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Selectively Contracting with D-SNPs to Promote Alignment with Medicaid Managed Care Plans

February 23, 2023

2:00-3:00 pm Eastern Time

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica and the Center for Health Care Strategies.

Logistics

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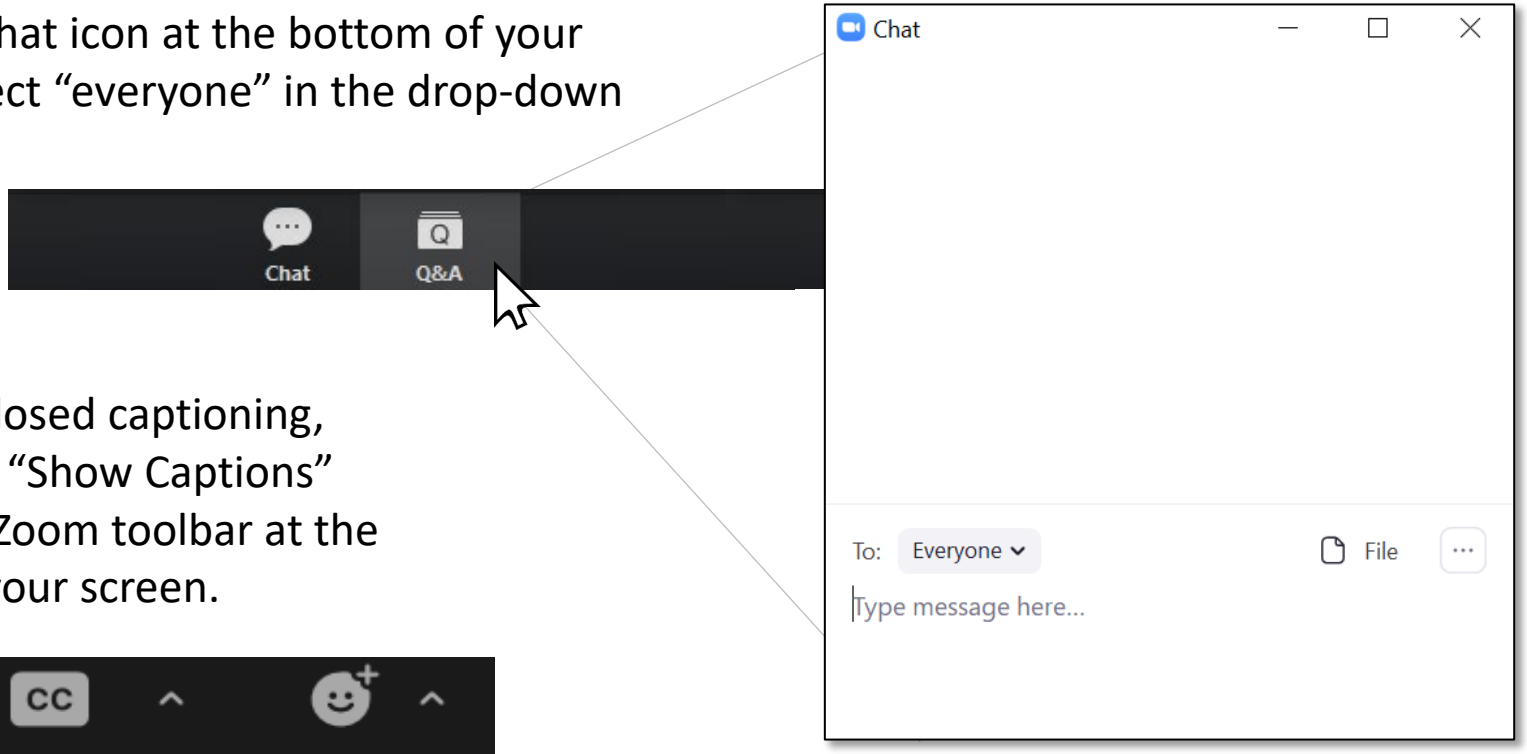

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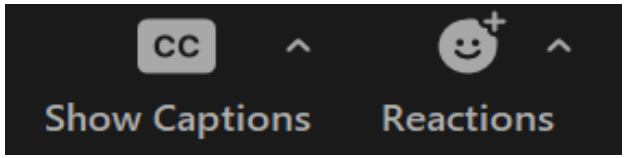

