

Serving Low-Income Seniors: Lessons and the Impact of COVID-19

Friday, November 6, 2020



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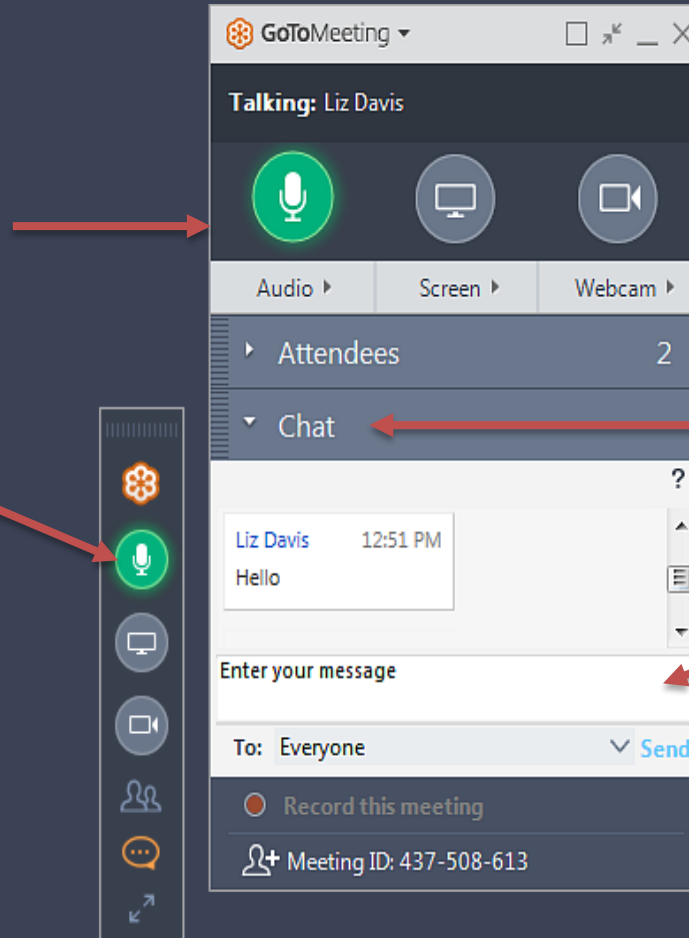
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Materials

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- Agenda
- Selected Resources List
- Selected Experts List
- Speaker Bios
- Presentation Slides
- Video (posted later)

Today's Panelists



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#AHPSummit20



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Medicare-Medicaid Integration Models for Low-Income Seniors

