Agenda

I. Welcome and Introductions
II. Dual Eligibles – Who are they now?
III. Platforms for Service Delivery and Integration
IV. Overview of MLTSS Landscape
V. Movement to Integrated Care
VI. D-SNPs and State Contracting Options
VII. Questions and Answers
Welcome and Introductions

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

- **Priorities:** (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.

- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.

- **Funding:** philanthropy and the U.S. Department of Health and Human Services.
Working With States

Implementing New Systems of Integration for Dual Eligibles (INSIDE)

• Supported by The SCAN Foundation and The Commonwealth Fund

• Brings together 16 states implementing programs of integrated care for group learning and innovation sharing, as well as opportunities to work with federal partners

• Arizona, Arkansas, California, Colorado, Idaho, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, and Washington
Working With Community-Based Health Organizations

Promoting Integrated Care for Dual Eligibles (PRIDE)

• Supported by The Commonwealth Fund
• Brings together seven integrated health organizations to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees

• PRIDE consortium membership:
  - CareSource (OH)
  - Commonwealth Care Alliance (MA)
  - Health Plan of San Mateo (CA)
  - iCare (WI)
  - Together 4 Health (IL)
  - Ucare (MN)
  - VNSNY Choice (NY)
Integrated Care Resource Center (ICRC)

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

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

Dual Eligibles - Who are they Now? Trends

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

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

• In 2009, the federal and state governments spent more than $250 billion on dual eligibles’ health care benefits
  ▶ Dual eligibles are 13% of combined population of Medicare beneficiaries and aged, blind, or disabled Medicaid beneficiaries and account for 34% of combined Medicare and Medicaid total program spending

• The managed care enrollment rate for full benefit Medicare-Medicaid enrollees grew from 7.8% in 2006 to 15.2% in 2011

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

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

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

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<td>Medicaid FFS with enhanced care coordination</td>
<td>CO, NC</td>
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<td>Medicaid Managed Long-Term Services and Supports</td>
<td>AZ, CA, DE, NJ, FL, KS, MI, MN, NM, NY, TX</td>
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<td>CA, CO, IL, MA, MN, NY, OH, SC, VA, TX, WA</td>
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<td>Dual Eligible Special Needs Plan Platform</td>
<td>AZ, HI, NM, TN</td>
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<td>Fully Integrated Dual Eligible Special Needs Plans</td>
<td>MA, MN, WI</td>
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Key Component - Fundamental Elements of a Person-Centered Care Model

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

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

States with MLTSS Programs

- Arizona
- California
- Delaware
- Florida
- Hawaii
- Kansas
- Massachusetts
- Michigan
- Minnesota

- New Jersey
- New York
- New Mexico
- North Carolina
- Ohio
- Pennsylvania
- Tennessee
- Texas
- Washington
- Wisconsin
## Promoting Rebalancing and Choice of MLTSS

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

Source: Mildred Consulting -- Flexible Accounting for Long-Term Care Services: State Budgeting Practices that Increase Access to Home- and Community-Based Services -- Recommendations for California. 2012. [http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf](http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Mildred_Flexible_Accounting.pdf)
New Mexico Coordination of Long Term Services (CoLTS) - Controlling Cost Trends

- CoLTS authorized to operate as an MLTSS program under Section 1915(b)/1915(c) concurrent waivers

- CoLTS goals
  - Address acute physical health and long-term care needs in a coordinated, consumer-centered system
  - Focus service delivery on community-based services rather than institutional care
  - Realize cost-savings from community-based orientation

- CoLTS eligibility
  - Age 21 or older
  - NF level of care
  - Dually eligible for Medicare and Medicaid
New Mexico Coordination of Long Term Services (CoLTS) - Controlling Cost Trends

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

Source: HealthInsight New Mexico. *Independent Assessment of New Mexico’s Medicaid Managed Care Program-Coordination of Long-Term Services, Final Report*, June 28, 2013.
MLTSS Outcomes – Tennessee Experience with Money Follows the Person and MLTSS

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

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

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

Baseline 2010 program, years 2011 and 2012 results:

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

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

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

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

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

<table>
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<tr>
<th>Capitated</th>
<th>MFFS</th>
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<td>CA, IL, MA, MI, NY, OH, RI, SC, TX, VA, WA</td>
<td>CO, CT*, MO*, WA</td>
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- Joint procurement of high-performing health plans
- Three-way contract: CMS, state, health plan
- Single set of rules for marketing, appeals, etc.
- Blended payment, built-in savings
- Voluntary, passive enrollment with opt-out provisions

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

*As of June 2014 do not currently have signed Memorandums of Understanding with CMS
Emerging Best Practices - Communications and Engagement

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

- SNPs are Medicare Advantage (MA) plans authorized to target enrollment to three specific vulnerable populations:
  - Beneficiaries who are dually eligible (D-SNPs)
  - Beneficiaries who live in long-term care institutions (or would otherwise require an institutional level of care) (I-SNPs)
  - Beneficiaries who have certain chronic conditions (C-SNPs)

- SNPs focus on care management of their targeted population
  - Health risk assessments (HRA)
  - Model of care (MOC)

D-SNPs as a Platform for Integration

• Coordinating care is the main purpose of D-SNPs
  ▶ D-SNP models of care must outline how Medicare and Medicaid covered benefits will be coordinated
  ▶ Benefit integration under D-SNP contracts varies by state

• Some states were early leaders in contracting with D-SNPs to further integration (MA, MN, WI)
State Contracting with D-SNPs

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

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

A few examples include:

- Alignment of D-SNP contracts with Medicaid managed care contractors (AZ, MN)
- Coverage of Medicaid benefits to reduce fragmentation of care (long-term services and supports and/or behavioral health) (AZ, MA, NM)
- Alignment of D-SNP program with statewide delivery system reforms to improve overall performance and care outcomes (MN)
Where is D-SNP enrollment concentrated today?


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