NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Providing Integrated Care for New York's Dual Eligible Members

Stakeholder Discussion

December 17, 2018

Agenda

- ❑ Introductions
- ❑ FIDA Demonstration Updates
- ❑ NY's Duals Population
- ❑ Paths to Integration
  - Other States
- ❑ Next Steps

FIDA demonstration updates

- At its highest peak, 8,900 members were enrolled in FIDA Demonstration
- As of October 2018 approximately 3,800 members were enrolled in 10 FIDA plans that serve NYC, Nassau and Westchester
- Four FIDA plans will leave the Market at the close of this year
- FIDA demonstration ends December 31, 2019 (FIDA/IDD ends December 31, 2020)
- In 2019, the last year of the FIDA demonstration, there will be six FIDA plans operating (Centers Plan, Elderplan, RiverSpring, Healthfirst, Senior Whole Health, VNSNY)

What is the path for transitioning FIDA Members?

- Each of remaining six FIDA plans also has a Medicaid Advantage Plus (MAP) product that serve the same geographic area as their FIDA
- CMS has indicated that exiting FIDA members can be defaulted/passively enrolled to an affiliated MAP if three Medicare requirements are satisfied:
  - ✓ Financial Test – Medicare costs for the MAP cannot be more than Medicare fee-for-service in the same county
  - ✓ Network Test – Compare Medicare networks between FIDA and the MAP
  - ✓ Benefits Comparison Test – Must be substantially similar between FIDA and MAP
- Timing – CMS plans to use preliminary 2019 Plan bids data, refresh with 2020 information – test anticipated to be completed in August – does not leave much time to educate and inform members of their options
- FIDA benefit package more expansive than MAP (e.g., Behavioral Health Benefits and NHTD/TBI like waiver services)

NY's Duals comprised 15% of the Medicaid population and Account for 36% of Medicaid Spending

December 2017 NY Duals Enrollees			
	Medicaid Enrollees	% Total Enrollees	% Total Medicaid Spending
Non-Dual	5,224,479	85%	63.6%
Dual	921,524	15%	36.4%
Total	6,146,092	100%	100.0%

New York's Current Duals Programs

	Medicaid Advantage (MA)	Medicaid Advantage Plus (MAP)	Programs for All Inclusive Care for the Elderly (PACE)	Partial Managed Long Term Care (MLTC)
	Integrated Plans			
Authority	1115 Waiver	1115 Waiver	Section 1934 Social Security Act	1115 Waiver
Age	18+ Voluntary	18+ Voluntary	55+ Voluntary	Voluntary, non-dual 18+ Voluntary, dual 18-20 Mandatory, dual 21+
# Enrollees 12/2017	7,743	8,972	5,130	178,222
Enrollment Criteria	Medicare Parts A&B, or enrolled in Medicare Part C; Enrolled in plan's Medicare Advantage Product	>120 days of LTSS, NH LOC Medicare Part A&B, or enrolled in Part C; Enrolled in plan's Medicare Advantage Plus Product	>120 days LTSS, NH LOC May be any or all of the following: Medicare Part A; enrolled under Part B; or eligible for Medicaid	Voluntary; >120 days LTSS, NH LOC Mandatory; >120 days LTSS
LTSS	Provided by Medicaid FFS	Yes	Yes	Yes
# of Plans	4	8	9	29

(LTSS) Long Term Services and Supports: nursing, personal care, home care, consumer directed personal assistance, adult day health care, private duty nursing