Current designs for dually eligible individuals

Prepared for the Alliance for Health Policy

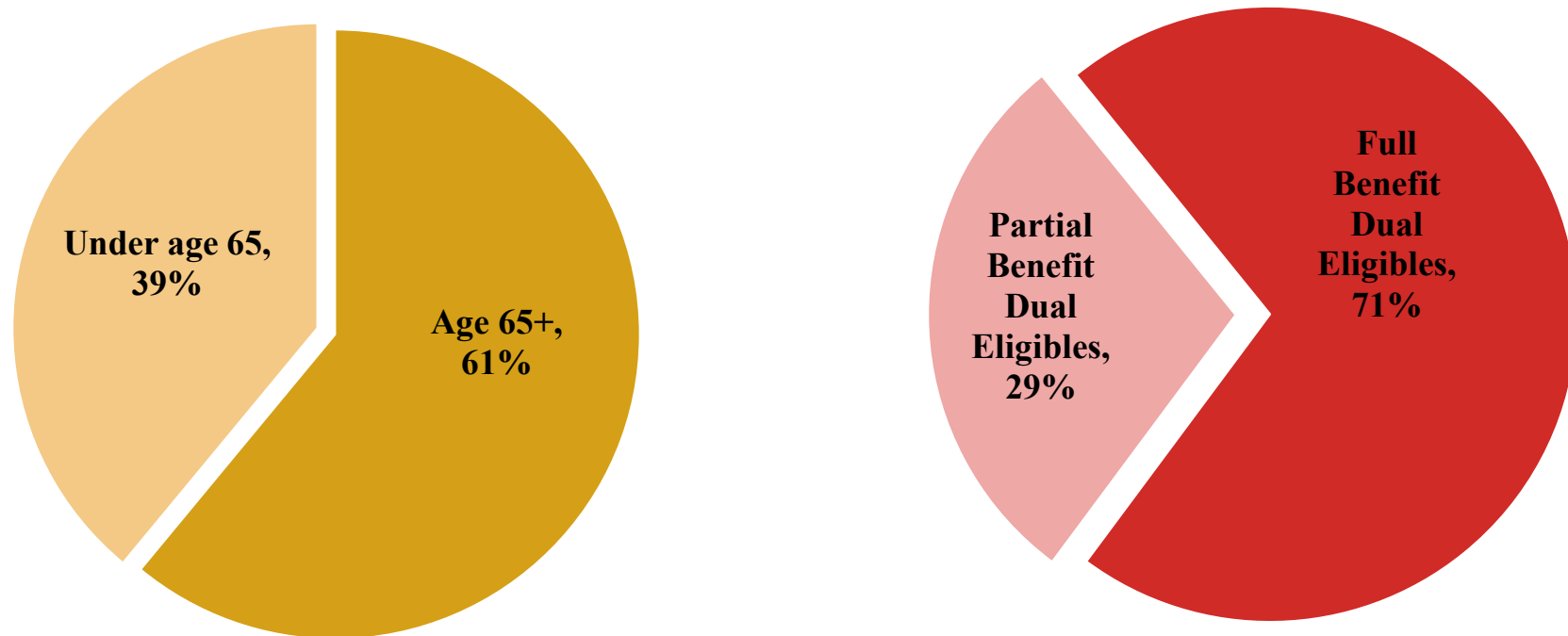
Serving Low-Income Seniors: Lessons and the Impact of COVID-19 Webinar

November 6, 2020

Elizabeth Wood, MPAP, Health Researcher, Mathematica

Dually Eligible Beneficiaries: Age and Eligibility Categories

/ Of the 12.2 million dually eligible beneficiaries in 2018...



Source: Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. “Twelve-Year Trends Report – Accompanying Data Tables (2006-2018)”. January 2020. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources>

Medicaid Coverage of Cost Sharing for Dually Eligible Individuals

Category of Dually Eligible Individuals	Full or Partial Benefit?	Medicaid Payment Responsibility				Percent of All Dually Eligible Individuals in Category (CY2018)	Percent of FBDEs in Category (CY2018)
		Part A premium (when applicable)	Part B premium	Parts A&B cost sharing	Full Medicaid coverage		
Qualified Medicare Beneficiary only (QMB only)	Partial	X	X	X		14.1%	N/A
Qualified Medicare Beneficiary Plus (QMB+)	Full	X	X	X	X	49.9%	70.1%
Specified Low-Income Medicare Beneficiary only (SLMB only)	Partial		X			9.3%	N/A
Specified Low-Income Medicare Beneficiary Plus (SLMB+)	Full		X	Depends on State Plan*	X	2.7%	3.8%
Qualifying Individual (QI)	Partial		X			<0.1%**	N/A
Qualifying Disabled and Working Individual (QDWI)	Partial	X				5.4%	N/A
Full Medicaid Only ("Other FBDEs")	Full		Depends on State Plan*	Depends on State Plan*	X	18.5%	26.1%

*States can opt to cover Medicare Parts A&B cost sharing in their state plan for SLMB+ and/or Other FBDE categories. As of October 2020, at least 25 states and the District of Columbia extend their coverage of Medicare Parts A&B cost sharing to SLMB+ and Other FBDEs. If states do not exercise this option, SLMB+ and Other FBDE individuals will have Medicaid coverage as secondary to Medicare for services (and providers) covered by Medicaid, but will not have coverage for cost sharing if a service (or the provider) is not covered by Medicaid.

**In CY2018, 519 individuals were enrolled in the QDWI program nationwide, which constituted 0.004% of the 12.2 million individuals who were dually eligible during that year.

Data Sources:

CMS Dually Eligible Individuals – Categories, Table 1. 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>

Centers for Medicare & Medicaid Services. Medicare-Medicaid Coordination Office. "Twelve-Year Ever-enrolled Trends Report – Accompanying Data Tables (2006-2018)". January 2020. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>

ICRC analysis of state plans. Six states were not included in this analysis because their state plans were not readily available or the state(s) did not make a selection in section 3.2(b)(1)(ii) of their state plan.