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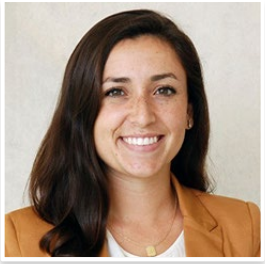
Agenda

- Refresher: What are Dual-Eligible Special Needs Plans (D-SNPs)?
- What is Selective Contracting?
- Benefits of Selective Contracting with D-SNPs to Promote Alignment with Medicaid Managed Care (MMC) Plans
- Additional Considerations
- State Examples
- Key Steps in Implementing Selective Contracting
- Q & A

Presenters



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What are Dual Eligible Special Needs Plans (D-SNPs)?

What are D-SNPs?

- D-SNPs are Medicare Advantage plans that **only enroll dually eligible individuals.**
- All D-SNPs must:
  - At least **"coordinate" Medicaid benefits** for their members;
  - Have a **Model of Care** that describes how the D-SNP will meet the needs of the dually eligible population being served; and
  - Have contract-level **enrollee advisory committees** that solicit input on ways to improve access to covered services, coordination of services, and health equity among underserved populations.

State Contracting with D-SNPs

- In addition to contracts with CMS, D-SNPs must have a **State Medicaid Agency Contract** (SMAC) with each state in which they operate.

- State contracts with D-SNPs must include **minimum contract elements**, but states may include additional requirements to improve administrative, clinical, and financial integration for enrollees.

- States are **not required to contract with D-SNPs**, and states have the authority to deny contracts to potential D-SNPs.

Levels of Integration of D-SNPs

Coordination-Only D-SNPs

- Must meet minimum CMS requirements for D-SNPs.
- Must notify the state Medicaid agency or its designee of hospital and skilled nursing facility admissions for at least one designated group of "high-risk," full-benefit dually eligible (FBDE) enrollees.

Highly Integrated D-SNPs

- Must cover Medicaid behavioral health benefits, long-term services and supports (LTSS), or both.
- Contract for coverage of Medicaid benefits may be with the D-SNP, the D-SNP's parent company, or another entity owned and controlled by the D-SNP's parent company.
- In 2025, a HIDE SNP's capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP.

Fully Integrated D-SNPs

- Must cover Medicaid primary and acute care services and LTSS, including at least 180 days of nursing facility coverage.
- Must use specialized care management and network methods to coordinate care for high-risk beneficiaries
- Entity contracted to cover Medicaid benefits must be the same legal entity that holds the D-SNP contract with CMS
- In 2025, must operate with exclusively aligned enrollment and cover additional Medicaid benefits. FIDE SNP's capitated contract with the state Medicaid agency must also cover the entire service area of the D-SNP.

For more information, see Weir Lakhmani, E. "Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025." Integrated Care Resource Center. December 2022. Available at: https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023

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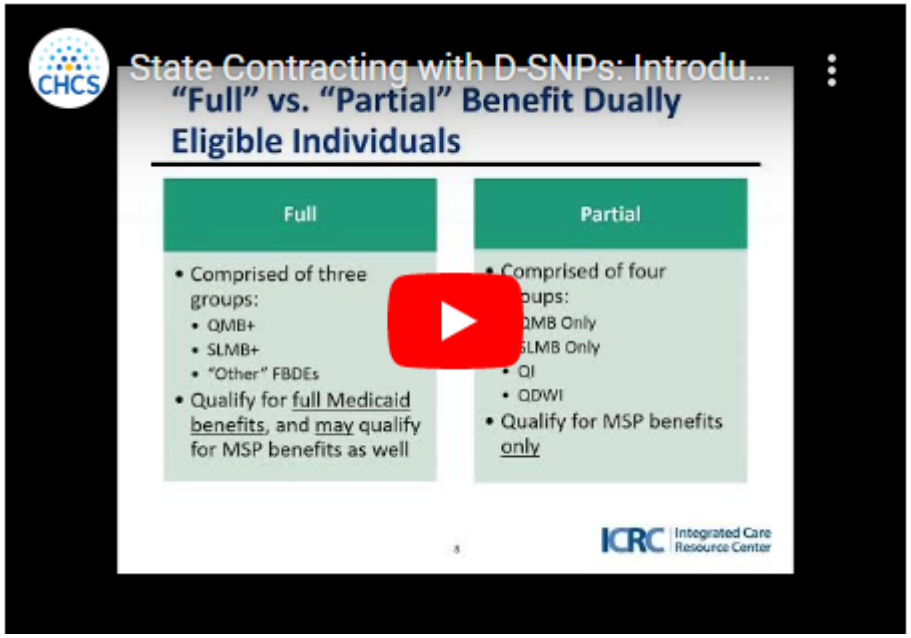
More Information on D-SNPs

