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Medicaid and Medicare Managed LTSS

What States Are Doing

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Introduction and Overview

- Opportunities for states to link Medicaid long-term supports and services (LTSS) to Medicare acute care services for dual eligibles
- Brief overview of Dual Eligible Special Needs Plan (D-SNP) and Medicare-Medicaid Plan (MMP) enrollment
- Challenges and opportunities for health plans in coordinating Medicare and Medicaid LTSS for dual eligibles
  - Understanding Medicaid long-term supports and services (LTSS) in specific states
  - Understanding the tools available to manage those benefits in specific states
  - Assessing how the LTSS portions of capitated rates have been set
  - Assessing opportunities for savings and improved care when Medicare and Medicaid benefits are combined

Opportunities for States to Link Medicaid LTSS to Medicare Services for Dual Eligibles

- **More than half of all states now cover some or all Medicaid LTSS in capitated managed care arrangements**
  - **NASUAD, *State Medicaid Integration Tracker*, January 11, 2016**
    - http://www.nasuad.org/sites/nasuad/files/State%20Medcaid%20Integration%20Tracker%2C%20January%202016_0.pdf
- **States can link Medicaid LTSS to Medicare services for dual eligibles through:**
  - **MMPs in the CMS Financial Alignment Initiative capitated model**
  - **D-SNPs through contracts with the state that all D-SNPs are required to have**
- **For more information see:**
  - **MaryBeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared,* December 2015**
    - https://kaiserfamilyfoundation.files.wordpress.com/2015/12/8426-07-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-dec-2015.pdf
  - **Integrated Care Resource Center, *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options,* February 2015**
    - http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf

D-SNP and MMP Enrollment Growth

- **D-SNP growth***
  - **January 2015**
    - 1,645,848 enrollees in 336 plans in 38 states, DC, and PR
  - **January 2016**
    - 1,732,123 enrollees in 350 plans in 38 states, DC, and PR
      - Two-thirds of enrollment is in 11 states (FL, NY, CA, TX, PA, AZ, TN, AL, GA, MA, and MN)
- **MMP growth****
  - **January 2015**
    - 331,190 enrollees in 30 plans in 6 states (CA, IL, MA, NY, OH, and VA)
  - **January 2016**
    - 382,705 enrollees in 60 plans in 9 states (CA, IL, MA, MI, NY, OH, SC, TX, and VA)
      - SC, MI, and TX began enrollment in 2015
      - RI will begin enrollment in 2016
- **No additional dual demos planned, but D-SNP contracting remains an option for states and plans**
  - **Current statutory authorization for D-SNPs extends through December 31, 2018**

*From monthly CMS SNP Comprehensive Reports, available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

** ICRC analysis of CMS Monthly Enrollment by Contract reports, available at: http://www.integratedcareresourcecenter.com/

D-SNP Enrollment by State, January 2016

State	Number of D-SNP Plans	Total D-SNP Enrollment
Puerto Rico	14	273,084
Florida	58	228,580
New York	36	195,012
California	32	148,041
Texas	25	126,975
Pennsylvania	11	109,406
Arizona	21	79,642
Tennessee	7	78,851
Alabama	4	50,815
Georgia	9	49,873
Massachusetts	7	37,469
Minnesota	9	36,891
Louisiana	9	30,503
Washington	6	23,627
South Carolina	3	23,428
Oregon	7	22,409
Wisconsin	13	21,175
Hawaii	6	19,921
North Carolina	7	19,392
Ohio	11	15,545
Mississippi	4	14,320

Source: CMS SNP Comprehensive Report, January 2016.

D-SNP Enrollment by State, January 2016

State	Number of D-SNP Plans	Total D-SNP Enrollment
Arkansas	4	13,570
New Jersey	4	13,364
New Mexico	4	12,900
Connecticut	2	12,382
Michigan	4	11,608
Illinois	5	11,307
Missouri	3	10,586
Colorado	4	9,025
Utah	2	8,168
Kentucky	8	5,917
Washington DC	3	5,532
Maryland	3	2,884
Maine	2	2,443
Delaware	1	1,996
Idaho	1	1,936
Virginia	2	1,751
Indiana	3	1,476
West Virginia	1	251
Montana	1	36
TOTAL[1]	**356**	**1,732,088**

Source: CMS SNP Comprehensive Report, January 2016.

[1] Five Plans operated in two or more states. In this table, we divided the number of enrollees in those plans evenly across the states and added the plan to each state's total number of D-SNP Plans. The total excludes 35 enrollees in plans with fewer than 11 enrollees.