Source: Integrated Care Resource Center (ICRC) Medicare 101-102 Webinar: Key Issues for States, February 2020. Available at: <https://www.integratedcareresourcecenter.com/webinar/medicare-101-and-201-key-issues-states-0>

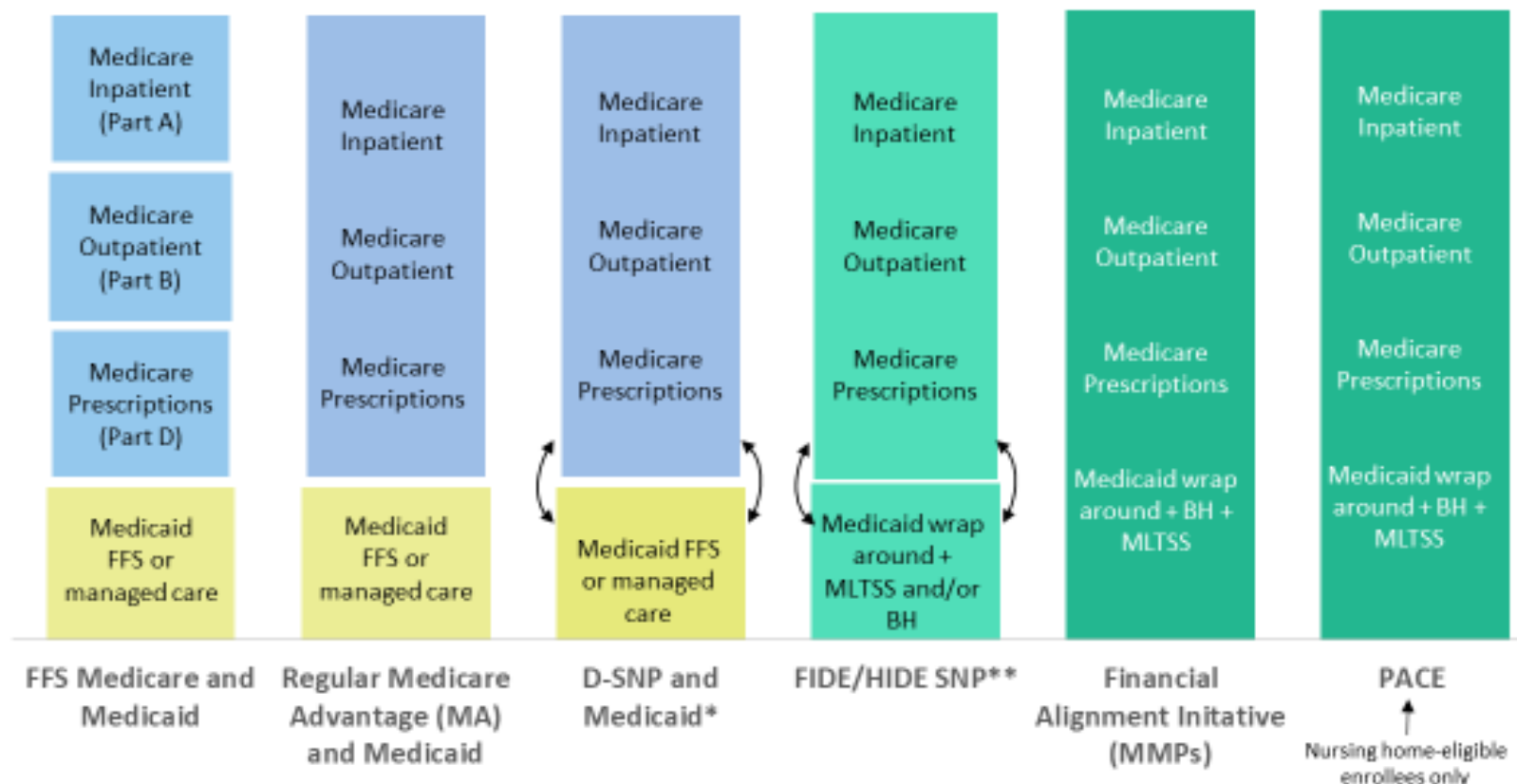
Capitated Managed Care

/ Program Overviews

- **Program of All-Inclusive Care for the Elderly (PACE):** Organizations that provide **integrated Medicare- and Medicaid-covered services**, including primary, acute, specialty, and long-term services and supports for those **55 and older who are nursing-home eligible**. PACE organizations receive capitated rates to provide comprehensive and coordinated Medicare and Medicaid benefits.
- **Capitated Model Demonstrations under the Financial Alignment Initiative (Medicare-Medicaid Plans):** Three-way contracts between the state, CMS, and health plans enable delivery of integrated primary, acute, behavioral health and long-term services and supports for dually eligible enrollees. Plans receive **capitated blend payments** to provide comprehensive, coordinated care.
