Geographic Availability of Integrated Care Models for Dually Eligible Beneficiaries

Medicaid and CHIP Payment and Access Commission

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Overview

• Recent MACPAC work
• What we mean by integrated care
• Review of integrated care models
• Overview of maps: Analysis of geographic availability
• Key takeaways
Recent MACPAC Work

- Panel on federal and state integration efforts
- Panel on beneficiary, provider, and health plan perspectives
- Staff presentation on barriers to integrated care
- Work in last report cycle on:
  - Factors associated with enrollment in the Financial Alignment Initiative (FAI)
  - Evaluations of integrated care models
  - Care coordination standards
Work Ahead

• Chapter(s) for June report
• Specific recommendation language
• Rationale to support recommendations
• Discussion of other policy issues (potential recommendations for subsequent reports)
• Contextual information
What is Integrated Care?

• Designed to align the delivery, payment, and administration of Medicare and Medicaid services

• Can improve care for dually eligible beneficiaries and reduce spending arising from duplication of services or poor care coordination

• Promoting integrated care means:
  – increasing enrollment, and
  – making care as close to fully integrated as possible by coordinating primary and specialty acute care, behavioral health services, and long-term services and supports
Integrated Care Models

• CMS and states have adopted different models to achieve integration.
  – Medicare-Medicaid plans (MMPs) under the FAI
  – Medicare Advantage dual eligible special needs plans (D-SNPs) combined with managed long-term services and supports (MLTSS), including fully integrated dual eligible special needs plans (FIDE-SNPs)
  – Managed fee for service
  – Program of All-Inclusive Care for the Elderly (PACE)
Variation in Availability of Integrated Care Models

- Offerings vary for several reasons including state experience, population density, political considerations, and state capacity.
- Discussions of integrated care often focus on variation in adoption across states.
  - This can overlook geographic variation in the availability of these models within states.
Count of Dually Eligible Beneficiaries by County, December 2018

Note: These numbers represent counts of dually eligible beneficiaries enrolled in a given month. These point-in-time snapshots of enrollment are inherently lower than ever-enrolled numbers which include individuals enrolled at any time during the calendar year.

Source: MACPAC, 2020, analysis of CMS Quarterly Enrollment Snapshots by County as of December 2018.

January 23, 2020
Note: One state, Minnesota, is operating a demonstration outside the capitated or managed FFS models and is focused on administrative alignment. Because Minnesota's demonstration is not designed to result in any new enrollment, it is not included here.

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Note: The MLTSS program in North Carolina is not included because it currently only includes certain services for individuals with intellectual or developmental disabilities. Map does not include Ohio and South Carolina which only operate MLTSS through the FAI.


January 23, 2020
Availability of D-SNPs by County, 2020

Source: MACPAC, 2020, analysis of Medicare Advantage special needs plan landscape file for calendar year 2020.
January 23, 2020
Notes: The MLTSS program in North Carolina is not included because it currently only covers certain services for individuals with intellectual or developmental disabilities. Map does not include Ohio and South Carolina which only operate MLTSS through the FAI.


January 23, 2020
Key Takeaways

• Best opportunities to integrate care currently where MLTSS and D-SNPs are both available or active FAI model

• Even in states that have implemented integrated care programs, they may not be available statewide

• States may need to pursue a combination of approaches for more dually eligible beneficiaries to have access to an integrated care option
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