BIPARTISAN POLICY CENTER

Replicating Successful Models through Spread and Scale

LEGAL AND POLICY BARRIERS TO INTEGRATION OF MEDICARE AND MEDICAID SERVICES FOR DUAL ELIGIBLE INDIVIDUALS

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WHO WE ARE

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell

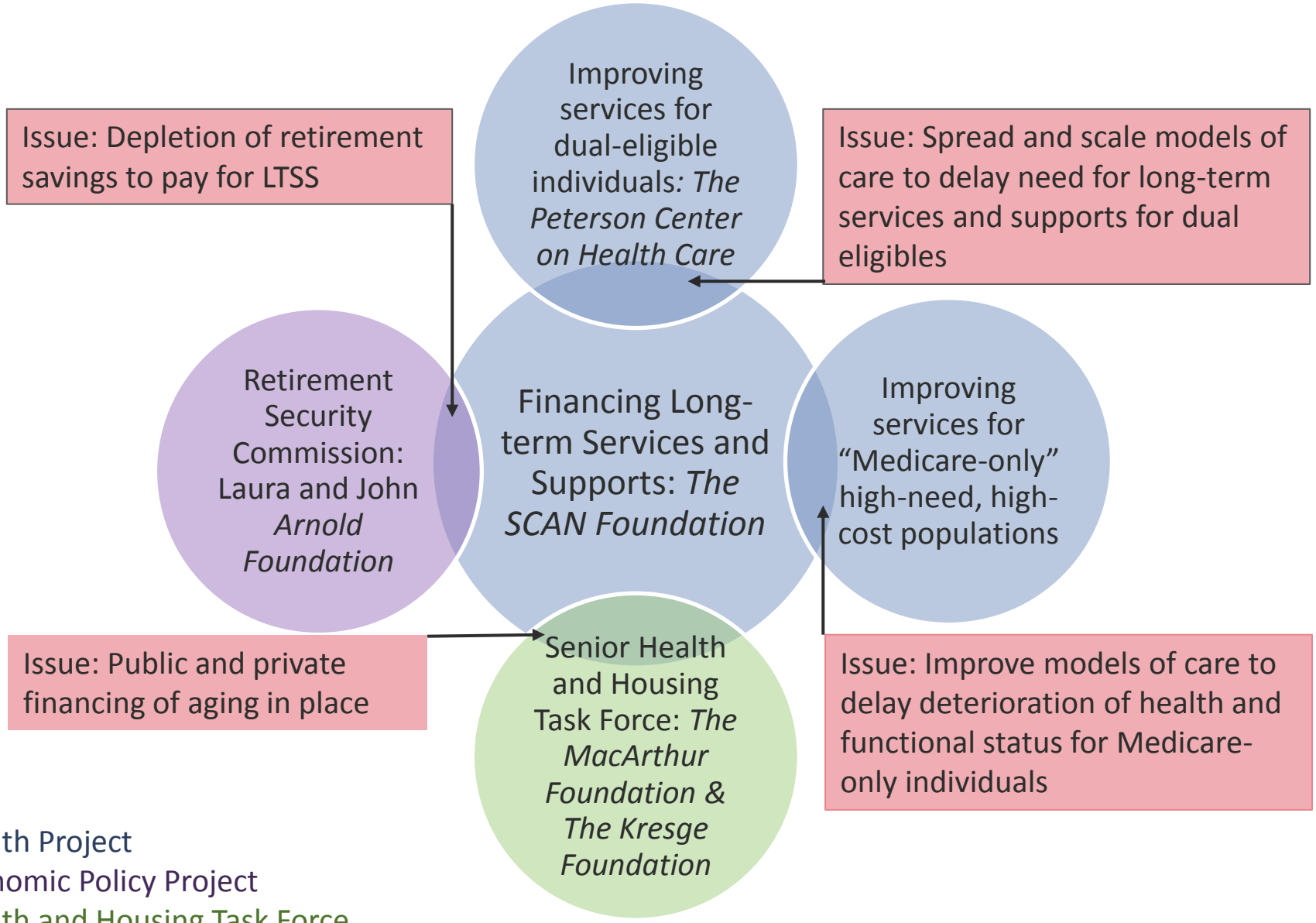
For more information see: www.bipartisanpolicy.org

HEALTH PROJECT – LONG-TERM CARE INITIATIVE

- Leaders:
- Former Senator Tom Daschle (D-SD)
- Former Senator Bill Frist (R-TN)
- Former CBO Director Alice Rivlin

- Former Governor and HHS Secretary Tommy Thompson

BPC Projects to Improve Care for Older Americans



Health Project
Economic Policy Project
Health and Housing Task Force

BPC'S ROLE IN COLLABORATION

Drawing from findings of Harvard School of Public Health, National Academy of Medicine, research and stakeholder engagement BPC will:

- Identify legal and policy barriers to spread and scale of successful models in treating high-need, high-cost individuals
- Identify initial policy recommendations to address barriers and assure that reimbursement and coverage models are aligned to permit scale and spread of models
- Work with modelers to estimate the federal fiscal impact of policy recommendations
- Filter recommendations for political and fiscal viability
- Issue recommendations to mitigate or eliminate barriers

INITIAL FINDINGS

- High-need, high-cost dual-eligible individuals typically have needs that require additional services and supports, including services such as care management, patient assessment, development of individual care plans with patient and caregiver support, home visits, team-based care and other services and supports identified by our last panel.