- **Dual Eligible Special Needs Plans (D-SNPs):** Medicare Advantage plans for dually eligible beneficiaries that must at least coordinate Medicare and Medicaid benefits. **D-SNPs must hold a contract** (called a State Medicaid Agency Contract or “SMAC”) with the **state Medicaid agency, with at least certain minimum required elements**, which determine the level of administrative, clinical, and financial integration that may be achieved.
 - D-SNPs may be paired with affiliated Medicaid managed care plans, including **Managed Long Term Services and Supports (MLTSS)** plans.
- **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNPs):** Medicare Advantage plans that provide dually eligible beneficiaries access to Medicare and Medicaid benefits under a **single legal entity** that holds both a **D-SNP contract with CMS and a Medicaid managed care contract** with the state Medicaid agency to cover Medicaid long-term services and supports and other Medicaid services.

Source: Integrated Care Resource Center. *Medicare 101-102 Webinar: Key Issues for States*. February 2020. Available at: <https://www.integratedcareresourcecenter.com/webinar/medicare-101-and-201-key-issues-states-0>

Capitated Managed Care: Spectrum of Integration



ICRC Integrated Care Resource Center

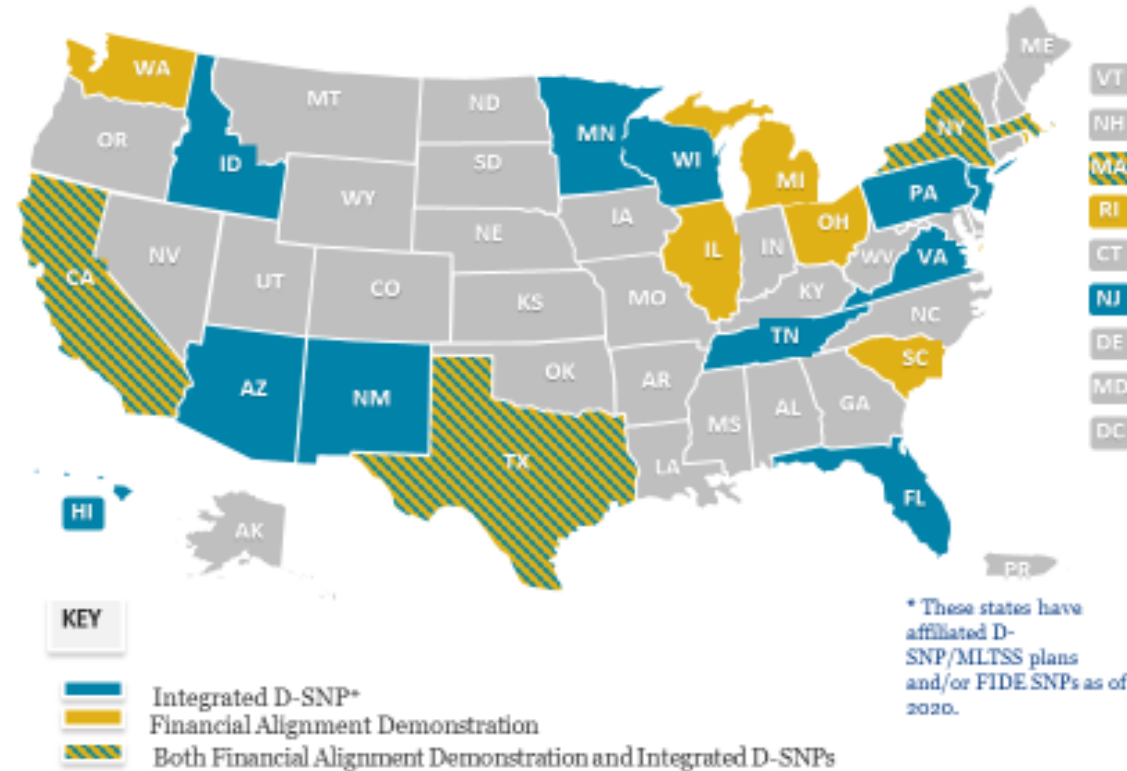
Integrated Care Paths: Managed Fee-for-Service (MFFS)

