Integrated Care Boot Camp, Part I

How Health Plans Get Paid
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Humana
Healthy Horizons™
Medicare Advantage

Non-medical benefits
Medicare Beneficiaries Have Two Options for Medicare Coverage

Medicare Fee-For-Service ("Original” Medicare)

→ Federal government pays directly for healthcare benefits

→ To fill coverage gaps, individuals may have access to other products, e.g.,
  • Supplemental Insurance: Individuals may choose to buy supplemental insurance ("Medi-gap")
  • Employer-Sponsored Insurance*
  • Medicaid: Gap filler for low-income*

Medicare Advantage (Part C)

→ Private insurance companies contract with CMS (and in some instances, states) to offer “Medicare health plans” to older adults

→ In exchange for a flat monthly fee, insurance companies are responsible for all Medicare-covered healthcare benefits for people who enroll in their plan

*Available to those in Medicare Advantage as well
Medicare Has Four Parts

**Part A**
- "Hospital Insurance" Medical Coverage
  - Inpatient stays
  - Skilled nursing stays
  - Some home health visits
  - Hospice care

**Part B**
- "Outpatient" Medical Coverage
  - Physician visits
  - Outpatient services
  - Preventive services
  - Some home health visits

**Part C**
- Medicare Advantage
  - All Part A and B Benefits
  - Supplemental benefits, including lower cost share, additional benefits like dental, vision, hearing aides, wellness and fitness, mental health, other nonmedical benefits

**Part D**
- Prescription Drugs
  - Outpatient prescription drugs through private plans that contract with Medicare

"Original" Medicare

Medicare Advantage (MA)

Many MA plans include Part D ("MA-PD" plans)
Payments to Medicare Advantage plans are established by a plan’s bid relative to a county-level benchmark of average spending in FFS Medicare. If the bid is below benchmark, enrollees pay no premium and plans are required to use this portion, known as plan rebates, to provide extra benefits (lower cost sharing, supplemental benefits). If the bid is above benchmark, enrollees will pay the difference between the bid and benchmark, known as a premium.

**PAYMENT EXAMPLE (ILLUSTRATIVE)**

- **Benchmark = $1,000**
- **Beneficiary premium for Part A/B services = $100**
- **CMS savings = $50**
- **Rebate amount = $50**
- **Plans that receive 4 or 5 stars are eligible to receive a higher rebate percentage**

**Plan Bids above Benchmark**
- **Plan bid = $1,100**
- **Plan payment from CMS = $1,000**

**Plan Bids below Benchmark**
- **Plan bid = $900**
- **Plan payment from CMS = $950**
Increasing Medicare Advantage Penetration, with Variation Across the Country

According to recently released data from CMS, Medicare Advantage now provides Medicare coverage for over half of eligible beneficiaries.

In January 2023, 30.19 million of the 59.82 million people with both Medicare Part A and Part B were enrolled in Medicare Advantage.

Source(s): ATI Advisory analysis of CMS’ Medicare Advantage State/County Penetration File (Jan 2023). CMS data do not yet reflect new plans.
Medicare Beneficiaries are More Likely to Be Low Income than FFS Beneficiaries...

Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey. FPL – Federal Poverty Level
… And Are More Likely to Be Dually Eligible for Medicaid

Source: ATI Advisory analysis of 2020 Medicare Current Beneficiary Survey. FPL – Federal Poverty Level
Supplemental Benefit Offerings and Care Models Achieve Member Growth, Retention, and Health Outcomes

Supplemental Benefits

- Filed benefits that exceed traditional Medicare Part A and B services, and can be medical or non-medical in nature

Care Model

- Clinical and innovative approaches (e.g., enhanced care team, digital health apps) targeted to individuals based on medical or functional conditions, medical utilization, spend

Enrollment

- Benefits attract members and influence market competitors to offer more robust programs

Experience

- Meaningful benefits and models create positive plan experiences and encourage plan retention

Meeting Need

- Benefits and models can help plans move upstream (e.g., address SDOH, home care needs)

ROI

- Meeting beneficiaries’ needs can lead to cost savings and reinvestments in new programs

Flexibility

- Plans may make mid-year changes or change eligibility criteria for care model coverage while supplemental benefits must be filed annually
Medicare Advantage Plans Have Recent Greater Flexibility in Benefit Offerings

Prior to 2019, Medicare Advantage supplemental benefits had to be primarily health-related and available uniformly to all enrollees. Expanded authorities now allow health plans to offer a broader variety of meaningful benefits and allow for more targeting of benefits.