For more information about D-SNPs and ways that states can leverage contracts with D-SNPs to better coordinate / integrate benefits for dually eligible individuals please see ICRC's December 2022 Working with Medicare webinar on D-SNP Contracting Basics.



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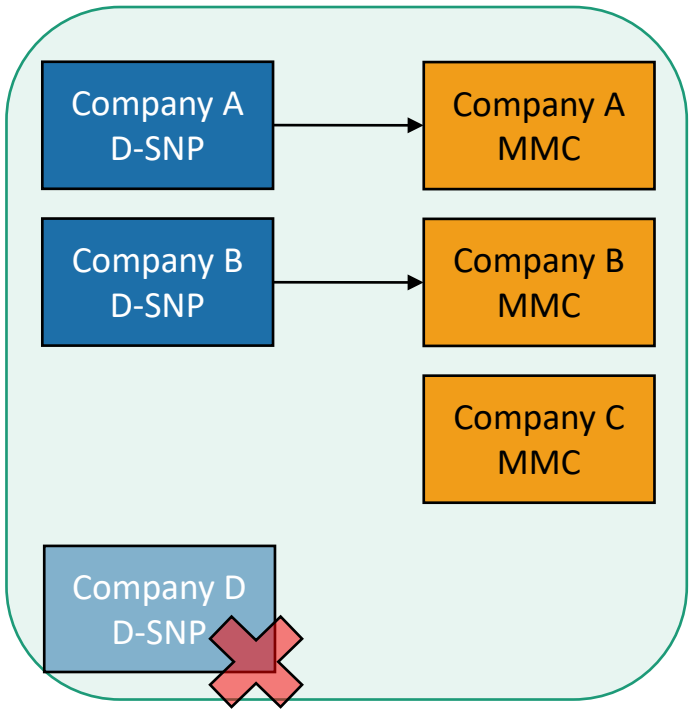
What is Selective Contracting?

What is Selective Contracting?

- Selective contracting is when a state chooses to **only contract with certain D-SNPs.**
- **Selective contracting enables states to:**
  - Limit the number of D-SNPs operating in the state;
  - Only contract with D-SNPs that meet certain criteria (for example, thresholds for certain quality/performance measures); and/or
  - **Align D-SNP parent companies with Medicaid Managed Care (MMC) parent companies to promote opportunity for aligned enrollment (focus of today's discussion).**
- **Starting in 2025:** To qualify as a FIDE SNP or HIDE SNP, a D-SNP will have to have an affiliated Medicaid Managed Care plan that covers the entire service area as the D-SNP.

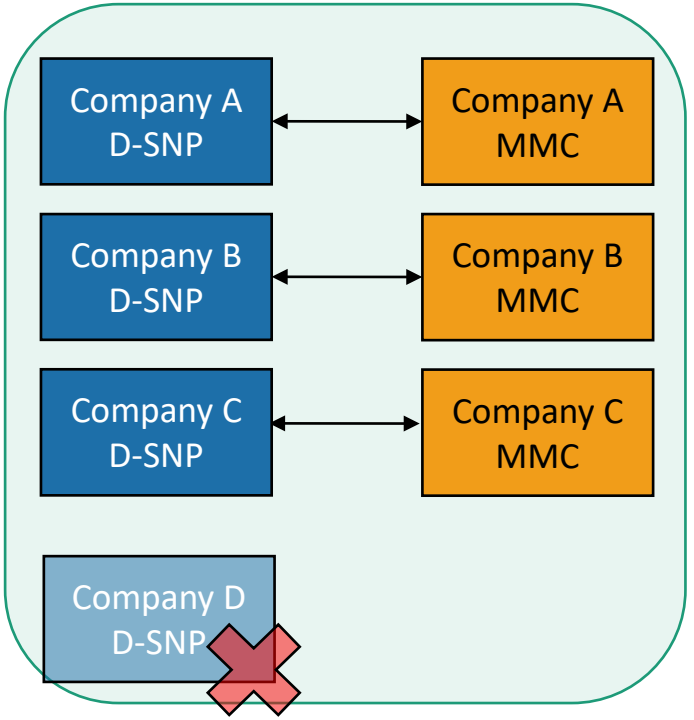
State Options for Selective Contracting with D-SNPs to Promote Alignment with Medicaid Managed Care (MMC) Plans

