ATI ADVISORY

IDEAS TO ACTION IN HEALTHCARE & AGING

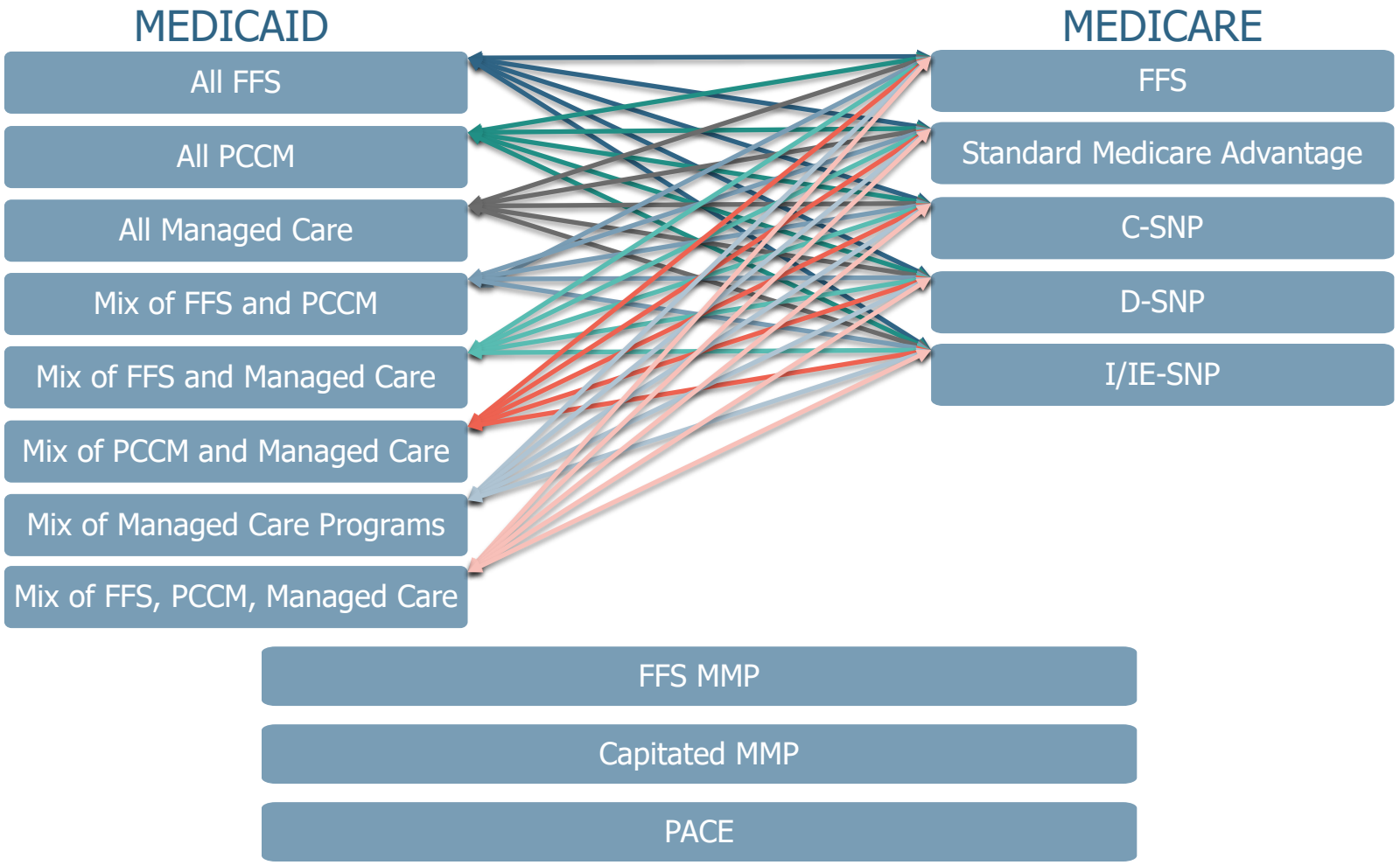
Key Programs Serving Dual Eligibles

Descriptions, Strengths, and Limitations

June 2020

Overview

At Least 43 Medicare-Medicaid Coverage Combinations Nationwide



Key Programs Are the Foundation of Medicare-Medicaid Integration Efforts

Medicaid Managed Care, Related Programs — *MCO, PIHP, PAHP, PCCM*

Contract between Medicaid agency and health plan/other organization to administer Medicaid benefits; may be comprehensive or limited to specific services