<table>
<thead>
<tr>
<th>Needs to be Primarily Health-Related?</th>
<th>Expansion of Definition of “Primarily Health-Related” for Supplemental Benefits (EPHRB)</th>
<th>Special Supplemental Benefits for the Chronically Ill (SSBCI)</th>
<th>Uniformity Flexibility (UF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, but under the new definition of “primarily health-related”</td>
<td>No, plans have the flexibility to offer benefits that are not primarily health-related</td>
<td>Yes, but under the new definition of “primarily health-related”</td>
<td></td>
</tr>
</tbody>
</table>

| Examples of Benefits (Non-exhaustive) | | |
|---------------------------------------| | |
| • In-Home Support Services            | • Food and Produce                     | • N/A                                      |
| • Support for Caregivers of Enrollees | • Meals beyond a limited basis         |                                            |
| • Adult Day Health Services           | • Pest Control                         |                                            |
| • Home-Based Palliative Care          | • Transportation to Non-Medical Locations|                                            |
| • Therapeutic Massage                 | • Structural Home Modifications         |                                            |

Non-medical Benefits Are Becoming Increasingly Available in Medicare Advantage

Growth in Percentage of MA Plans Offering New Benefits, 2020 to 2023

**EPHRB Examples**
- Adult Day Health Services
- Home-based Palliative Care
- Caregiver Supports
- In-Home Support Services
- Therapeutic Massage

**SSBCI Examples**
- Food and Produce
- Pest Control
- Transportation for non-medical needs
- Social needs Benefit
- Home modifications

**Expanded Primarily Health-Related Benefits**
- 2020: 11%
- 2021: 15%
- 2022: 19%
- 2023: 25%

**Special Supplemental Benefits for the Chronically Ill**
- 2020: 6%
- 2021: 19%
- 2022: 24%
- 2023: 25%

Source(s): ATI Advisory analysis of CMS' PBP files, 2020-2022.
Medicaid LTSS Facts and Trends

Populations and Payment
Over Half of LTSS is Paid for by Medicaid

Medicaid LTSS Spending = $196.9 billion

Total National LTSS Spending = $379 billion

NOTE: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care ($83.3 billion in 2018). All home and community-based waiver services are attributed to Medicaid.

MLTSS & Dually-Eligible Beneficiaries

• **Over 80%** of Medicaid beneficiaries are enrolled in **managed care plans**

• Early managed care waivers often **carved out** Aging and Disabled populations in many states

• Recent trend is for states to bring Aging and Disabled populations into managed care through **managed LTSS (MLTSS) plans**  

  ▶ LTSS beneficiaries make up **6% of total Medicaid population** and account for **34%** of Medicaid costs

• **75% of LTSS recipients** are also dually eligible for both Medicare and Medicaid
Managed Long-Term Services & Supports (MLTSS)

• 1.8 million beneficiaries in MLTSS in 2017 (more than one third of all Medicaid beneficiaries using LTSS)

• 25 states have capitated managed LTSS programs (2022)

• Growing interest in remaining states – likely to accelerate with efforts to give states more flexibility and control Medicaid spending.
# Fee-For-Service vs. Managed Care

## MEDICAID OPTIONS FOR STATES

<table>
<thead>
<tr>
<th>Fee-For-Service (FFS)</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In FFS Medicaid, the state pays providers directly for each instance of any covered service</td>
<td>• Involves the state contracting with a managed care organization (MCO) to provide medical and other benefits</td>
</tr>
<tr>
<td>• Medicaid payments follow set fees</td>
<td>• MCOs are paid capitated monthly payments for each beneficiary</td>
</tr>
<tr>
<td></td>
<td>• Aims to better manage costs, increase coordination, and improve quality</td>
</tr>
</tbody>
</table>
MLTSS Contract Types