Example 1



In Example 1, all D-SNPs are required to have an affiliated MMC plan, but MMC plans are not required to have an affiliated D-SNP.

Example 2



In Example 2, all D-SNPs are required to have affiliated MMC plans, and vice versa.

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Building Blocks of Selective Contracting with D-SNPs to Promote Alignment with MMC Plans

Core Building Blocks

A MMC program that **enrolls Full-Benefit Dually Eligible (FBDE) individuals** and appropriate federal Medicaid **managed care authority**

Contracts with D-SNPs or be considering contracting with D-SNPs

Other Initial Considerations

Selective contracting may achieve greater results if **a state carves behavioral health benefits and/or long-term services and supports** in to existing or planned MMC contracts

If MMC program and D-SNP contracts already exist, **do parent companies** offering MMC plans offer D-SNPs?

Is there potential over time for contract and **service area alignment** between D-SNPs and MMC plans?

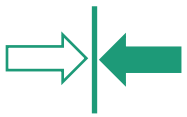
Benefits of Selective Contracting with D-SNPs to Promote Alignment with MMC Plans

Benefits of Selective Contracting

- Streamlines **state oversight** and contract management by limiting the number of plans/parent companies operating within the state.

- **Simplifies plan comparison** and enrollment choices for dually eligible individuals.

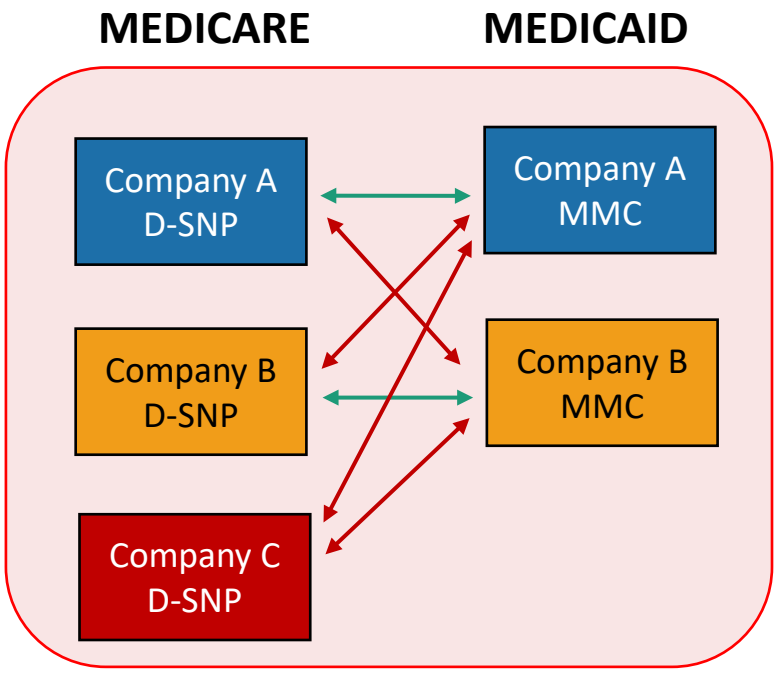
- Encourages **MMC participation** by only contracting with D-SNPs that also offer MMC plans