- **Managed Care Organization (MCO)**: Partially or fully comprehensive benefit package; payment is capitated
- **Prepaid Inpatient Health Plan (PIHP)**: Limited benefit package with inpatient or institutional services (e.g., behavioral health); payment may be risk or non-risk-based
- **Prepaid Ambulatory Health Plan (PAHP)**: Limited benefit package with*out* inpatient or institutional services (e.g., transportation); payment may be risk or non-risk-based
- **Primary Care Case Management (PCCM)**: Case management services (e.g., coordination) typically paid FFS

Dual Eligible Special Needs Plan — *D-SNP, HIDE SNP, FIDE SNP*

Medicare Advantage plan limited to duals and includes a contract between plan and the state (state Medicaid agency contract/MIPPA agreement); all D-SNPs must coordinate with Medicaid but not all D-SNPs bear risk for Medicaid

- **Highly-Integrated DSNP (HIDE SNP)**: D-SNP with Medicaid risk for behavioral health (BH) and/or long-term services and supports (LTSS), requires a Medicaid MCO, PIHP, or PAHP contract, or D-SNP capitation
- **Fully-Integrated D-SNP (FIDE SNP)**: D-SNP with Medicaid risk for LTSS (including ≥180 days nursing facility care) and potentially BH, requires managed LTSS MCO or D-SNP capitation; must integrate member materials

Medicare Medicaid Plan Program — *MMP*

Demonstration under the Financial Alignment Initiative (FAI) that uses a CMS-state partnership to test financial and administrative alignment models for full duals; may be capitated or managed FFS

Program of All-Inclusive Care for the Elderly — *PACE*

Provider-based program for individuals 55 years and older, residing in the community with a nursing facility level of care; includes a PACE Center and provides access to all necessary services based on individual needs

Program Nuances Are Important

Enrollment Alignment

A state may operate an aligned Medicaid/D-SNP program, but beneficiaries may or may not receive Medicaid and Medicare services with a single organization; an organization is able to provide aligned experiences for aligned members even when the plan enrolls unaligned members

Additional Demonstration Flexibilities

States can work with CMS to deploy Financial Alignment Initiative outside the MMP program, for example adding certain authorities onto a D-SNP contract

Variation in D-SNP Contract Terms

States have considerable latitude in how they shape D-SNP contracts, even within each category (standard D-SNP, HIDE SNP, FIDE SNP), such as Medicare data sharing, care model engagement, and product design

