Integrating Care for Dually Eligible Beneficiaries

Medicaid and CHIP Payment and Access Commission

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Overview

- Background on MACPAC
- Prior work related to dually eligible beneficiaries
- Focus for June 2020 report including recommendations and rationale

Background on MACPAC

MACPAC's structure

- Independent agency in legislative branch
- Nonpartisan (as opposed to bipartisan)
- Evidence-based
- Commissioners appointed by Comptroller General for three-year terms
- Began work in 2010

MACPAC's role

- Provide advice to Congress, the Secretary of Health and Human Services, and the states
- Examine federal and state policies related to Medicaid and CHIP
- Produce reports, comments on proposed rules and agency reports to Congress
- Coordinate with MedPAC and CMS duals office
- Cannot make recommendations affecting Title XVIII of the Social Security Act

Prior MACPAC Work

Examples of prior work

- Documenting state Medicaid policies for paying for Medicare cost sharing; assessing impact on access
- Producing descriptive work: MLTSS, functional assessment
- Producing databook with MedPAC
- Review of care coordination requirements in different integrated models
- Factors affecting enrollment in demonstrations
- Links to other areas: LTSS, behavioral health, setting capitation rates

Inventory of evaluations

- Preliminary findings on integrated care models are mixed
- Some positive findings related to reductions in:
  - Hospitalization and readmission
  - Nursing facility entries
  - Per-person Medicare spending

June 2020 Report to Congress

Commission process

- Report cycle begins in September
- Multiple panels featuring states, plans, providers, and beneficiary advocates
- Process involves:
  - defining policy questions
  - building evidence base
  - identifying and vetting policy options
  - making recommendations
- Iterative process that will carry into next report cycle

Starting point

- Less than 10 percent of dually eligible beneficiaries enrolled in integrated care
- Integrated care can lead to better care for individuals and more effective and efficient coordination between programs
- Identify barriers to increased enrollment, greater availability of products, and greater levels of integration

June report: Chapter 1

- Background and context
  - Who are dually eligible beneficiaries
  - How the programs work (or don’t work) together
  - Delivery systems
  - Continuum of integrated models
  - Evaluations of integrated models

June report: Chapter 2

- Key points
- Recommendations
- Signal areas for future work

Analytic themes

- Increasing enrollment in integrated products
- Making integrated products more widely available
- Promoting greater integration in existing products
- Future of integrated care

Key points

- States have leverage under current law to promote integration; should use existing authorities such as MIPPA to the greatest extent possible
- Some states may want to make greater use of these authorities, but may not have capacity to do so effectively
- States should be mindful about D-SNP look-alike plans; interaction with move to greater integration

Increasing enrollment in integrated products: policy options

- Default enrollment
- Understanding role of enrollment brokers
- Exception to the special enrollment period for Medicare-Medicaid Plans*

*=subject of recommendation

Making integrated products more widely available: policy options

- Improving state capacity on Medicare*
- Funding upfront costs of establishing integrated care models*
- Strengthening MMPs
- Addressing network adequacy standards

*=subject of recommendation

Promoting greater integration in existing products

- Congress has provided states with authorities that have produced a continuum of integrated care options
- State choices are guided by a variety of factors, including resource constraints
- As states gain experience with integrated care, their programs may evolve
- It is the Commission's view that federal policy should support state efforts to move along the integrated care continuum

Promoting greater integration in existing products: policy options

- Maximizing state use of D-SNP contracting authorities
- Increasing selective contracting with D-SNPs
- Diminishing the potential for D-SNP look-alike plans to affect integrated care programs
- Limiting D-SNP enrollment to full-benefit dually eligible beneficiaries

Future of integrated care

- Work on integrated care for dually eligible beneficiaries will be a multi-year project
- The Commission will review proposals that would restructure coverage for dually eligible beneficiaries in a more comprehensive way than is possible under two separate programs

Recommendations and Rationale

Recommendation 2.1

- The Centers for Medicare & Medicaid Services should issue subregulatory guidance to create an exception to the special enrollment period for dually eligible beneficiaries eligible for Medicare-Medicaid Plans. This exception would allow such individuals to enroll on a continuous (monthly) basis. For purposes of switching plans or disenrolling under the special enrollment period, Medicare-Medicaid Plan enrollees should be treated the same as other dually eligible beneficiaries in Medicare Advantage.

Rationale

- Would maintain continuous SEP for enrollment, but limit beneficiaries' ability to switch plans or disenroll to the narrower SEP
- Allows MMP-eligible individuals to benefit from the continuity of care that narrower SEP was intended to promote while retaining state preferences to enroll eligible beneficiaries on a continuous (monthly) basis

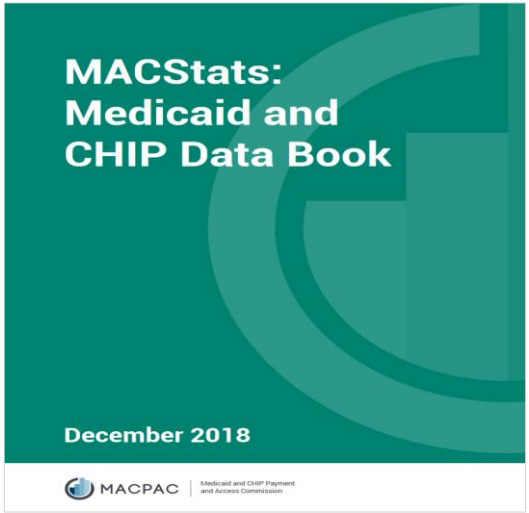
Recommendation 2.2

- Congress should provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models.

