WEBINAR *presented by Altarum Medicare-Medicaid Services for States (AMMS)*

Supporting States to Build Better Programs for Dually Eligible Individuals

Learn from expert panelists from the Centers for Medicare & Medicaid Services, Center for Health Care Strategies, Arnold Ventures, and the state of Virginia

Moderated by Sarah Barth, Executive Director, AMMS

Thursday, July 28, 2022
3:00–4:00pm ET

Agenda

Introduction	**Sarah Barth,** Executive Director of Altarum Medicaid-Medicare Services for States
New Tools Available to States - Overview of D-SNP CY 2023 Medicare Advantage and Part D Rule	**Lindsay Barnette**, Director for Models, Demonstrations, and Analysis Group, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services **Stacey Lytle**, Health Equity Coordinator, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services
Efforts to Advance and Increase State Capacity to Further Dual Integration Initiatives	**Nancy Archibald**, Associate Director for Integrated Care, Federal Programs, Center for Health Care Strategies **Arielle Mir**, Vice President of Healthcare, Arnold Ventures
Virginia's Road to Developing a Mature Duals Model – Capacity Challenges and Tips Moving From a Dual Demo to D-SNP Mode	**Karen Kimsey**, former Medicaid Director, Virginia Department of Medical Assistance Services
Q&A Discussion	All

Altarum Medicare-Medicaid Services for States

Helping States Build Better Programs for Dually Eligible Individuals

Altarum Medicare-Medicaid Services for States (AMMS) is a non-profit organization that helps states create financially sustainable solutions to *advance health, health equity, wellness, and community-based, independent living for dually eligible individuals* (individuals eligible for Medicare and Medicaid).

Assess and Partner With States

Meeting them where they are along the continuum of dual integration expertise and programming

Enhance and Build State Capacity

Improving coordination and integration the two programs to improve individuals' experience of care and quality of life, address cost shifting between the two programs, and ensure Medicare is maximized as primary payer of services and supports

Provide Policy *and* Program Administration Services

From national experts and tailored to the needs of each state and their dually eligible populations, including:

Strategy and Program Design

Administration and Operations

Communications

Advancing Dual Integration is Possible – Current Focus and State Landscape

Focus at State and National Levels

COVID-19 escalation of health and economic challenges for dually eligible individuals

State and federal government focus on health equity

CMS Final Rule for Contract Year 2023 Medicare Advantage and Part D Programs

Congressional and Medicaid and CHIP Payment and Access and Commission (MACPAC) activity:

- Advancing Integration in Medicare and Medicaid (AIM) Act (S. 4264)
- June 2022 MACPAC Chapter 5 Raising the Bar: Requiring State Integrated Care Strategies
- Comprehensive Care for Dual Eligible Individuals Act – All Inclusive Medicare-Medicaid (AIM) Program (S. 4635)

State Dual Integration Landscape

States are at different points along the continuum of dual integration efforts and expertise

It is not one-size fits all: States can take a stepped approach, while others may be ready to implement and refine fully integrated programs

Supports are available for all states to improve programs for dually eligible individuals

Overview of D-SNP CY 2023 Medicare Advantage and Part D Rule

Lindsay Barnette, Director for Models, Demonstrations, and Analysis Group

Stacey Lytle, Health Equity Coordinator

Medicare-Medicaid Coordination Office

July 2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Background

- D-SNPs are intended to integrate/coordinate care for dually eligible beneficiaries more effectively than most MA plans or Medicare FFS
- D-SNPs are required to contract with the state Medicaid agency in the service area(s) to provide benefits/arrange for provision of Medicaid benefits
  - Because states are not obligated to contract with a D-SNP, states have 1) significant control over D-SNP availability and 2) flexibility to require greater integration of Medicare and Medicaid benefits
- To promote coordination of care, D-SNPs are also subject to health risk assessment (HRA) requirements and evidence-based model of care

Dual eligible special needs plan provisions

Many provisions import successes from Financial Alignment Initiative into broader D-SNP market including:

- Enrollee input on D-SNP operations: D-SNPs would be required to have enrollee advisory committee (similar to Medicaid requirements at 438.110)
- Health risk assessments: All SNPs would be required to include questions on housing stability, food security, and access to transportation in their HRAs
- Simplify D-SNP enrollee materials: Would allow states to require certain D-SNPs to use integrated materials
- Pathway for assessing local D-SNP performance: Would allow certain states with integrated care programs to require D-SNPs to apply for separate MA contracts (and therefore separate star ratings and performance data)
- Mechanisms for joint oversight of D-SNPs: Would allow certain states access to HPMS and for CMS-state coordination of audits
- Simplified appeals and grievances: Would expand universe of D-SNPs required to implement unified appeals/grievance processes
- Technical/definitional updates for FIDE SNPs and HIDE SNPs: For example, all FIDE SNPs would have exclusively aligned enrollment and cover Medicaid home health, DME, and BH services through a SMAC

Final rule provisions that apply FAI features into D-SNPs

(Remember, too, that states can require additional things through their contracts with D-SNPs)

FAI Characteristic	FIDE SNP	HIDE SNP	Coordination-only D-SNP
Enrollee advisory committee	Required	Same as FIDE	Same as FIDE
HRA to include social risk factors	Required starting 2024	Same as FIDE	Same as FIDE
Exclusively aligned enrollment	Required starting 2025	Not addressed in this rulemaking	Not addressed in this rulemaking
Capitation for behavioral health, except for limited carve-outs	Required starting 2025	Codifies current policy regarding limited carve-outs	Not addressed in this rulemaking
Capitation for Medicare cost-sharing	Required starting 2025	Not addressed in this rulemaking	Not addressed in this rulemaking
Unified appeals & grievances	Required starting 2025 for all FIDE SNPs	Not addressed in this rulemaking	Required for certain plans
Continuation of Medicare benefits pending appeal	Required starting 2025 for all FIDE SNPs	Not addressed in this rulemaking	Required for certain plans
Integrated member materials	Finalized a new pathway for states to require for certain D-SNPs at § 422.107(e)	Same as FIDE	Same as FIDE
Contract only includes within-state plans limited to dually eligible individuals; quality data/ratings based solely on performance in contracts that only include within-state plans limited to dually eligible individuals	Finalized a new pathway for states to require for certain D-SNPs at § 422.107(e)	Same as FIDE	Same as FIDE
Mechanisms for joint federal-state oversight	Finalized for states meeting criteria at § 422.107(e)	Same as FIDE	Same as FIDE
State HPMS access	Finalized for states meeting criteria at § 422.107(e)	Same as FIDE	Same as FIDE

State Resources

- Medicare-Medicaid Coordination Office
  - Lindsay Barnette Lindsay.Barnette@cms.hhs.gov
  - Stacey Lytle Stacey.lytle@cms.hhs.gov
- Integrated Care Resource Center https://www.integratedcareresourcecenter.com/
  - State Contracting with D-SNPs
  - Aligning Enrollment
  - Oversight and Monitoring of D-SNPs
  - And more