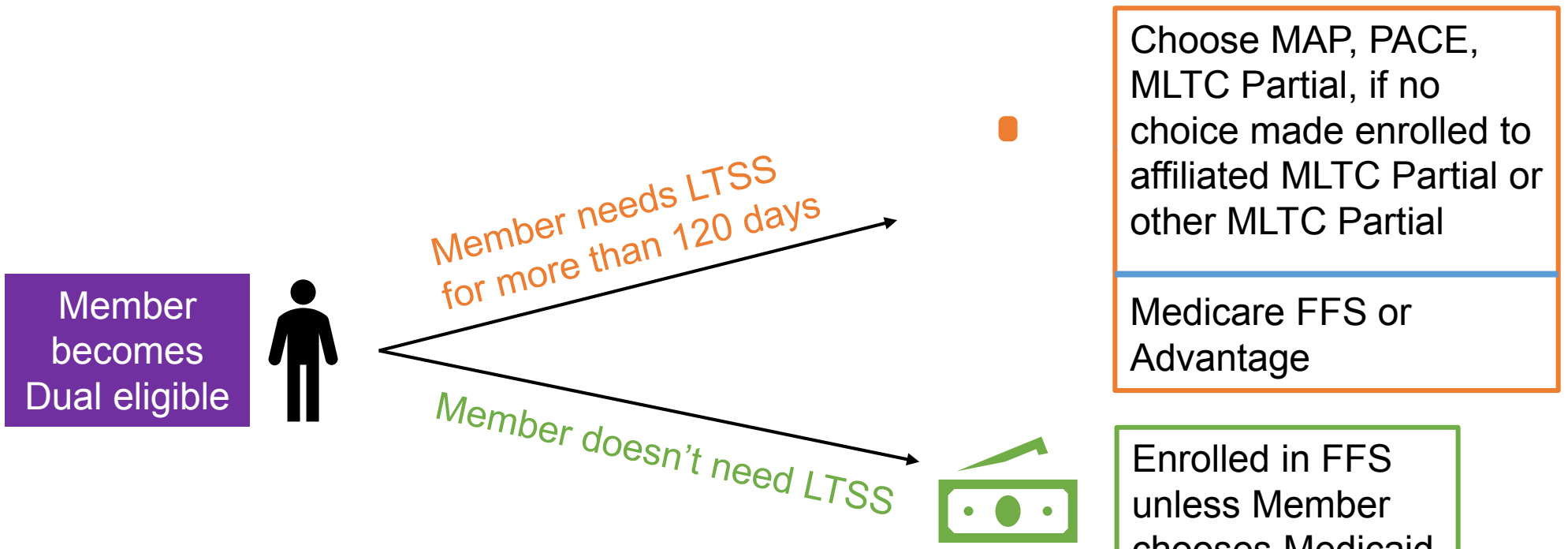
Where are Duals enrolled today?

December 2017 Data	Unique Member Count	Percent of Total
MLTC Partial	***178,222***	***19%***
Medicaid Advantage Plus	**8,972**	**1%**
Medicaid Advantage	**7,743**	**1%**
PACE	**5,130**	**.5%**
FIDA	**4,339**	**.5%**
MMC (transitioning duals)	***20,209***	***2%***
Fee-for-Service (FFS)	***696,909***	***76%***
Total	***921,524***	***100%***

In the month of December 2017:

- ✓ 696K Duals enrolled in FFS. Of these:
  - 355K utilized a non-LTC service in that month
  - 62K utilized LTC services
    - 17% received homecare, personal care or CDPAP
    - 83% resided in nursing homes
- ✓ 270k duals were in D-SNPs

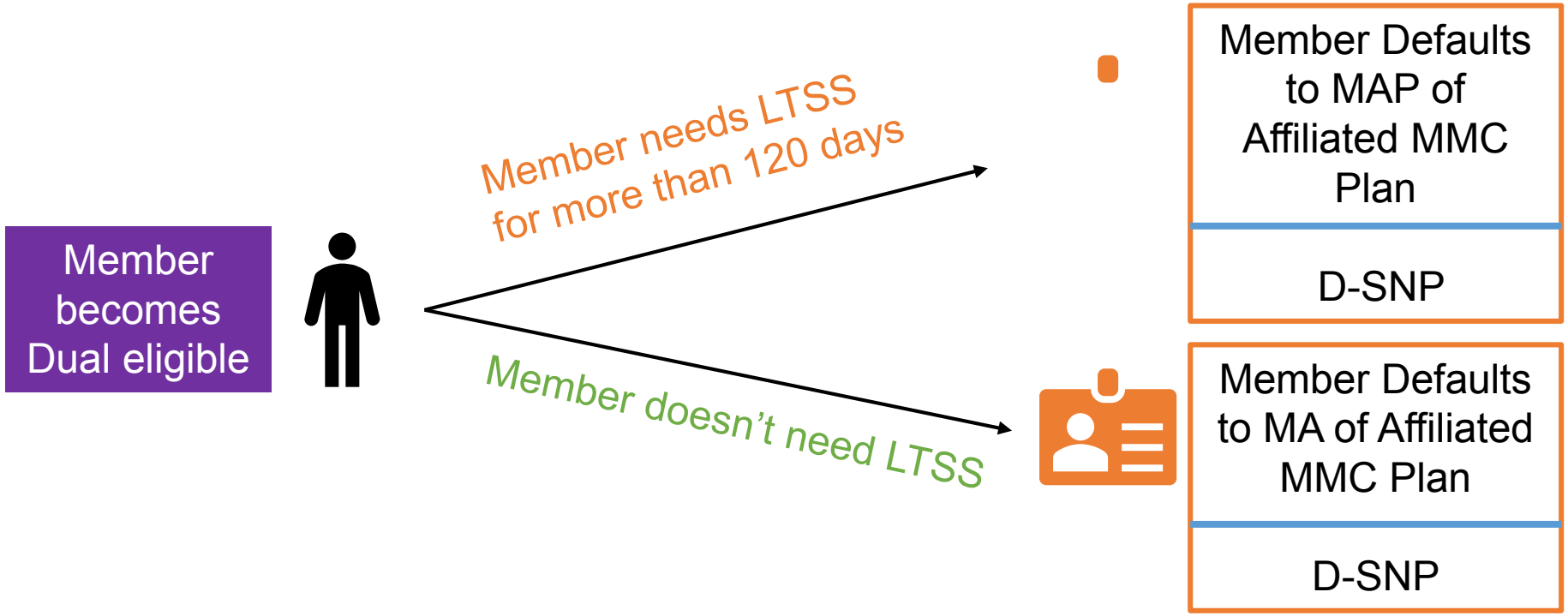
What happens today when a Medicaid member is about to become a Dual?



