare Advantage operations

Medicare plan options continue on next page…

Medicare Plan Options

- Aligned D-SNP
  - Traditional D-SNP having agreement with Medicaid agency
  - Many of same provisions available as with FIDE-SNPs
  - Advantages
    - Fewer requirements integrating enrollment forms, payments, etc.
    - Wider latitude to carve out select services
  - Disadvantages
    - No frailty adjuster in Medicare capitation rate
- Non-Aligned D-SNP
  - Leverage existing D-SNPs but without requiring linked enrollments
  - Greater chance beneficiaries go into different sponsors' Medicare and Medicaid plans
- Other Medicare Advantage Plans
  - Limited contracts – or no contracts – with conventional MA plans
- PACE (Not mutually exclusive of other Medicare plan options)
  - Opportunity to consider expansion, but PACE not comprehensive solution

Additional Variables and Considerations

Timing and Sequencing

- Length of time from launch of PHPs for non-dual-eligibles
  - Tentative proposition: 2 years following first PHP effective date
    - ⇨ First date for duals program 7/1/2021, assuming PHPs begin 7/1/2019
- Phasing
  - Geographic options:
    - Statewide all at once
    - Staged by regions
  - Service options:
    - Comprehensive benefits all at once
    - Defer behavioral care to LME-MCOs
- Order of implementation
  - Options:
    - Voluntary linked program first
    - Mandatory Medicaid program first
    - Both at same time

Enhancing Medicaid Benefits

- Rationale for enhancing benefits
  - Attract enrollees to voluntary program
  - Increase cost-effectiveness of managed care
    - Emphasis on HCBS alternatives to institutional placement
- Types of benefits enhancements possible
  - Home modifications
  - Caregiver counseling and respite
  - Home meal delivery
  - Adult dental
  - Non-medical but medically necessary transportation
  - Skill building for institutional residents to enable transition to community
  - Various enhancements to services for persons with SMI and SUD
- Use of 1115 demonstration waiver authority
  - Potential modification to waiver currently awaiting CMS approval
  - Show budget neutrality: new costs offset by savings

Quality Measurement and Incentives

- Quality measurement
  - Medicare Advantage “Star ratings” – well-established regime
    - Beneficiary satisfaction
    - Processes of care
    - Health outcomes
  - Medicaid can add complementary measures
    - Focus measures on LTSS performance
- Incentives for quality
  - Medicare capitation to MA plans has built-in quality incentives
    - Payment to plans rises with higher Star ratings
  - Medicaid payment to plans can be made to vary
    - Ex: Hold back 2-3% of capitation to all plans, distribute in proportion to quality scores

Supporting Beneficiaries & Providers in Transition

- Beneficiary supports
  - Enhance current resources
    - State Health Insurance Assistance Program (SHIP)
      - Expand capacity
      - Make capable of counseling on duals program
    - Long-Term Care Ombudsman
      - Broaden and bolster ombudsman to go beyond long-term care: address concerns about managed care, HCBS, etc.
- Provider supports
  - Training and technical assistance to aid transition
    - Focus on LTSS providers unfamiliar with managed care