- Socio-economic factors affect health and functional status.

- Services to help mitigate socio-economic factors are typically not covered under Medicare fee-for-service, and Medicaid coverage varies significantly from state-to-state.

- One of the principle barriers to spread and scale of successful models is financial sustainability over time.

INITIAL FINDINGS (CONT.)

- Combining Medicare and Medicaid financing through integrated care models has the potential to permit providers to expand the scope of services available to dual-eligibles and begin to address socio-economic factors.

- Given the dual funding sources, integrated programs may be more financially sustainable if problems in current structures are addressed.

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- In the near-term, the federal government and the states have little appetite for covering additional benefits in Medicare or Medicaid fee-for-service.

- Alternative models operating within a "spending target" can provide opportunities to better coordinate care and offer services to address socio-economic factors. (Examples: D-SNPs, ACOs, certain-PCMH models, PACE, and MMPs operating under CMMI authority.)

INTEGRATION OF MEDICARE AND MEDICAID SERVICES

Integrated care models for the purposes of this discussion include:

- Special Needs Plans (SNPs)
- The Program of All-Inclusive Care for the Elderly (PACE); and
- Demonstration programs operated through the Center for Medicare and Medicaid Innovation (CMMI) in partnership with the Medicare-Medicaid Coordination Office or "duals office." The most prominent program is the financial alignment initiative, which includes both fully capitated plans, or Medicare-Medicaid plans (MMPs), and managed fee-for-service.

Are there other models we should consider?

BASIC LEGAL RESEARCH QUESTIONS

- Do plans and providers serving dual-eligibles through integrated care programs have sufficient authority to spend Medicare dollars on Medicaid-covered services, or other services not covered by Medicare or Medicaid?

- How do these models vary in terms of spending flexibility and the targeting of services to high-need, high cost individuals?

- How are payments to integrated care models determined?
  - SNPs
  - PACE
  - MMPs
  - Certain PCMHs operating through the Comprehensive Primary Care Initiative demonstration – Arkansas Payment Improvement Initiative

FINANCIAL ALIGNMENT DEMONSTRATION

- If participants in the financial alignment initiative have flexibility in spending Medicare and Medicaid funds, why are providers and plans hesitant to use this authority?
  - Do other Medicare reporting requirements limit that authority?
  - Do anti-fraud and abuse laws discourage providers from providing and billing for services?
  - Do practice patterns or plan reimbursement policies inhibit the provision of non-traditional items or services? Example: Vacuum cleaner for person with asthma or pest abatement when discovered during a home visit.

- Should the federal government develop a uniform definition of services covered under Medicare and Medicaid?

- To what extent has the financial alignment demonstration resolved barriers such as alignment of grievance and appeals process, particularly for services covered by both programs?

FINANCIAL ALIGNMENT DEMONSTRATION (CONT.)

- Are incentives for state participation sufficient? (Examples: shared savings, waiver authority, enhanced match rates). If not, what changes are necessary?

- Is the calculation of the per capita Medicaid payment to plans sufficient to permit long-term financial sustainability? Since the rate is based on prior year spending for dual eligibles under Medicaid, it does not take into account unmet need, such as services for persons with mental illness who did not receive services~~?~~.

- Are the "guaranteed savings" requirements, which reduce per capita rates by set percentages each year, sustainable? Would budget neutrality over 5 years with savings in year 6 be more realistic?

- Given the requirements for savings under the CMMI demonstration authority, should integrated care demonstrations be operated under new demonstration authority?

GENERAL QUESTIONS

- Does operating authority for integrated programs belong in the Center for Medicare Operations? Does the center have sufficient incentive to design models that give equal weight to the two programs?

- Should the duals office be strengthened and given operational authority for integrated care models?

- In addition to Medicare and Medicaid covered services, can services offered by community-based organizations (CBOs) help address socio-economic factors affecting health status? Examples include meals for older adults, patient self-management training, housing-related services and other services that may or may not be covered under Medicaid in all states?

- If so, do CBOs have the business acumen to contract with plans and providers to offer services, and how can this be addressed? Examples include the ability to price services, determine capacity, and negotiate contracts.

GENERAL QUESTIONS

- Under what circumstances, if any, should integrated plans and providers be required to demonstrate that they cover and refer patients for community-based services?

- Rather than or in addition to trying to amend a patchwork of existing rules to permit integration, should we instead be considering a reformed regulatory structure?

- If so, what are the essential components of a regulatory structure that is designed the regulatory structure? (i.e., eligibility, enrollment, program administration, covered services, quality measures, calculating Medicare-Medicaid rates, etc.)

- What other questions should we consider?

PROJECT STATUS

- Compiling research findings and analyzing stakeholder responses to identify legal and policy barriers to integration of care. Stakeholders include health plans, providers, state, and consumer representatives.

- Developing a preliminary list of policy options to address barriers.

- Vetting policy options with stakeholders.

- BPC's Health Project welcomes further input, contact khayes@bipartisanpolicy.org.