/ Program Overviews

- **Managed Fee-for-Service Model Demonstration under the Financial Alignment Initiative:** A state and federal option to enroll dually eligible beneficiaries into integrated Medicare and Medicaid programs that **cover primary, acute, behavioral health, and long-term services and supports services.**
- **Primary Care Case Management (PCCM):** A state plan option to enroll Medicaid beneficiaries who select or are assigned into the program by the state. The PCCM entity provides, **care management, administrative oversight, performance measurement, and reporting** as well as bringing the pieces of the fee-for-service system together to meet the complex needs of dually eligible beneficiaries.
- **Medicaid Health Homes:** A state plan option to enroll Medicaid beneficiaries with **chronic physical or behavioral health conditions** and cannot exclude dually eligible beneficiaries. The health home must provide: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care/follow-up; (5) individual and family support; and (6) referral to community and social support services.

Source: Integrated Care Resource Center. *Medicare 101-102 Webinar: Key Issues for States*. February 2020. Available at: <https://www.integratedcareresourcecenter.com/webinar/medicare-101-and-201-key-issues-states-0>

Capitated Managed Care: What States Are Doing in 2020



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ICRC Integrated Care Resource Center

Medicare-Medicaid Integrated Care Model Evaluations

/ 2020 overview of MMP, D-SNP, and PACE evaluations prepared by MACPAC

- **Beneficiary experience** is an important driver of enrollment retention in integrated models. Beneficiary experience is mixed across states and administrative processes.
- **Clinical outcomes.** When compared to Medicare FFS:
 - Hospitalizations decreased for all models but changes in emergency department use were mixed.
 - Admission to nursing facilities for long-term care, nursing facility re-admission, and mortality decreased for enrollees in California and Massachusetts D-SNP evaluations.
 - Care coordination may support better outcomes, but results were mixed and appear to vary by beneficiary awareness of how to contact and use care coordinators.
- **Cost.** Evaluators found an association between integrated care and reduced Medicare spending when compared to Medicare FFS. Early results for D-SNP savings are mixed though there is some evidence for decreased Medicaid spending among enrollees using home and community-based services.
- **Administration.** Integrating administrative processes across Medicare and Medicaid remains a challenge for government agencies, health plans, and providers.

/ More research is needed to understand Medicaid spending, beneficiary experience, care coordination, and effective integrated program and benefit design and implementation within integrated care models for dually eligible individuals.

Sources: *Evaluations of Integrated Care Models for Dually Eligible Beneficiaries*. Medicaid and CHIP Payment and Access Commission. August 2020: Key Findings and Research Gaps. Available at: <https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/> and *Inventory of Evaluations of Integrated Care Programs for Dually Eligible Beneficiaries*. Medicaid and CHIP Payment and Access Commission. August 2020. Available at: <https://www.macpac.gov/publication/inventory-of-evaluations-of-integrated-care-programs-for-dually-eligible-beneficiaries/>

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Addressing Determinants of Health among Dual Eligibles Enrolled in Health Plans