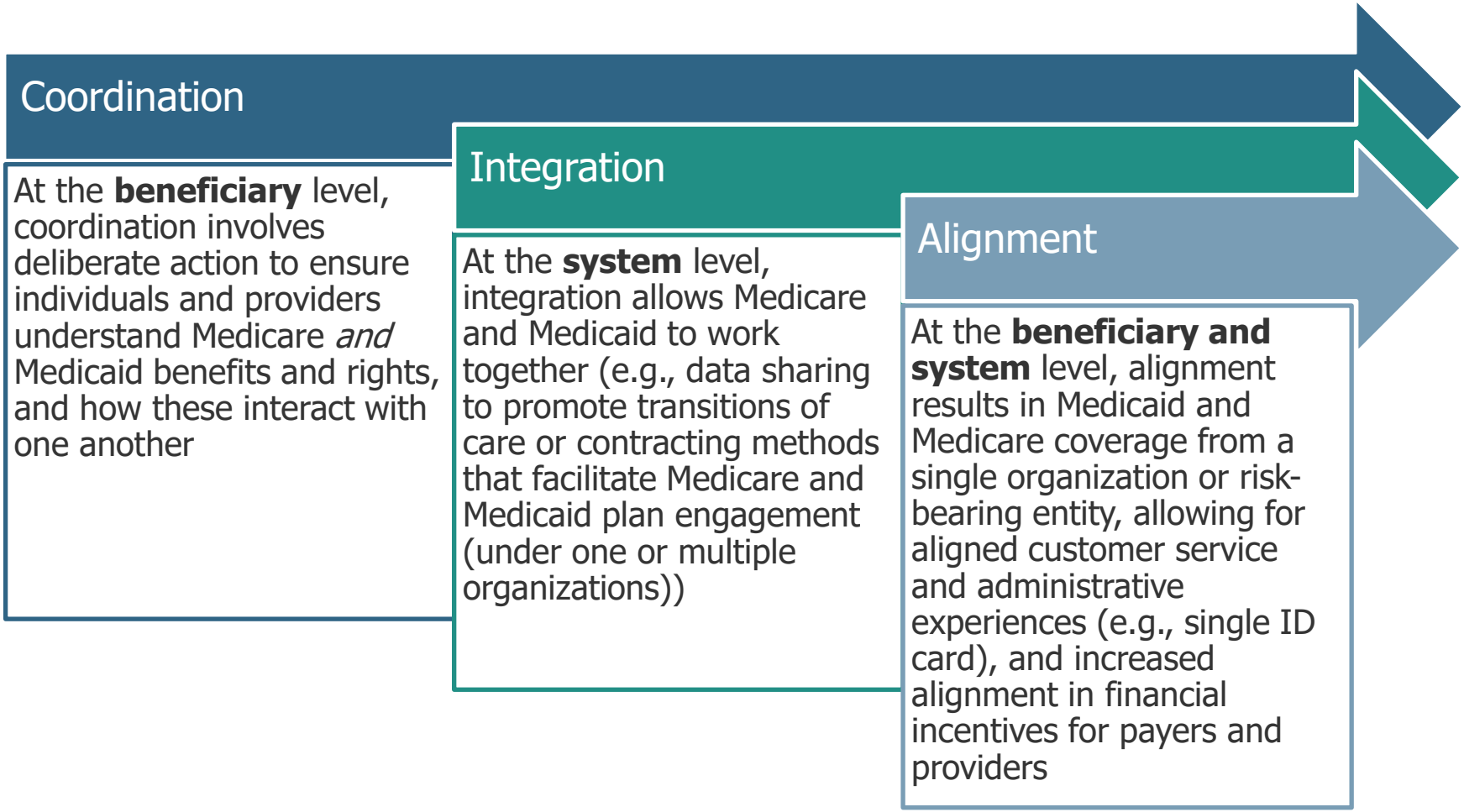
Medicaid Managed Care Carve-Outs

Medicaid programs vary considerably by state often with Medicaid benefits administered across multiple Medicaid programs; Medicaid program carve-outs complicate Medicare-Medicaid integration by increasing the entities serving a dual beneficiary and creating additional vulnerability for misaligned incentives

Targeted Population

The value of integration will vary based on an individual's unique circumstances, meaning something different to those who use both Medicare and Medicaid services (e.g., BH and/or LTSS) than those who rely primarily on Medicare services (physical health and acute care)

Approaches Occur at the Beneficiary and System Levels (and Terminology Matters)



Note: Definitions are specific to Medicare-Medicaid approaches. These terms, in particular coordination and integration, may have different meanings in other healthcare contexts.

Program Strengths and Limitations

Each Program Has Different Strengths

	Aligned member experience	Maximized enrollment	Integrated financing	Medicare savings for state	Ease of implementation
Standard D-SNP					
Capitated D-SNP					
Medicaid MCO aligned with D-SNP					
FFS MMP		N/A			
Capitated MMP					
PACE					

 Typically Not, None, Never

 Minimal, Limited, Difficult

 Some, Moderate

 Often, Very Much

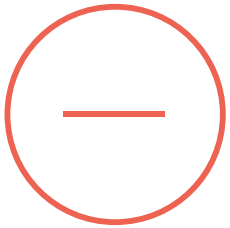
 Always, Nearly Complete, Easiest

Standard/Coordinated D-SNP

What it is:

A D-SNP without comprehensive Medicaid risk BH or LTSS that, at a minimum, must share information with a state or other entity to facilitate transitions of care when an enrollee is admitted to a hospital or skilled nursing facility

- Expands access to Medicare duals products that might not otherwise be available, allowing for a targeted care model and Medicaid coordination
- Data sharing requirements can facilitate transition from a Medicare stay into the community via Medicaid supports
- Creates a stairstep approach to more robust methods of integration and alignment
- Can enroll full and partial dual beneficiaries



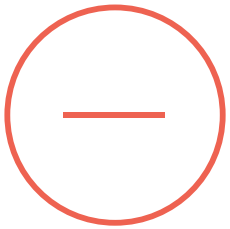
- D-SNP often has no line of sight into Medicaid experiences
- D-SNP may not have relationship with Medicaid providers
- Minimal alignment in financial incentives
- Minimal alignment in beneficiary experience