*LTSS includes nursing, personal care, home care, consumer directed personal assistance, adult day health care, private duty nursing

How can we use CMS default rules to begin to create a continuum of integrated care for Duals?

- Approximately 58,000 Medicaid members became duals in 2017
- CMS has provided preliminary positive feedback that would allow the use of default enrollment



Under default enrollment, members may opt out of default and make other choices, including PACE

Benefits of Integrated Care

Simplification for Members

- All services through one entity (Medicare A&B and D, and Medicaid)
- Simpler member materials with integrated explanations of how all services work together
- Assistance with navigation across primary, acute and Medicaid services

Aligned Clinical and Financial Incentives between Medicare and Medicaid

- Evaluations indicate better care outcomes (reduced hospitalizations and increased access to primary care)
- Tools for rebalancing institutional and home based care
- Incentives for least restrictive care setting vs cost shifting

Access to Stronger Care Coordination Model

- Integrated Model of Care (must be approved by and meet NCQA requirements and regular audits)
- Deeper care coordination across all services
- Integrated person centered care plan
- Interdisciplinary care team
- Provider education
- Monitoring and reporting of quality goals and outcomes

Other Benefits

- Coordination of Communications with CMS
- Access to supplemental benefits available through Medicare

Features of an integrated care product

- ✓ Continuity of care
- ✓ Provide services in the right setting through person-centered care coordination
- ✓ Integrated member services, member materials and review process
- ✓ Unified process and review of marketing materials
- ✓ Coordinated appeals and grievances
- ✓ Aligned enrollment/disenrollment
- ✓ Increased provider engagement
- ✓ Ability to offer consumer incentives under Medicare
- ✓ Coordinated communication with CMS
- ✓ Frailty adjuster
- ✓ Integrated data to better inform analytics, risk adjustment, and rate setting
- ✓ Benefit package alignment

Medicare Supplemental Benefit Opportunities for Duals

- Supplemental benefits are Non-Medicare benefits paid through plan savings called “rebates” which must be used to benefit enrollees, Medicare becomes primary
  - New CMS rule expands Medicare “health related” supplemental benefits (published 4/27/18) starting in 2019
  - 2018 Bipartisan Budget Act also allows additional new “non-health related” supplemental benefits for chronically ill enrollees effective 2020
- Three types of supplemental benefits:
  - Standard (must be offered to all enrollees, 2019)
  - Targeted (offered based on health status or disease state, 2019)
  - Chronic (offered based on chronic illness effective in 2020, may address SDOH needs)
- May provide more opportunities for services to Duals (CMS examples):
  - Respite care, health related adult day care, assistance with ADLs/IADLs, transportation to doctor’s visits, in home support, meals, caregiver supports, safety devices, etc.
- Additional flexibility for FIDE/HIDE-SNPs
  - Waiting for additional CMS guidance

State Design for NY Model Consideration

Arizona

- Mandatory Medicaid enrollment for Duals with corresponding D-SNPs
- Use Default Enrollment to facilitate integration
- Benefit set in managed care is robust so D-SNPs can qualify for FIDE D-SNPs
- Segment enrollment categories so that plans are eligible for the Frailty Factor

