Innovations in Serving Dually Eligible Individuals: Streamlining Access to Coverage and Promoting Integrated Care

Agenda

1. Improving access to the Medicare Savings Programs

2. The evolution of integrated care models from Medicare-Medicaid Plans to integrated D-SNPs

3. Q and A

Background

Enrollment in Medicare Savings Programs

MSPs improve access to health care while freeing up already limited income for food, housing, and other life necessities.

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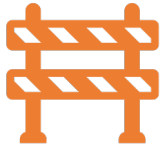
Yet, only about half of eligible individuals were enrolled in MSPs, according to a 2017 study conducted for the Medicaid and CHIP Payment and Access Commission.



Certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of coverage for eligible individuals

Executive Orders

E.O. 14009- Strengthen Medicaid and the Affordable Care Act and remove barriers to obtaining coverage for the millions of individuals who are potentially eligible.

E.O. 14070- Help more Americans enroll in quality health coverage.

E.O. 14058- Supports streamlining state enrollment processes to ensure eligible individuals are automatically enrolled in critical benefit programs.

Overview

In **September 2023,** CMS published the Streamlining Medicaid: Medicare Savings Program Eligibility and Enrollment Final Rule

- **Publication**: https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment

Through changes to the Medicare Savings Program eligibility and enrollment rules, this regulation will:

- Reduce overall state burden by over **2 million hours per year**.
- Reduce burden on older adults and people with disabilities by over **19 million hours per year**.

Automatically Enroll Certain Supplemental Security Income Recipients into the Qualified Medicare Beneficiary Group (§ 435.909)

Facilitates enrollment of individuals known to be eligible for the MSPs

Current

Supplemental Security Income (SSI) recipients entitled to Medicare are always financially eligible for the Qualified Medicare Beneficiary (QMB) MSP eligibility group, but over 500k are not enrolled.

New

Require most states to deem SSI recipients entitled to Medicare into the QMB group.

Exception: Deeming would be optional for states that do not have a Part A buy-in agreement with CMS ("group payer states")

Facilitate Enrollment in the Medicare Savings Programs Using Part D Low-Income Subsidy Data (42 CFR §§ 435.4, 435.601, 435.911, and 435.952)

Facilitates alignment of LIS and MSP eligibility and enrollment and maximizes assistance with Medicare premiums and cost-sharing

Current

Most individuals eligible for the full-subsidy Low-Income Subsidy (LIS) for Medicare Part D meet the eligibility requirements for a MSP eligibility group, but over 1 million such LIS recipients are not enrolled in the MSPs.

New

Streamline enrollment for individuals in LIS into the MSPs and simplify enrollment for all MSP applicants

Codify statutory requirement that states initiate MSP applications using LIS application data

Encourage states to adopt targeted income and resource disregards, to fully align LIS and MSP financial methodologies.

Reduce documentation burden for income and resources counted for MSPs but not counted for LIS

New

Generally, requires states to accept LIS leads data without further verification and deem full-subsidy LIS recipients as eligible for MSPs if income and resource methodologies are aligned

Define family size in MSPs to be no less than the LIS definition: the applicant, the applicant's spouse, and certain other financially-dependent relatives living in the same household

Opportunity for full Medicaid eligibility application for LIS applicants.

Implementation Timeframe

- We recognize ongoing state work to unwind from the continuous enrollment condition effective during the COVID-19 public health emergency

- We sought to balance implementation of new requirements with the unwinding period, new requirements by the Consolidated Appropriations Act, 2023, systems and operations.

Compliance dates:

- Optional provisions and new requirements - States can adopt upon final rule's effective date.
- Deeming SSI recipients entitled to Medicare into QMB - Compliance by October 1, 2024.
- Leads data provisions - Full compliance by April 1, 2026.

Evolution of Integrated Care Models:

Overview of D-SNP Provisions in the CY 2023 Part C and Part D Rule

Key Findings: MyCare Ohio Third Evaluation Report

- On average, nearly two-thirds of eligible beneficiaries, approximately 82,500 out of 142,000 have been enrolled in the demonstration
- Beneficiary satisfaction has increased over time with 68 percent of beneficiaries rating their plans a 9 or 10
- Over the course of the demonstration, MMPs have been able to provide better data analytics, allowing AAAs to target care management interventions more effectively

Key Findings: MyCare Ohio Third Evaluation Report

SERVICE UTILIZATION AND QUALITY OF CARE: Demonstration Years 1 through 6 (2014–2020)

Favorable Results	Unfavorable Results
↑ Increase in probability of a 30-day follow-up visit after a mental health discharge	↑ Increase in monthly probability of any emergency department (ED) visit
↓ Decrease in monthly probability of any inpatient admission	↑ Increase in monthly number of preventable ED visits
↓ Decrease in number of all-cause 30-day readmissions	
↓ Decrease in monthly probability of any skilled nursing facility (SNF) admission	
↓ Decrease in annual probability of any long-stay nursing facility use	

- There were no demonstration effects on the monthly probability of any ambulatory care sensitive condition (ACSC) admission (overall), monthly probably of an ACSC admission (chronic), and the monthly number of physician evaluation and management visits.

Background

- Dual Eligible Special Needs Plans, or 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 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 must administer health risk assessments (HRAs) and evidence-based model of care

D-SNP Provisions in the CY 2023 Part C and Part D Rule

Many provisions import successes from MMPs into the broader D-SNP market including:

- **Enrollee input on D-SNP operations**: D-SNPs newly required to have enrollee advisory committee (similar to Medicaid requirements)
- **Health risk assessments**: All SNPs newly required to include questions on housing stability, food security, and access to transportation in their HRAs
- **Simplify D-SNP enrollee materials**: Allows states to require certain D-SNPs to use integrated materials
- **Pathway for assessing local D-SNP performance**: Allows 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**: Allow certain states access to CMS systems and for CMS-state coordination of audits
- **Simplified appeals and grievances**: Expands 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

What Does This Mean For MMPs?

- **Integrated care landscape has changed since FAI began**
  - D-SNPs are now permanent, and legislative and regulatory steps have raised the bar for integration
  - New flexibilities in MA benefit design (e.g., supplemental benefits that address LTSS and SDOH)
- **New D-SNP provisions presents opportunity to strengthen integrated care options outside of demonstration context.**
- **CMS is working with states to convert MMPs to integrated D-SNPs**
  - Would allow CMS, states, and plans to concentrate quality improvement resources on smaller number of plans
  - Offers greater stability to states and plans and signals longer term commitment to stakeholders than time-limited demonstration
  - Alleviates states and plans of additional administrative burden of operating demo
  - CMS would continue to offer many of the TA/quality improvement activities initially developed for MMPs but with a focus on D-SNPs
  - Transition process would likely vary by state; goal would be to mitigate disruptions and maximize continuity for MMP enrollees to greatest extent possible

Questions