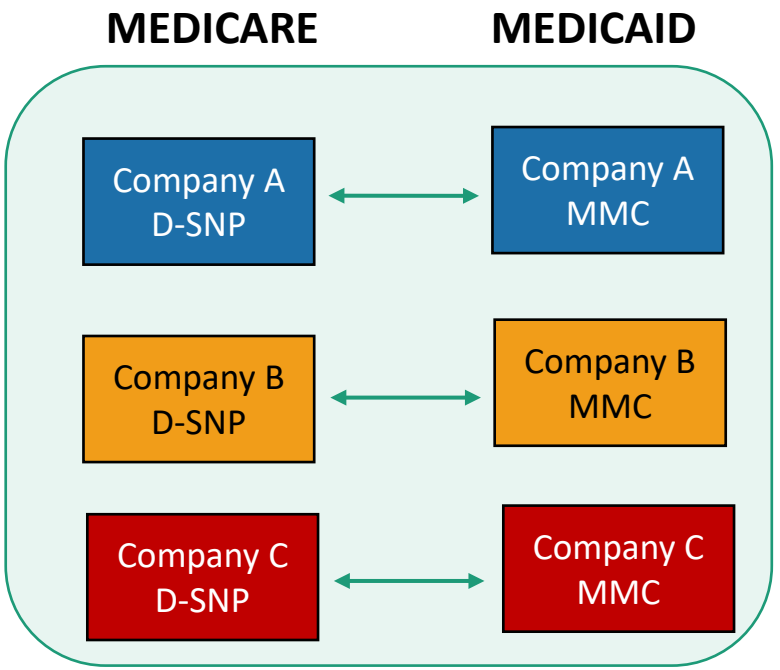
- Enables **aligned enrollment** between Medicare and Medicaid plans.

What is Aligned Enrollment?

Aligned Enrollment occurs when a beneficiary is enrolled in a D-SNP and MMC plan offered by the **same parent company** in the same geographic area.



Aligned and Unaligned Enrollees



All Aligned Enrollees

For more information, see: E. Weir Lakhmani and A. Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." ICRC, April 2018. Available at: https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf

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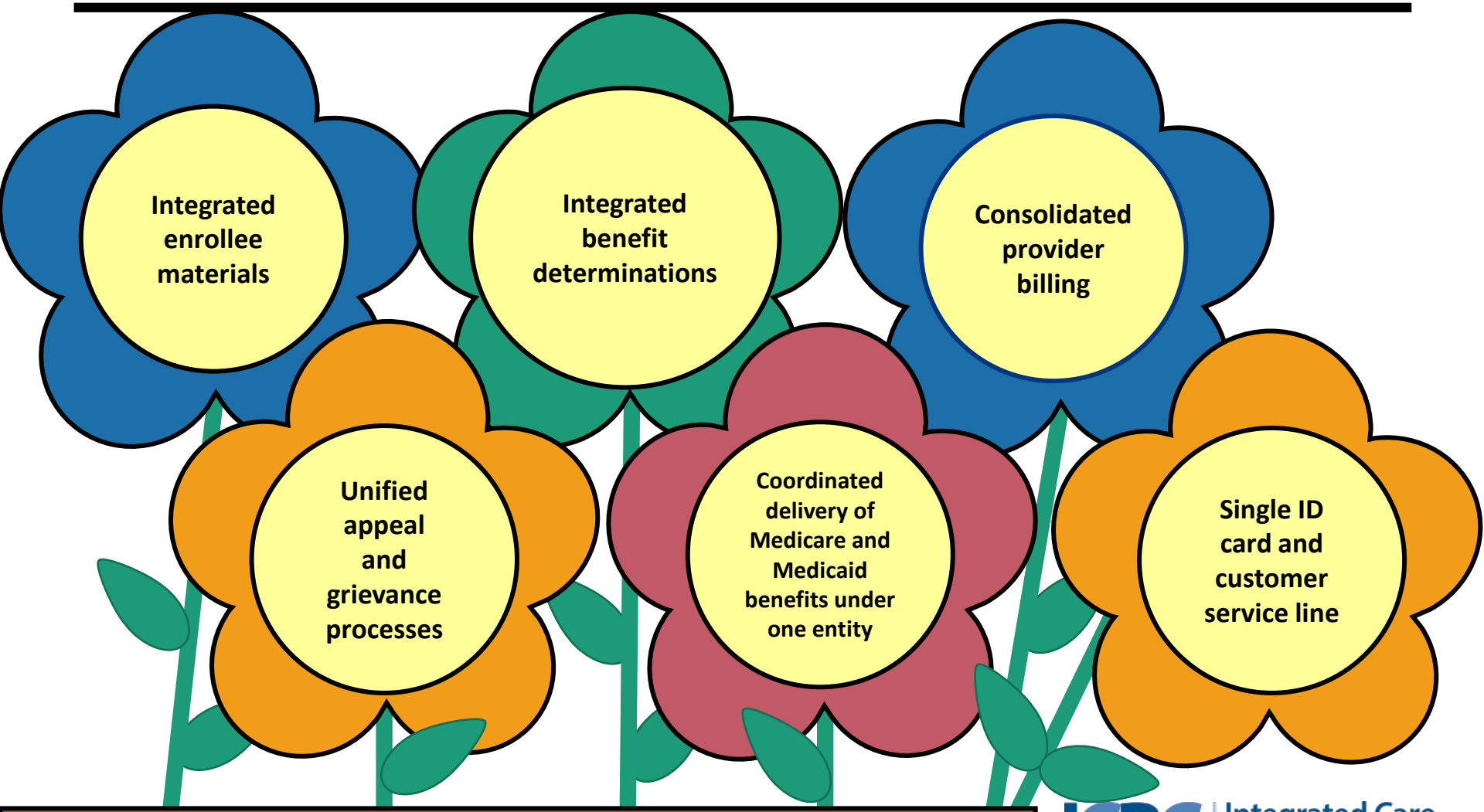
What is Exclusively Aligned Enrollment?