**Alliance for Health Policy Briefing
November 6, 2020**

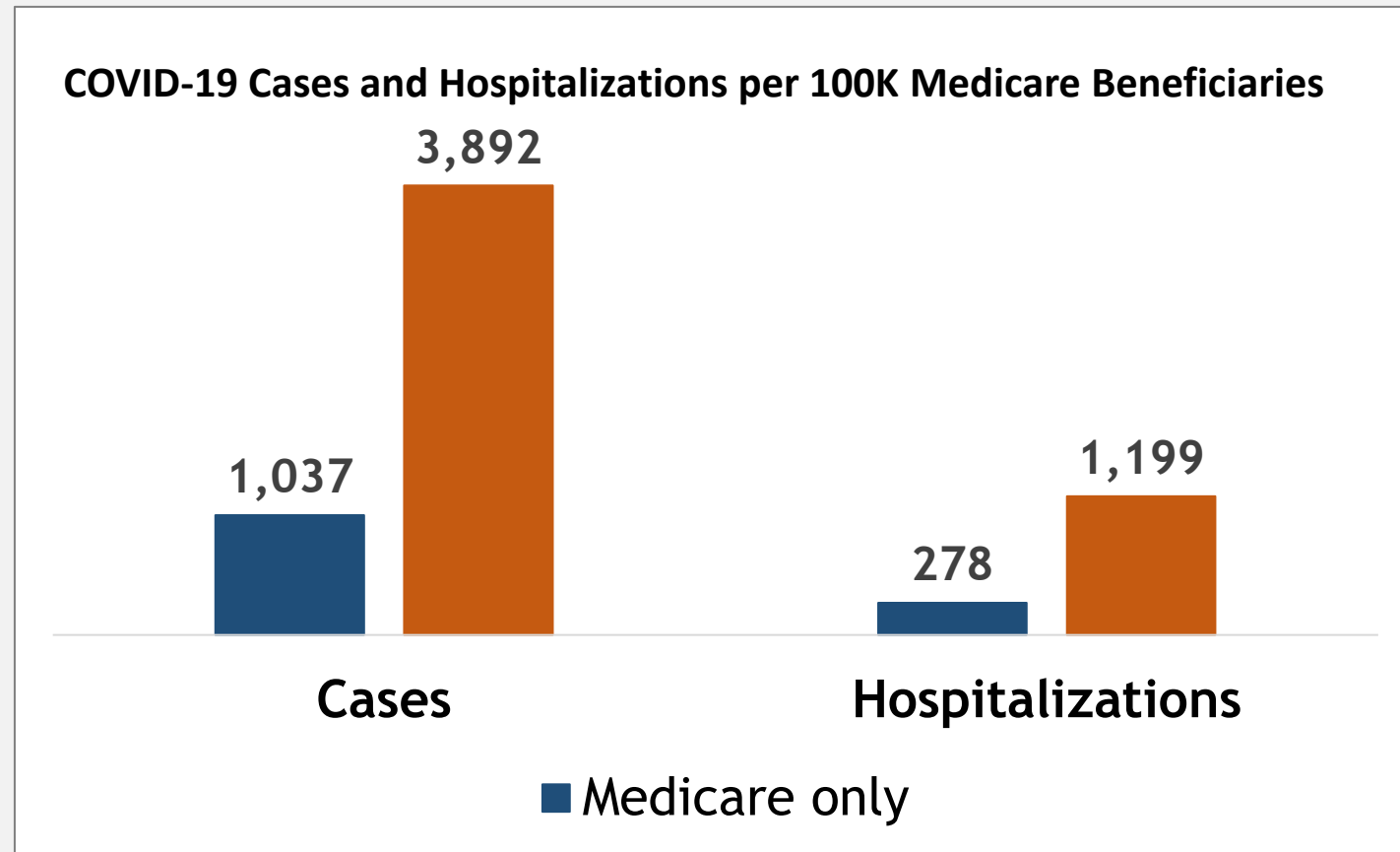
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AARP Public Policy Institute

The AARP Public Policy Institute (PPI) promotes the development of sound, creative policies to address our common need for economic security, health care, and quality of life.