Fully Integrated Dual Eligible (FIDE) SNPs

- **FIDE SNPs are the most integrated Medicare-Medicaid plans outside of the CMS financial alignment demonstrations**
- **40 FIDE SNPs in nine states in January 2016 (AZ, CA, ID, IL, MA, MN, NJ, NY, and WI)**
  - **Total enrollment of 121,530**
  - **61 percent of total enrollment was in MN (37,469) and MA (36,891)**
- **FIDE SNPs must:**
  - **Have an aligned Medicare and Medicaid care management model**
  - **Offer a capitated benefit package that includes LTSS benefits (carve outs of benefits are allowed under some circumstances, but must be reviewed and approved by CMS)**
  - **Employ CMS and state approved policies and procedures to coordinate or integrate enrollment, member materials, communications, grievance and appeals and quality improvement**
  - **See Chapter 16-B in Medicare Managed Care Manual, Sec. 40.4.3 for more detail on these requirements** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf)
- **FIDE SNPs may be eligible for:**
  - **The PACE frailty factor payment adjustment to reflect the cost of treating high concentrations of frail individuals if their risk scores indicate a "similar average level of frailty" as the PACE program**
    - For details on the frailty factor, see CMS February 2015 Draft Call Letter, pp. 23-24, at this link: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf
  - **Additional benefit flexibility**
    - See Chapter 16-B, Medicare Managed Care Manual, Secs. 40.4.4 and 40.4.5, for details
    - Applies to FIDE SNPs and other highly integrated D-SNPs that meet criteria in Sec. 40.4.4

Medicare and Medicaid LTSS Benefits

- **Medicare covers only post-acute care**
  - **Skilled nursing facility (SNF) services for up to 100 days after a three-day hospital stay**
  - **Short-term medically necessary home health care**
  - **No long-term nursing facility (NF) services or home-and community-based services (HCBS) and related services**
- **Medicaid covers long-term NF, home health, HCBS, personal care assistance, and other LTSS**
  - **Service definitions, coverage limitations, payment rates and systems, providers, beneficiary advocates, political support, history, and context are different in every state**
  - **This underlying FFS complexity is the starting point for setting capitated rates**
  - **For details on Medicaid LTSS, see MACPAC, *Medicaid's Role in Providing Assistance with Long-Term Services and Supports,* Report to the Congress, Chapter 2, June 2014**
    - https://www.macpac.gov/publication/ch-2-medicaids-role-in-providing-assistance-with-long-term-services-and-supports/
  - **See also MACPAC, *State Medicaid Payment Policies for Nursing Facility Services* (October 2014)**
    - https://www.macpac.gov/publication/nursing-facilty-payment-policies/

Medicaid MLTSS Capitated Payments

- **A number of states have Medicaid capitated payment systems for LTSS that provide incentives to make greater use of community-based LTSS**
  - AZ, MA, MN, NY, TN
- **But few states have risk adjustment systems that fully account for variation in risk within nursing facility (NF) and community-based LTSS populations**
  - NY and WI Medicaid LTSS risk adjustment systems focus on community-based LTSS
  - States with case-mix/acuity-based FFS reimbursement systems for NFs have a form of risk adjustment that health plans can build on when making payments to NFs
  - The Center for Health Care Strategies (CHCS) and Mathematica are partnering in a project for the West Health Policy Center to help states improve Medicaid MLTSS risk adjustment
    - See next slide for details

Overview of West Health MLTSS Rate-Setting Initiative

- **Project goal**
  - Examine, refine, and/or develop states' rate setting methodologies for MLTSS or Medicare-Medicaid integrated care programs
- **Approach**
  - Convene and connect with state and federal government, industry, and research experts to examine current challenges in setting and risk adjusting rates for these programs
  - Work with eight project states to test new rate setting, risk adjustment, and data collection approaches with a particular focus on using functional assessment
  - Examine best practices and develop technical guidelines for states and other key stakeholders to improve rate-setting methodologies
- **Participants**
  - AZ, MA, MN, KS, TN, TX, VA, WI
- **Funder**
  - West Health Policy Center
- **Project Partners**
  - Center for Health Care Strategies, Mathematica Policy Research, and Airam Actuarial Consulting
- **Initial Publication**
  - Debra Lipson, et al. *Developing Capitation Rates for Medicaid Managed LTSS Programs: State Considerations,* January 2016
    - http://www.chcs.org/media/MLTSS-Rate-Setting_Final2.pdf

How Medicare and Medicaid Capitated Rates Are Set

- **Medicare**
  - **Financial Alignment Initiative Capitated Model**
    - Maria Dominiak. *Financial Alignment Demonstration Capitated Model Medicare Rate Methodology.* Integrated Care Resource Center Webinar, November 1, 2013.
      - http://www.chcs.org/media/ICRC_Medicare_Rate_Setting_for_Duals_Demo_11-01-13.pdf
  - **Medicare Advantage**
    - MedPAC. *Medicare Advantage program payment system.* Payment Basics, October 2014.
      - http://www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0
- **Medicaid**
  - **Managed LTSS**
    - Jenna Libersky and James Verdier. *Financial Considerations: Rate Setting for Medicaid Managed Long Term Services and Supports (MLTSS) in Integrated Care Programs.* Conference Presentation, February 25, 2014.
      - http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf
- **Combined**
  - CMS/MMCO. *Joint Rate-Setting Process for the Capitated Financial Alignment Model*. FAQs updated August 9, 2013.
    - https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