Exclusively aligned enrollment occurs when the state contract **limits enrollment** in the D-SNP to FBDE individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid Managed Care plan offered by the **same parent company** as the D-SNP.

For more information, see: the ICRC webinar "Exclusively Aligned Enrollment 101: Considerations for States Interested in Leveraging D-SNPs to Integrate Medicare and Medicaid Benefits," May 2022. Available at: https://www.integratedcareresourcecenter.com/webinar/exclusively-aligned-enrollment-101-considerations-states-interested-leveraging-d-snps

Opportunities That Stem From Exclusively Aligned Enrollment



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Selective Contracting Enables Other Strategies to Promote Aligned Enrollment

- **Medicaid managed care auto-assignment:** When a state automatically enrolls a new D-SNP enrollee into the affiliated MMC plan.
- **Default enrollment:** When a D-SNP automatically enrolls a MMC plan enrollee into the affiliated D-SNP when the person first becomes Medicare-eligible.*

Default Enrollment Resources:

- ICRC fact sheet, "Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries" (updated May 2019): https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries
- ICRC webinar, "Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment" (July 2018): https://www.integratedcareresourcecenter.com/webinar/aligning-coverage-dually-eligible-beneficiaries-using-default-and-passive-enrollment

* Individual may opt out of D-SNP and receive Medicare benefits via fee-for-service Medicare, a different D-SNP, or another Medicare Advantage plan.

Additional Considerations

Current D-SNP/MMC Marketplace and State Context

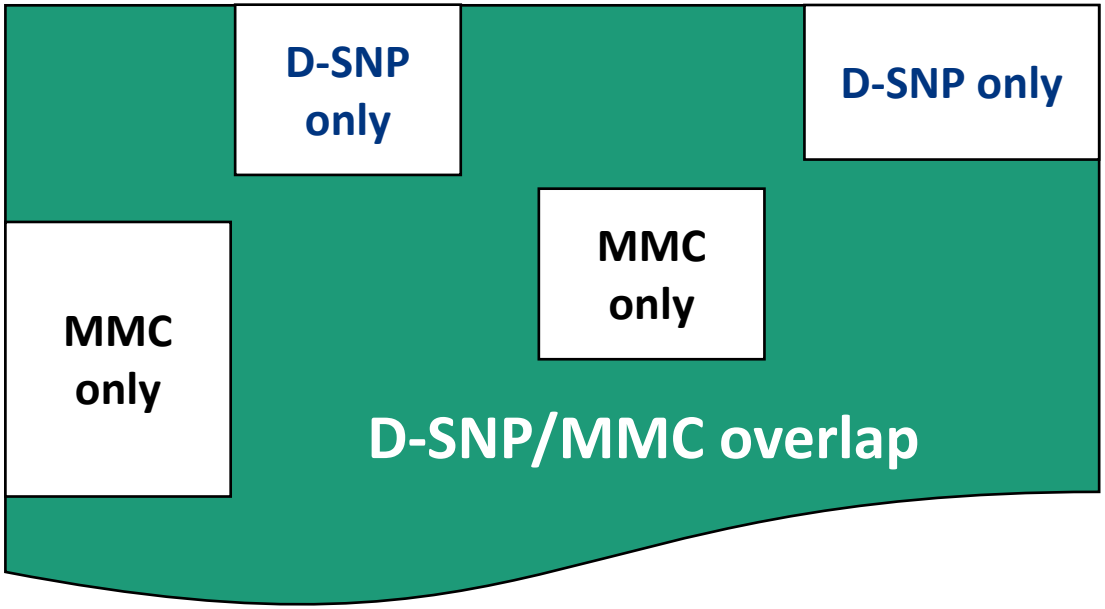
- **States with existing D-SNPs and MMC plans with misalignment between D-SNP and MMC parent companies**:
  - Choosing to no longer contract with D-SNPs that do not operate affiliated MMC plans can cause short-term enrollment disruptions for enrollees in the terminating D-SNPs.
    - In the long run, however, having only aligned D-SNPs can lead to better care coordination and a better experience of care for enrollees.
  - **Other contextual factors:** current D-SNP enrollment, state relationship(s) and communications with existing D-SNPs and/or MMC plans and understanding of the plan(s) existing operations and the plan(s) experience with integrated care and delivery of particular benefits of interest, such as behavioral health or LTSS (within the state or in other states)