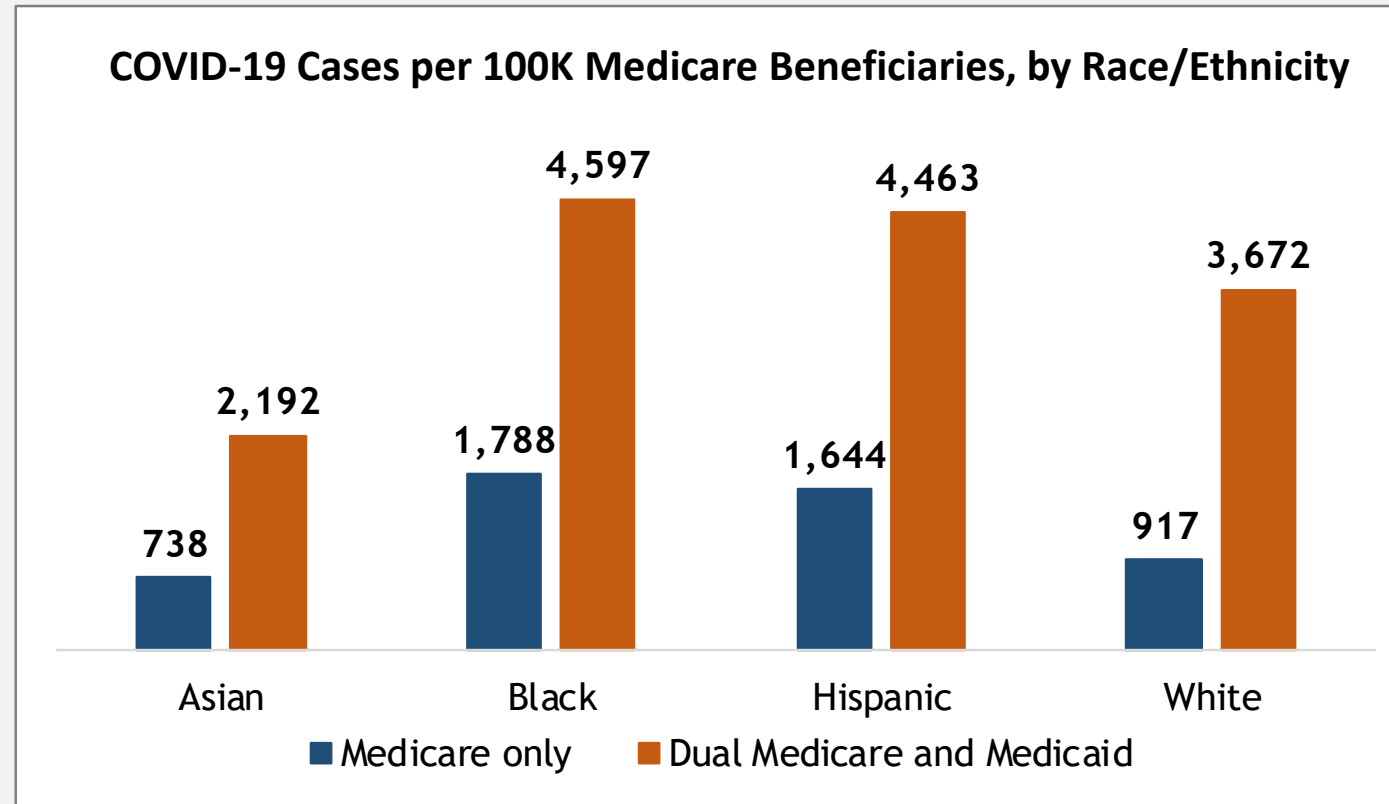
COVID-19: Disparate Outcomes for Dually Eligible Medicare Beneficiaries

The Coronavirus Has Disproportionately Affected Duals



Source: Based on *Preliminary Medicare COVID-19 Data Snapshot*, Centers for Medicare and Medicaid Services. Accessible at: <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>. Note: Data on COVID-19 cases and hospitalizations among Medicare beneficiaries covers the period from January 1 to August 15, 2020. It is based on Medicare Fee-for-Service claims and Medicare Advantage encounter data CMS received by September 11, 2020.

Black and Hispanic Duals Experience the Negative Impact of COVID-19 More Than Other Duals



Source: Based on *Preliminary Medicare COVID-19 Data Snapshot*, Centers for Medicare and Medicaid Services. Accessible at: <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>. Note: Data on COVID-19 cases and hospitalizations among Medicare beneficiaries covers the period from January 1 to August 15, 2020. It is based on Medicare Fee-for-Service claims and Medicare Advantage encounter data CMS received by September 11, 2020.

Several Factors Account for These Outcomes

- Duals have a disproportionately higher needs for social supports.
- Lack of certain basic needs—like access to nutritious foods—leave many duals with weakened immune systems, putting them at higher risk for COVID-related illness.
- Duals tend to have more underlying health conditions that also increase their risk for illness from COVID-19.