Rationale

- Medicare expertise essential to integrating care
  - Designing D-SNP contracts requires expertise in MA eligibility rules, benefits, and processes
  - States have competing demands on their resources
- New models require extensive planning and dedicated staff
  - Upfront costs may be significant if new model ultimately reduces state spending
  - Funding for upfront costs may require state legislative approval

MACPAC resources




IssueBrief

MACPAC

July 2019

Advising Congress on Medicaid and CHIP Policy

Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps

The federal government and states are testing a variety of models to integrate care for beneficiaries enrolled in both Medicare and Medicaid. These beneficiaries are eligible for both programs by virtue of their age or disability and low incomes. This diverse population includes people with multiple chronic conditions, physical or developmental disabilities, cognitive impairments, and some people who are relatively healthy. Dually eligible beneficiaries account for a disproportionate share of spending in both programs. In Medicaid, dually eligible beneficiaries comprise 15 percent of the population but 32 percent of spending, amounting to $118.9 billion in 2013 (MACPAC and MedPAC 2018).

Integrated care models are designed to align the delivery, payment, and administration of Medicare and Medicaid services to improve care for dually eligible beneficiaries and reduce spending. For example, such models can improve beneficiaries' transitions from acute inpatient hospital settings (paid for by Medicare) to home- and community-based settings (paid for by Medicaid), which could help reduce hospital readmissions.

There are three primary models for integrating Medicare and Medicaid services:

- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) or fully integrated dual eligible special needs plans (FIDE-SNPs) that are aligned with Medicaid managed long-term services and supports (MLTSS) programs;
- the Financial Alignment Initiative (FAI); and,
- the Program of All-Inclusive Care for the Elderly (PACE).[1]

Some states are using more than one model to address the needs of different types of beneficiaries or to take into account differences between geographic regions in the state, and to offer beneficiaries choices in how they receive their care.

There is a limited but growing body of evidence examining the effects of integrated care on Medicare and Medicaid spending and outcomes for dually eligible beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has funded formal evaluations of the FAI, which are being published on a rolling basis. In addition, researchers have published a variety of evaluative studies on other integrated care models that cannot be considered formal evaluations. Understanding the successes, challenges, and outcomes of integrated care models can help policymakers determine if the models have worked as intended and inform future policy.

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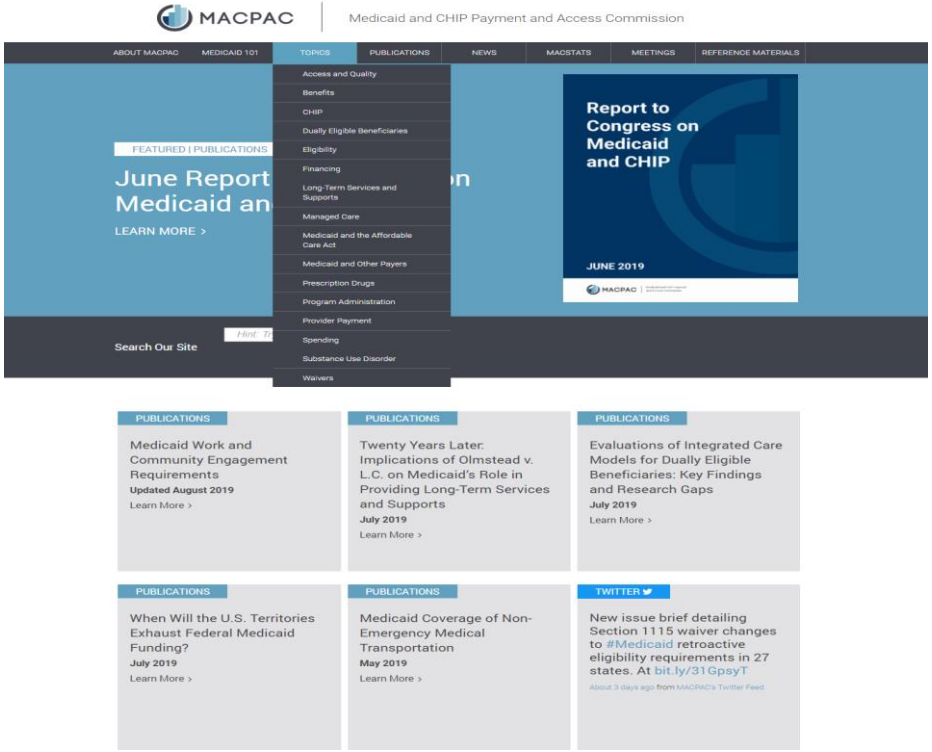

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Stay tuned!

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