Center for Health Care Strategies
Better care where it's needed most

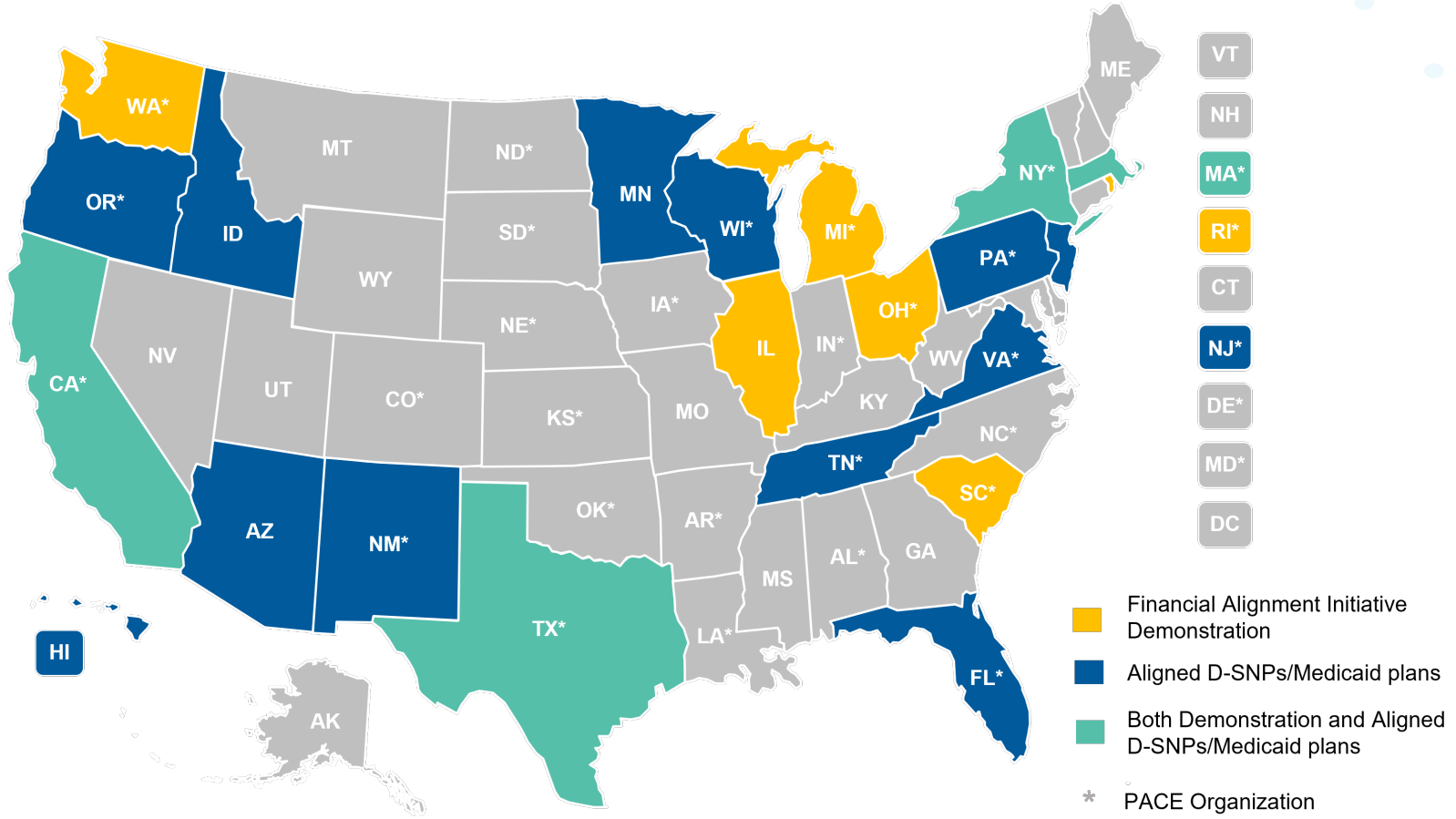
Supporting States to Build Better Programs for Dually Eligible Individuals

July 28, 2022

Nancy Archibald, Associate Director, Integrated Care
Center for Health Care Strategies

Supported by Arnold Ventures

Medicare-Medicaid Integration Landscape, 2022



Source: N. Archibald. "States Want To Integrate Medicare And Medicaid, But They Need Federal Resources And Flexibilities." Health Affairs Forefront, May 17, 2022. DOI: 10.1377/forefront.20220513.925768

Center for Health Care Strategies

Key Resources Needed for Medicare-Medicaid Integration

- Organizational and staffing capacity
- Medicare expertise
- Leadership champions
- Data and analytic capabilities
- Financial/budget support

Sources of Support

Organizational

- Medicare-Medicaid Coordination Office
- Integrated Care Resource Center
- Resources for Integrated Care

Data/Analytics

- State Data Resource Center

Financial

- *Advancing Medicare & Medicaid Integration* Initiative

Arnold Ventures

Improving Policy at the Intersection of Medicare and Medicaid

arnoldventures.org/work/complex-care

Arielle Mir, Vice President of Healthcare

July 28, 2022

Advancing Medicare & Medicaid Integration

Advancing Medicare & Medicaid Integration

- **New funding opportunity** made possible by Arnold Ventures and coordinated by the Center for Health Care Strategies (CHCS)
- **Developed to help state policymakers** improve care for low-income older adults and people with disabilities
- **Targeted to states ready to make meaningful transformations** in care delivery for individuals eligible for both Medicare and Medicaid
  - Increase integration between Medicare and Medicaid through existing or new models
  - Increase enrollment in integrated coverage options
  - Ensure that dual-eligible individuals receive services that lead to better patient experiences, higher quality of care, and reduced health care costs
- **Project activities include** model implementation, contracting support, evaluation and improvement, data analytics, and outreach and education.