Capitated D-SNP (HIDE/FIDE SNP)

What it is:

Single D-SNP contract with a state and CMS into which the state capitates certain Medicaid services, mutually exclusive from a separate Medicaid managed care contract in the state

- Easier to implement than comprehensive Medicaid managed care and can transition into formal Medicaid managed care program
- Exclusively aligned enrollment if all Medicaid services capitated in D-SNP
- Aligned materials, customer service
- Eliminates reprocurement volatility
- Allows program focus exclusively on duals (versus broader programs that include non-dual Medicaid populations)



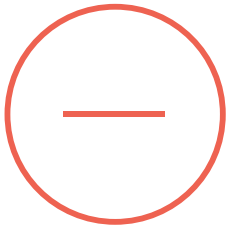
- States unable to mandate Medicaid enrollment
- State-specific legislative barriers may exist around capitating Medicaid services
- LTSS and BH providers may be unaccustomed to managed care initially

Medicaid Managed Care Contract Aligned with D-SNP (HIDE/FIDE SNP)

What it is:

Organization has Medicaid managed care contract with a state and a separate D-SNP contract with the state and CMS; covered Medicaid services vary based on what a state "carves-out" to FFS or a separate Medicaid managed care program

- States can mandate Medicaid enrollment if coupled with specific Medicaid authorities
- Contractor alignment provides opportunity for enrollment alignment in a single organization, particularly important for duals using Medicaid services
- Plans can offer aligned materials and customer service



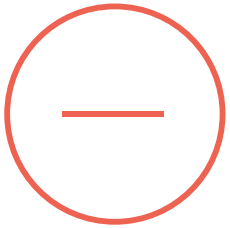
- Managed care programs take years to implement and can have considerable political and financial implications
- Reprocurement can cause significant disruption to dual beneficiaries
- Limiting D-SNP contracts and/or enrollment to Medicaid contractors can push duals to non-dual Medicare products (particularly "community-well" duals)

FFS MMP

What it is:

Managed FFS demonstration program under the Financial Alignment Initiative that includes an agreement between a state and CMS and allows the state to share in Medicare savings; currently a single state operates a FFS MMP program and uses a Medicaid Health Homes program as the infrastructure

- May be easier to implement than comprehensive managed care program
- Allows state to share in any Medicare savings with CMS
- Creates a seamless beneficiary experience at a program and clinical level



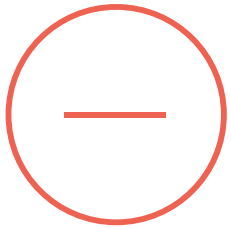
- Best if coupled with an existing Medicaid infrastructure that some states might not have (e.g., health home)
- State Medicare savings are retrospective, which does not align with annual budget balancing requirements
- Limited to full duals who are not enrolled in Medicare Advantage or PACE programs, and approach may not work with lower-complexity duals

Capitated MMP

What it is:

A Financial Alignment Initiative demonstration that includes a three-way contract between a state, CMS, and a health plan, that allows a state to share in Medicare savings with CMS and creates an aligned beneficiary experience

- Allows state to share in any Medicare savings with CMS
- Allows for aligned materials, customer service, and beneficiary experience
- Able to passively enroll into Medicaid and Medicare (with opt-out)
- Facilitates integrated/pooled financing



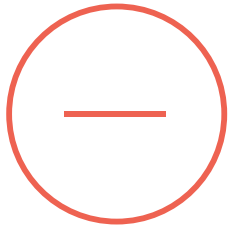
- Lower Medicare payment coupled with quality withholds increase program opt-outs and reduce plan/provider interest
- Plans may have less robust benefit packages than non-MMP plans
- Implementation costs are significant for states and plans
- Limited to full dual eligibles

PACE

What it is:

Capitated/risk-based Medicaid State Plan program that integrates preventative, acute care, and LTSS through a combined Medicare and Medicaid prospective payment (and premium payments for certain individuals), coupled with a PACE Adult Day Center

- Of all current models, offers the highest degree of financial integration
- Able to meet needs of individuals regardless of standard Medicare or Medicaid limits
- Combined funding and flexibility allows for coverage of certain social services



- Expensive to implement
- Limited to frail, older adults
- Requires a brick-and-mortar location
- Limited geographic availability

Questions?

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