Minnesota

- Mandatory Medicaid enrollment for Duals with corresponding D-SNPs
  - Medicaid coordinates enrollment with CMS so all enrollment is aligned
- Benefit set in managed care is robust so all D-SNPs are FIDE D-SNPs
- Demonstration to allow integrated Model of Care, coordinated Appeals and Grievances and unified process for material review
- Aligned administrative requirements such as joint reporting to meet Medicaid and Medicare requirements

New Jersey

- Mandatory Medicaid enrollment for Duals with encouragement for a corresponding D-SNP
- Benefit set in managed care is robust so D-SNPs can qualify for FIDE D-SNPs
- Unified process for materials review

Tennessee

- Mandatory Medicaid enrollment for Duals with corresponding D-SNPs
- Use Default Enrollment to facilitate integration

Next Steps

- Welcome stakeholder feedback for optional comment period on new CMS Medicare Advantage and Part D regulations ASAP (comments due to CMS by 12/31/18)
- Continue to receive stakeholder feedback on today's discussion through mid-January at: dualintegration@health.ny.gov
- Key dates to consider
  - Default enrollment can begin as soon as operational details are finalized
  - Plans should incorporate supplemental benefits into their 2020 Medicare Advantage bids due to CMS May 2019
  - Notice of Intent to Apply with CMS for new Medicare products is due in November 2019 for new 2021 offering
- Date to reconvene

Appendix

CMS Proposes to Further Integrate D-SNPs, as Required by the 2018 BBA

To be in compliance, D-SNPs must meet one of three following definitions/conditions by 2021 and in subsequent years

D-SNPs (Non Integrated)	• New minimum integration requirement: If not a FIDE or HIDE SNP, D-SNP must meet requirement of sharing SNF and hospitalization data with state or its delegates for a specified population of high risk full benefit dual eligible enrollees as determined by the state
Highly Integrated D-SNP (HIDE)	• Redefined, contract with state must provide MLTSS and/or Behavioral Health • Carveouts of minimal scope of services will be considered "to the extent permitted by state law" and "consistent with state policy"
Fully Integrated D-SNP (FIDE)	• Contract with state must provide "comprehensive" services including MLTSS and Behavioral Health under a "single entity" • Allowable carve outs not explicitly defined

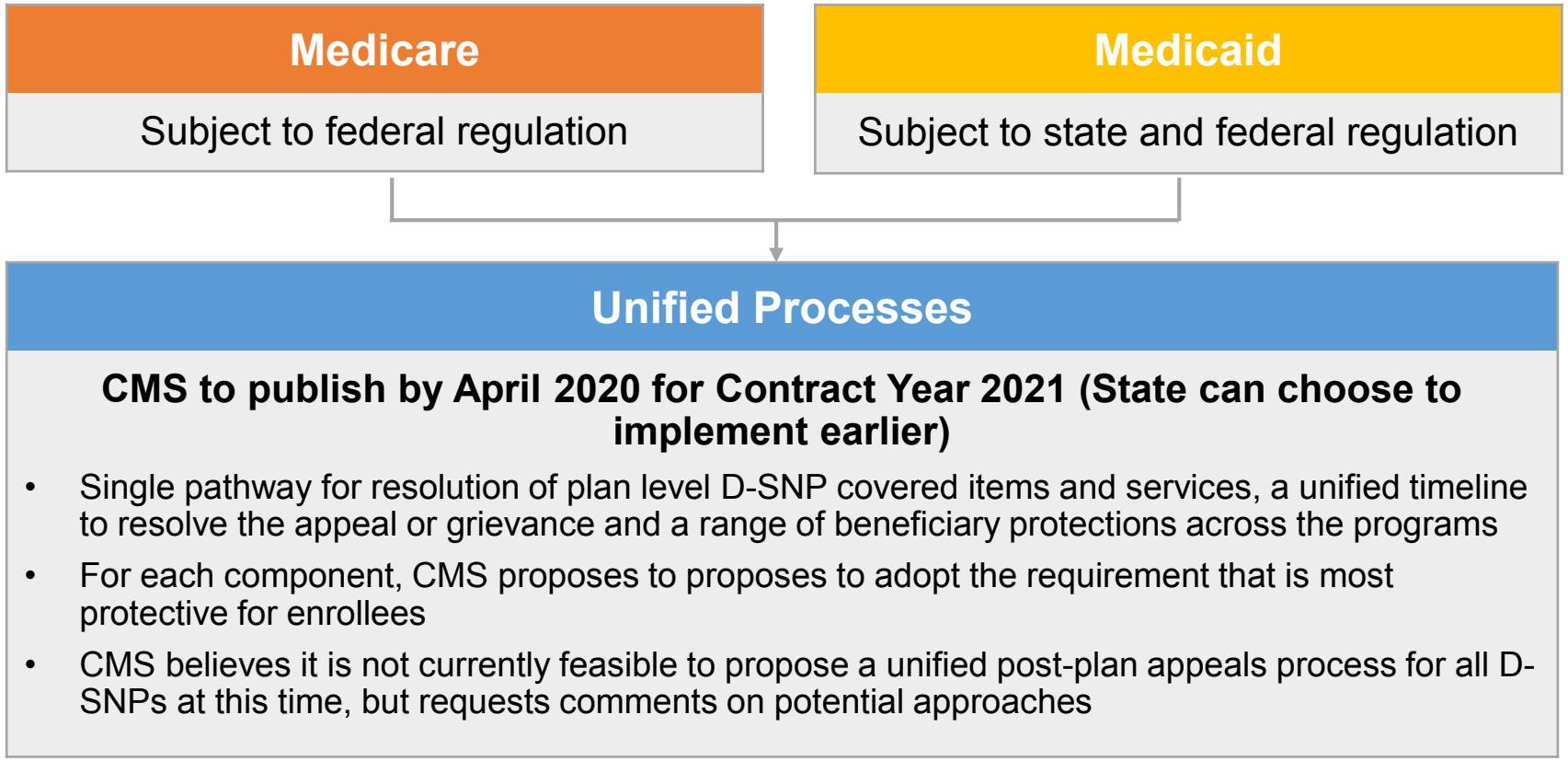
D-SNP Parent Organization with Medicaid Contract