All Determinants of Health Outcomes Must be Addressed

Determinants of Health Outcomes

- Millions of dually eligible Medicare beneficiaries enrolled in managed care have significant clinical and social needs.
- Social, economic, environmental, and stress-related factors account for 80 percent of health outcomes.
- Clinical care is comprised of access and quality and accounts for 20 percent of health outcomes.

Variation in Plan Ability to Address SDOH Among Dual Enrollees

- Some plans are constrained by costs associated with addressing SDOH with limited rebate dollars and the unpredictable return on investment.
- These plans prefer to focus on providing services that attract new members, like dental and vision. In addition, some lack the robust community contacts required to adequately address social needs.

Sources: ACAP, Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development, October 2020; Elanie Sobero, et al., Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans (RAND Corporation, 2018).

Variation in Plan Ability to Address SDOH Among Dual Enrollees, cont'd.

- Other plans view addressing SDOH as a critical part of their social mission.
- They are high-performing plans that attend to the clinical and non-clinical needs of their dually eligible enrollees.
- One key characteristic of these plans: they have established robust community partnerships to address housing, food, and non-medical transportation needs of duals. They also remained flexible in address needs.

Sources: ACP, Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans: Gap Analysis and Policy Development, October 2020; Elanie Sobero, et al., Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans (RAND Corporation, 2018).

Addressing Social Needs Among Dual Eligibles in Managed Care: Emerging Ideas

Two Medicare Models: The Emerging Importance of Community Partners

- The Community-Based Care Transition Program (completed 2017)
- Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) (in progress)

The Community-Based Care Transitions Program (CCTP)

- Tested models for improving care transitions from the hospital to other settings and reducing readmissions among FFS high-risk Medicare beneficiaries.
- While the majority of community-based organizations used Coleman's care transitions intervention(CTI®) as their formal model, they were flexible and adapted interventions to meet unique needs of individual clients.
- Community partners co-located staff to establish long-standing, stable relationships with their hospital partners.
- CBOs connected high-risk beneficiaries to needed social *and* clinical services.

The AHC Model Uses Bridge Organizations to Forge Collaboration between Clinicians and the Community

- Screens community-dwelling dual eligible to identify certain unmet health-related social needs (e.g., housing, food insecurity, utility needs, transportation, etc.)
- Increases awareness of community services among dual eligible
- Provides navigation services to help high-risk community-dwelling dual eligible access accessing community services
- Encourages alignment between clinical and community services to ensure that services are available and responsive to the needs of community-dwelling dual eligibles.

Common Characteristics of the Models that May be Useful for Addressing SDOH Moving Forward

- Community-centric
- Formation of strong, mutually beneficial relationships between institutions (hospitals, individual practices, MCOs) and CBOs
- Data driven but not data constrained
- Model driven but not model constrained
- Flexibility and ability to adapt to unforeseen needs
- Development of community workforce and strategic workforce placement

Using the Best of all Worlds to Address SDOH

- Health plans should play an important, but not singular, role in addressing the social needs of duals.
- It is important to look at other models and extract the best idea from each when seeking to address social needs of duals.
- Involving the communities in which duals live may help to create trust and buy-in to medical and non-medical interventions.
- Providers should be willing to forge strong partnerships with CBOs.
- More efforts need to be put into hearing directly from duals (e.g., focus groups, surveys, etc.); doing with them, not at them is important.

Improving the Other 20 Percent of Health Care: Access and Quality

In addition to ensuring clinical competency, health plans can make the 20 percent more robust by continually educating providers about the special needs of dual eligibles and promoting non-biased care delivery, equity, and trust building among network providers.

Examples of What Health Plans Can Do

- Trust building training
- Cultural competency/cultural humility training
- Training on providing language access
- Improving provider participation in interdisciplinary care planning
- Ensuring dual status does not affect access to providers

Summary

Concluding Thoughts

- It is critical to ensure that social needs of duals are assessed and addressed to promote improved health outcomes.
- It is also important to identify successful community-based strategies to meet the social needs of dual eligible in collaboration with plans, rather than making it the sole responsibility of plans.
- Finally, it is important for plans to look inward to ensure that providers are dealing with the critical issues that also influence care outcomes, like trust building, eliminating bias, and being willing to address the needs of individuals with low incomes.

Thank you!
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We value your input!

Please fill out the evaluation survey you will receive immediately after this presentation and by email this afternoon!



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