States can pursue a spectrum of contract types:

• Comprehensive managed care program that includes LTSS and non-LTSS benefits (some states limit enrollment to populations eligible for LTSS, others include all populations)

• Plan that provides only LTSS benefits

• Single comprehensive plan that covers Medicare and Medicaid benefits for dually eligible individuals (e.g., FIDE SNP, FAI)
MLTSS Waiver Authorities

States pursue waiver authorities to implement MLTSS programs, including:

- Section 1115 demonstration
- 1915(a) voluntary managed care program
- 1915(b) waiver (mandatory)
- 1932(a) state plan amendment
- Any of these managed care authorities can be paired with 1915(c) HCBS authority
The Spectrum of State Models

Source: ATI Advisory. The Spectrum of State Models to Support Medicaid LTSS. November 2022.
Percentage of LTSS Expenditures Spent on MLTSS by State (2018)
Populations Included

• Older adults
• Individuals with physical disabilities
• Some states also carve in various subpopulations:

<table>
<thead>
<tr>
<th>Subpopulation</th>
<th>Example States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with disabilities</td>
<td>Kansas, New Jersey</td>
</tr>
<tr>
<td>Dually eligible beneficiaries</td>
<td>Delaware, Wisconsin</td>
</tr>
<tr>
<td>Individuals with behavioral health conditions</td>
<td>Arkansas, Michigan</td>
</tr>
<tr>
<td>Individuals with traumatic brain injuries</td>
<td>Kansas, North Carolina</td>
</tr>
<tr>
<td>Individuals with intellectual/developmental disabilities</td>
<td>North Carolina, New York</td>
</tr>
</tbody>
</table>
Populations Included (Cont.)

- Individuals with I/DD and medically fragile children were most likely to be excluded from mandatory enrollment in MLTSS

### Exhibit 18: MLTSS Enrollment by Populations (# of States)

<table>
<thead>
<tr>
<th></th>
<th>Non-Dual Eligibles</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Seniors</td>
<td>Persons w/ Physical Disabilities</td>
<td>Persons w/ I/DD</td>
<td>Medically Fragile Children</td>
</tr>
<tr>
<td>Always mandatory</td>
<td>15</td>
<td>15</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Always voluntary</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Varies</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Always excluded</td>
<td>6</td>
<td>5</td>
<td><strong>6</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

<table>
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<tr>
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<td><strong>6</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Benefits Included

**Most common:** Comprehensive benefit package from one MCO to serve the whole person, including:

- Acute, primary care, and behavioral health services
- Long-term services and supports, including:

  - Direct Care Services
  - Residential Services
  - Respite Services
  - Caregiver Training & Supports
  - Housing Supports
  - Non-Medical Transportation
  - Supported Employment
  - Meal and Nutritional Services
12.2 Million Dually Eligible Beneficiaries are Covered by Both Medicare and Medicaid (2018)

Total Medicare Beneficiaries, 2018: 62.9 million
Total Medicaid Beneficiaries, 2018: 84.4 million

Medicare Only
50.7 Million

Medicaid Only
72.2 Million

12.2 Million

MACPAC. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group. Data Book. January 2018
Characteristics of Dually Eligible Beneficiaries

- Low-income by definition and more racially/ethnically diverse than the broader Medicaid population

- Have complex care needs:
  - 70% have 3+ chronic conditions
  - 41% have at least one mental health diagnosis
  - 49% use LTSS

- Costs 2x that of other Medicare beneficiaries, accounting for over $300 billion in state and federal spending each year
Medicare is the Primary Payer for Services Covered by Both Programs