- Options for an incremental approach:
  - Do not allow new FBDE individual enrollment in non-affiliated D-SNPs.
  - Do not contract with any new D-SNPs without affiliated MMC plans.

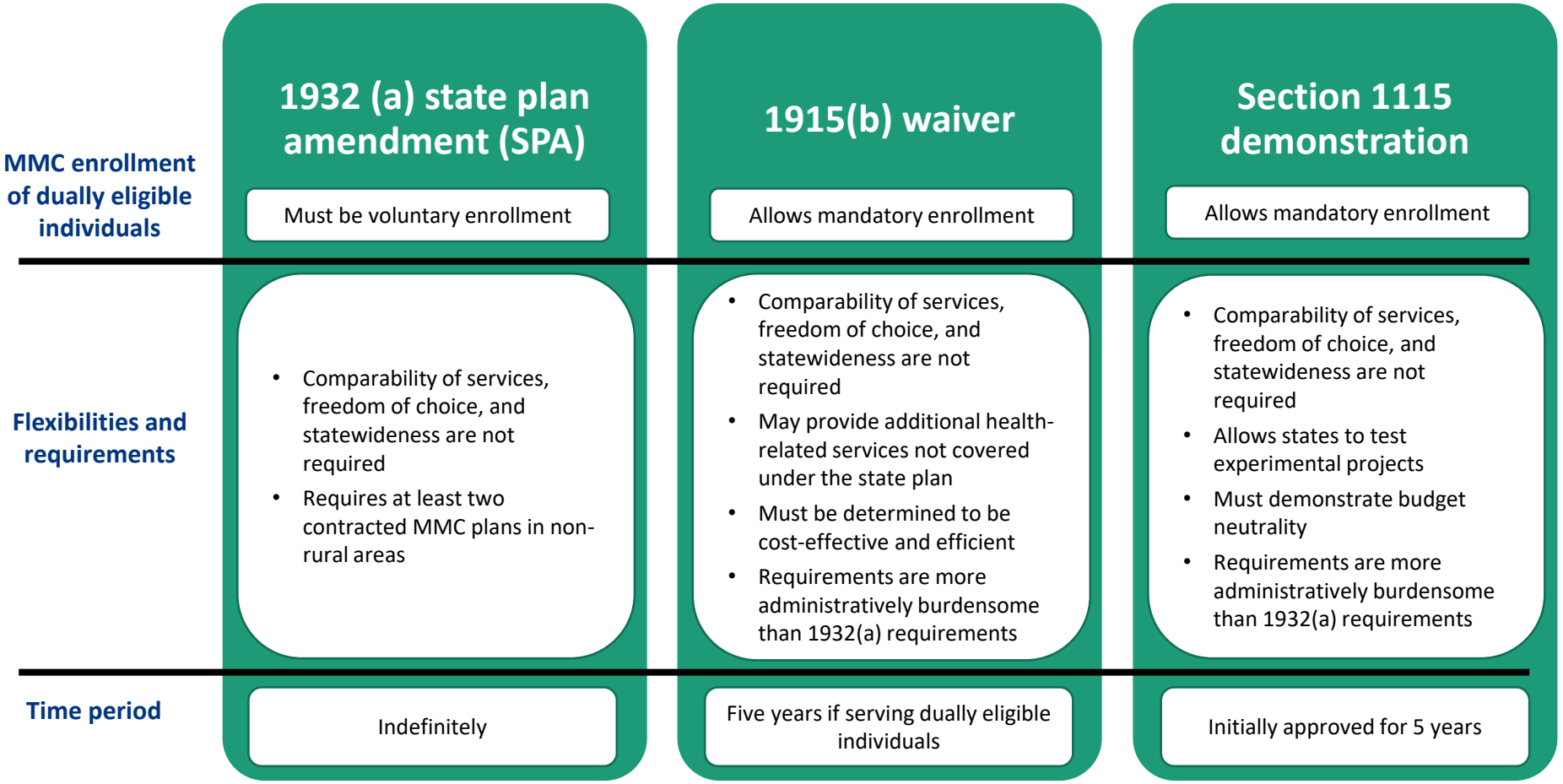
- **States *without* D-SNPs and/or MMC plans**: Can be easier to selectively contract when there are no D-SNPs and/or MMC plans already in operation, since there is less potential for market disruption.