- Parent Organization of a D-SNP that is also the parent organization of a Medicaid MCO must assume clinical and financial responsibility for benefits to enrollees of both. CMS states these are FIDE and HIDE SNPs with exclusively aligned enrollment but asks for comment on additional requirements

D-SNP: Dual Special Needs Plan; BBA: Bipartisan Budget Act of 2018; FIDE SNP: Full Integrated Special Needs Plan; HIDE SNP: Highly Integrated Special Needs Plan; CMS: Centers for Medicare and Medicaid Services; MA: Medicare Advantage; MLTSS: Managed Long-Term Services and Supports; SNF: Special Needs Facility; BH: Behavioral Health

CMS Proposes to Unify Plan Level Medicare and Medicaid Grievances and Appeals Processes for Subset of D-SNPs

The Proposed Unified D-SNP Grievances and Appeals processes are limited to FIDE and HIDE SNPs with "exclusively aligned enrollment" which include only about 170k out of 2.1M D-SNP enrollees.



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The Proposed D-SNP Integration Requirements Would Also Affect MIPPA and SMAC Contracts

MIPPA/SMAC Contract Changes

- Contracts must outline the new minimum integration requirement
- Contracts must list plan provided Medicaid services
- Contracts must define categories of dually eligible populations and any additional eligibility criteria (such as level of care or age) in contract
- All D-SNPs have new requirement for “arranging for benefits” and service access, regardless of coverage source

Sanctions

Must meet integration requirements by 2021, or face possible CMS enrollment sanctions in effect for 2021-2025

D-SNP: Dual Special Needs Plan; MIPPA: Medicare Improvements for Patients and Providers Act of 2008; SMAC: State Medicaid Agency Contracts

A Range of Additional D-SNP Integration Requirements Are Also Included Under the Proposed Rule

Enrollment Alignment

- CMS acknowledges range of enrollment alignment under same organization or plan dictates ability to apply integrated features
- CMS defines "Exclusively aligned enrollment": D-SNP companion plan limited to enrollment of Medicaid MCO members

Partial Duals

- CMS points out challenges of integration for this group, and asks for comment on continuing to allow them to enroll or not to enroll in D-SNPs

Supplemental Benefits

- Guidance is pending on potential additional FIDE and HIDE SNP flexibilities

Unified G&A System

- Codifies new Integrated Medicare and Medicaid grievances and appeals processes for certain D-SNPs, effective 2021.
- Applies only to "applicable integrated plans" defined as plans with "exclusively aligned enrollment"

New G&A Requirement for All D-SNPs

- CMS also codifies a new Medicare requirement for all D-SNPs to assist members with Medicaid grievances and appeals, regardless of benefit coverage source. This includes documenting requests for assistance, however D-SNPs are not required to represent enrollees in the Medicaid appeals process.

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