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visits</td>
<td>Primary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Inpatient Hospital Stays</td>
<td>Primary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Outpatient Hospital Services (including Emergency Room)</td>
<td>Primary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>Primary</td>
<td>Optional</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Prescription drugs are covered primarily through Part D plans. Original Medicare provides very limited prescription drug coverage under Medicare Part B</td>
<td>Prescription drugs excluded from Part D coverage, if covered by Medicaid for other Medicaid beneficiaries; Medicaid does not cover Medicare Part D copayments</td>
</tr>
<tr>
<td>Therapy (PT, OT, SLP)</td>
<td>Primary</td>
<td>Optional</td>
</tr>
<tr>
<td>Hospice</td>
<td>Primary</td>
<td>Optional</td>
</tr>
<tr>
<td>Home Health (skilled)</td>
<td></td>
<td>Depends on eligibility criteria for benefit (also, mandatory in Medicaid)</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td>Depends on eligibility criteria for benefit (also, optional in Medicaid)</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>Depends on specific benefit</td>
</tr>
<tr>
<td>Skilled Nursing Facility (short stay)</td>
<td>Primary</td>
<td>[benefit differs]</td>
</tr>
<tr>
<td>Nursing Facility (long stay, custodial, room &amp; board)</td>
<td>Not covered</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Home and Community Based Services</td>
<td>Typically not covered outside supplemental benefits</td>
<td>Optional</td>
</tr>
<tr>
<td>Social/non-medical (HRSN) Services</td>
<td>Typically not covered outside supplemental benefits</td>
<td>Typically not covered outside managed care/ waivers</td>
</tr>
<tr>
<td>Dental, Vision, Hearing</td>
<td>Typically not covered outside supplemental benefits</td>
<td>Optional</td>
</tr>
</tbody>
</table>
Dual Eligible

Special Needs Plans
Dually Eligible
Special Needs Plans:

Exploring Opportunities for AAAs and CBOs to Better Integrate Care

Cheryl Phillips, M.D., AGSF

Former President and CEO
Special Needs Plan Alliance,
and Senior Program
Consultant John A Hartford Foundation
Quick Review

Special Needs Plans (SNPs)

SNPs are a type of Medicare Advantage health plan. You must qualify for Medicare, as well as meet the specific criteria to enroll.

SNPs were first offered in 2006 and made permanent under the Bipartisan Budget Act of 2018 (BBA).

In 2023, SNPs are available in 48 states and the District of Columbia.

SNPs enroll approx. 5.5 million individuals in 2023.
Three types of Special Needs Plans

- **Dually Eligible SNPs (D-SNPs)** - with three subtypes,
  - **Coordination Only (CO)**
  - **Highly Integrated (HIDE)** and
  - **Fully Integrated (FIDE)**
  - Approx 4,900,000 total D SNP Enrolled

- **Institutional SNPs (I-SNPs and IE-SNPs)**
  - Approx 110,000 Enrolled

- **Chronic Condition SNPs (C-SNPs)**
  - Approx 450,000 Enrolled
Enrollment in D SNPs – Picture of Growth

1.4 Million Enrolled in 2019

5.2 Million Enrolled in 2023
Subtypes of D SNPs (Jan 2023 Enrollment)

- **Coordination Only D SNP**
  - 2,345,600 D-SNPs without financial and clinical Medicaid risk for long-term services and supports (LTSS) or behavioral health (BH)

- **HIDE SNP**
  - 1,957,500
  - Highly-Integrated D-SNP also has financial and clinical Medicaid risk for LTSS and/or BH in the state

- **FIDE SNP**
  - 396,800
  - Fully-Integrated D-SNP; D-SNP legal entity also has Medicaid financial and clinical risk LTSS and BH in the state
Comparison of Requirements of SNP Types