Visit medicare-medicaid.org to learn more

Virginia's Road to Developing a Mature Duals Model - Capacity Challenges and Tips Moving From a Dual Demo to D-SNP Mode

Karen E. Kimsey, MSW

Former Medicaid Director, Commonwealth of Virginia

July 28, 2022

Virginia's Duals Experience

- PACE Programs – 1,200 in 12 sites around the Commonwealth
- March 2014 – Commonwealth Coordinated Care Launched – Part of the Financial Alignment Demonstration, served 30,000 dually eligible Medicaid members
- "Toe In the Water" for regional MLTSS
- July 2017 - Commonwealth Coordinated Care Plus (CCC Plus) Launched- a Medicaid managed long-term services and support program that serves over 260,000 individuals throughout the Commonwealth of Virginia, including 136,000 dual eligible members

Key Differences

CCC Plus	CCC
Statewide in 6 regions	5 of the 6 regions
Required Enrollment: 260,000	Optional Enrollment: 30,000
Duals/non-duals, children/adults, NF and 5 HCBS Waivers	Full Dual adults; including NF and EDCD HCBS Waiver
6 Health plans across 6 regions	3 Health plans across 5 regions
Coordination of Medicare benefits through companion DSNP	Coordination of Medicare benefits through same Health Plan
Continuity of care period is 90 days	Continuity of care period is 180 days

Pivoting to CCC Plus

Stakeholder input significantly informed the DMAS CCC Plus program design and implementation strategy

- MLTSS proposed design strategy
- Meetings with State Legislators and Staff
- Constant communication

Design

Incorporating Input

- MLTSS Model of Care
- Comments received from advocates, providers, and health plans

- Transparency with rates, data
- Service auth, claims, utilization management consistency

Operations

Major Changes Moving to CCC Plus

Data

- Collect Robust Encounters and Clinical Data
- Enhanced Care Management Activities
- Enhanced monitoring, oversight and reporting

Quality

- Care Coordination for all Members with Ratios
- Quality Studies and Measures
- Quality Withholds

Common Core Formulary

- DMAS PDL is the CCC Plus Common Core Formulary
- Enhances Continuity of Care
- Decreases Admin Burden for Prescribers

Switching to CCC Plus - Tips

- Communicate early and often with CMS Regional and Central Office Staff
- Systems enhancements; testing with plans and providers prior to implementation
- Utilize technical assistance available
- Readiness with plans, providers, internal staff, and stakeholders (minimum of 6-9 months)
- Ongoing stakeholder & member engagement, outreach and education (webinars, townhalls, etc.)
- Anticipate implementation issues; respond quickly and effectively; keep stakeholders continuously informed
- Make sure you have an actuary with MLTSS experience
- DNSP Contract is an opportunity
- Champions

Switching to CCC Plus - Challenges

- Request for proposals – be prepared for a protest
- Program authority - 1915 b/c Waivers, Regulations, MCO Contracts
- Agency staffing – shifting to managed care
- Systems enhancements; testing with plans and providers
- Rate setting – development of rates
- Readiness with plans, providers, internal staff, and stakeholders (minimum of 6-9 months)
- System adjustment to MLTSS implementation
- DSNP requirement for health plans

Questions?

Closing Comments

A recording of today's webinar will be emailed to all participants. Please share!

To continue the discussion, contact Sarah Barth at **sarah.barth@altarum.org**

Let's connect in person!

HCBS CONFERENCE
Home & Community-Based Services

August 14-18

FALL 2022 NAMD CONFERENCE

November 14-16

For more information, visit: **altarum.org/amms**

Thank You!

A L T A R U M . O R G

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