Major Rate-Setting Dials in Combined Medicare-Medicaid Programs

- Projecting baseline costs
- Savings percentages
- Risk adjustment and rating categories
- Risk mitigation
  - Medical loss ratio
  - Risk pools
  - Risk corridors
- Quality measures and withholds
- For details, see MACPAC, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.* September 2015, pp. 9-14.
  - https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/
- There are provisions for joint CMS-state rate review "at any point" in MOUs and three-way contracts in all financial alignment capitated model demonstrations
  - Specific rate provisions can be modified if experience warrants and it would meet goals of the demonstrations

Financial Pressure Points in Combined Medicare-Medicaid Programs

- **Savings targets and quality withholds in financial alignment demonstrations**
  - **Savings targets are typically 1% in year 1, 2-3% in year 2, and 3-5% in year three**
    - See Table 4 in September 2015 MACPAC report for state-by-state details
    - Initial targets have been adjusted downward in some states (MA, for example)
  - **Quality withholds are typically an additional 1-3% and are returned to plans each year if quality measures are met**
    - Withhold measures in first year are mostly process-based (health risk assessment completion, for example)
    - See p. 14 in September 2015 MACPAC report for details
- **Financing up-front investments**
  - **Medicare-Medicaid Plans (MMPs) and other integrated plans often have to make substantial up-front investments in staff, organization, and IT infrastructure to develop capacity to integrate/coordinate care for dually eligible beneficiaries**
    - Plans with limited Medicare or Medicaid experience have the greatest challenges
    - Learning curve can be steep
- **Addressing unmet enrollee needs**
  - Required up-front health risk assessments (HRAs) and initial clinical visits will likely identify needs that were unmet in the FFS system
  - Addressing these needs can reduce future ER and inpatient hospital use, but those savings will likely not offset upfront costs in the first year or two

Medicare Payments to Skilled Nursing Facilities

- **Medicare FFS payments to skilled nursing facilities (SNFs), especially for therapies, substantially exceed costs**
  - **FFS SNF overpayments are part of MA rate-setting base**
    - MedPAC reports that MA plans they reviewed paid 22% less than FFS for SNF services (March 2015 Report, pp. 198-200)
  - **For more details, see**
    - MedPAC March 2015 Report to Congress, Chapter 8
    - DHHS Inspector General, September 2015
      - http://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf
- **Potential source of savings if Medicare and Medicaid benefits are combined in capitated managed care plans like D-SNPs and MMPs**

State Options to Improve Alignment of Financing and Care Needs

- **Require MMPs and D-SNPs to share MA bid information with the state**
  - Can help state determine whether and where Medicare savings are achievable
  - Can help identify gaps in coverage that Medicaid can fill
- **If state has capacity to effectively analyze MA encounter data, require MMPs and D-SNPs to submit that data directly to the state**
  - Another way of identifying potential savings and gaps in care
- **Make sure that Medicaid LTSS capitation payments provide appropriate incentives for community-based LTSS and adjust appropriately for risk in NF and community LTSS settings**
- **Make sure that Medicaid coverage of behavioral health, LTSS, and other "wrap-around" Medicaid services meshes effectively with Medicare coverage to fill gaps in care for dually eligibles beneficiaries**

Health Plan Options to Improve Alignment

- **Take advantage of fungible Medicare and Medicaid funding**
  - Use savings from reduced Medicare hospital and ER use to provide incentives to improve primary and preventive care and care transitions
  - Reduce avoidable hospitalizations for NF residents by paying NFs more for higher-acuity care
    - See April 2015 ICRC TA brief on *Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options*
  - Reduce overpayments to Medicare SNFs to fund more community-based care
  - Treat overlapping benefits like home health and DME as a single unified benefit with a single payer, eliminating administratively burdensome attempts to shift costs that exist in FFS
    - See April 2014 ICRC TA brief on *Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative*
- **Manage services more effectively**
  - Limit Medicaid NF use only to those who cannot be served in the community
  - Review Part D Rx drug use in NFs and HCBS waivers to identify opportunities for more effective use
- **Make sure that health plan organization, management, staffing, training, care coordination, financial, and IT systems are set up to maximize opportunities to improve care and reduce costs**
  - Eliminate or reduce Medicare-Medicaid organizational silos
  - Increase communication and cross-fertilization

Conclusion

- Medicare and Medicaid were not designed to work together
- The FFS financing that provides the starting point for capitated payments to MMPs and D-SNPs reflects all the gaps, disconnects, and historical rigidities and anomalies built into the two systems
- Joining the Medicare and Medicaid funding streams in a single accountable entity provides an opportunity to rethink how care should be provided for Medicare-Medicaid enrollees
  - States, CMS, and health plans can work together to identify opportunities and clear away obstacles

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