<table>
<thead>
<tr>
<th>Federal Requirement</th>
<th>CO D-SNP</th>
<th>HIDE SNP</th>
<th>FIDE SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must hold a Medicare Advantage contract with CMS that meets minimum requirements for D-SNPs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Must hold a contract with the state Medicaid agency in each state where the D-SNP operates, and those contracts must meet the minimum requirements described at 42 CFR 422.107</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Must have a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Social Security Act</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>May provide coverage of Medicaid services to full-benefit dually eligible enrollees via a Prepaid Inpatient Health Plan (PIHP) or a Prepaid Ambulatory Health Plan (PAHP)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Must provide coverage of applicable Medicaid benefits to full-benefit dually eligible enrollees through the same legal entity that contracts with CMS to operate as an MA plan</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Must have a capitated contract with the state Medicaid agency to provide coverage of LTSS to full-benefit dually eligible enrollees, consistent with state policy¹</td>
<td>No</td>
<td>No²</td>
<td>Yes</td>
</tr>
<tr>
<td>Must have a capitated contract with the state Medicaid agency that provides coverage of a minimum of 180 days of nursing facility services to full-benefit dually eligible enrollees during the plan year</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Must have a capitated contract with the state Medicaid agency that provides coverage of behavioral health services to full-benefit dually eligible enrollees, consistent with state policy¹</td>
<td>No</td>
<td>No²</td>
<td>Yes*</td>
</tr>
<tr>
<td>Must have a capitated contract with the state Medicaid agency that provides coverage of Medicaid primary and acute care benefits¹</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Must operate with exclusively aligned enrollment</td>
<td>No</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>Must implement unified plan-level appeal and grievance processes in accordance with the requirements at 42 CFR 422.107(c)(9), 422.629 through 422.634, 438.210, 438.400, and 438.402</td>
<td>No</td>
<td>No</td>
<td>Yes*</td>
</tr>
<tr>
<td>Must notify the state (or the state’s designee) of acute hospital and skilled nursing facility admissions for a designated group of “high risk” full-benefit dually eligible enrollees in accordance with the requirements described at 42 CFR 422.107(d)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

¹ To qualify as a HIDE SNP, a D-SNP must either cover Medicaid behavioral health services or LTSS

² To qualify as a HIDE SNP, a D-SNP must either cover Medicaid behavioral health services or LTSS

Source: ICRC integratedcareresourcecenter.com/sites/default/files/ICRC_DSNPDefinitions_2023-2025_0.pdf
Quick Overview: Key Tools and Terms Important to SNPs

• Model of Care (MOC) – The “who, what and how” of the Special Needs Plan (all types):
  • Describes how the plan will assess beneficiary needs; develop individualized care plans (ICPs); establish and utilize integrated care teams (ICTs); and coordinate care, including during care transitions
  • MOCs are created at the contract level by SNP type
  • Must be approved by National Committee for Quality Assurance (NCQA)
  • States can integrate requirements into the D-SNP MOC

• State Medicaid Agency Contract (SMAC): Ways States can use these requirements to:
  • Improve care coordination
  • Integrate Medicaid requirements into D-SNP Models of Care (MOCs)
  • Incorporate state-specific care coordination standards into SMACs
  • Promote use of clear, accurate enrollee materials
  • Require D-SNPs to cover Medicaid benefits
  • Align Enrollment with Medicaid MCOs
Examples of SMAC- D SNP Care Coordination: Indiana

- Refer within two (2) business days to the appropriate Indiana Area Agency on Aging (AAA) any enrollee identified as having strong predictors of needing LTSS but who may not already be enrolled in the Aged & Disabled waiver or may not be receiving any LTSS currently.
- Regularly communicate and collaborate with the state and Indiana AAAs to maintain up-to-date contact information and working knowledge of AAA operations and practices.
- Integrate AAA waiver service coordinator and service plan into D-SNP interdisciplinary care team and individualized care plan.
- Assess and document “What Matters” to enrollees and their advance directives.
- Assess and document enrollees’ informal caregiver supports.
- Provide dementia education and supports to D-SNP enrollees living with dementia and their informal caregivers.
- Assess D-SNP enrollees for social determinant of health (SDOH)-related needs, which include social risk factors and social needs (e.g., housing, food, and transportation).
- Address SDOH-related needs as part of person-centered care.

Source: Integrated Care Resource Center
Useful Webinar and Resources:

“Using State Medicaid Agency Contracts (SMACs) with D-SNPs to Improve Coordination of Medicare and Medicaid Benefits”

https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20D-SNP%2020201_FINAL.pdf

Resource links

• ATI Advisory: [https://atiadvisory.com/]
• Milliman: [https://us.milliman.com/en/insight/key-insights-into-2022-medicare-advantage-d-snp-landscape]
• Integrated Care Resource Center: [https://www.integratedcareresourcecenter.com/]
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