Potential Service Area Gaps

- Consider **potential service area gaps** when designing selective contracting requirements to ensure that D-SNPs and MMC plans will operate in all of the same service areas.
- **Different provider network adequacy** rules between Medicare and Medicaid can sometimes make it difficult to offer aligned enrollment in rural areas.



Federal Authorities States Can Use for Selective Contracting with MMC Plans



Cannot use 1915(a) waiver authority*

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Source: CMS Medicaid Managed Care Authorities, available at: https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html

Timing Considerations

- Medicaid **procurement cycles** and Medicare contracting cycles may differ.

- MMC contract award and **implementation delays due to plan protests of award results** may push back intended timelines for alignment of D-SNPs and MMC plans.

- Some Medicaid RFPs allow D-SNPs to **begin operation within a certain time period** after affiliated MMC plans begin operating

Challenges with Selective Contracting with D-SNPs to Promote Alignment with MMC Plans

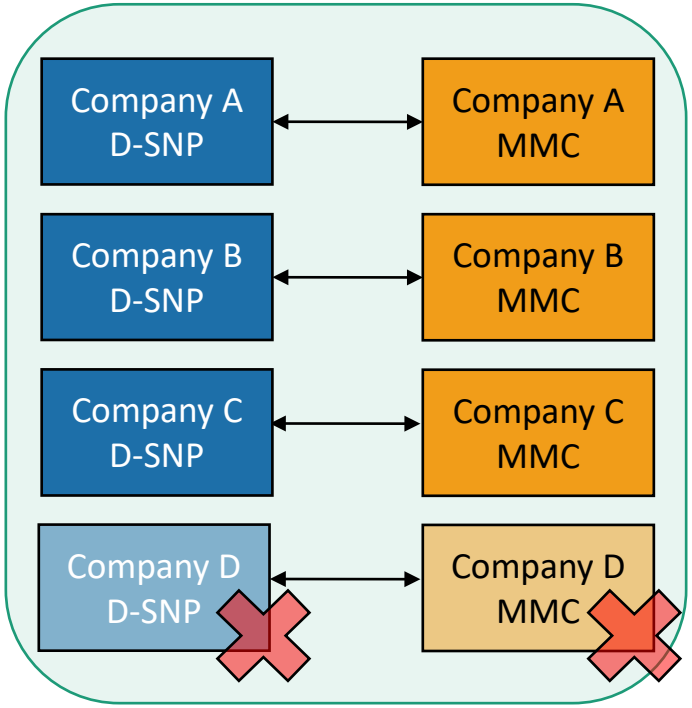
- **Limits D-SNP options** in the state to only the companies that operate MMC plans. Existing D-SNPs in the state that do not or cannot operate MMC plans may resist.

- May **exclude higher-quality D-SNPs** from operating in a state if they do not have, or do not want to operate, an affiliated MMC plan.

- May be **difficult for smaller or local MMC plans** to launch a D-SNP.
  - If a state requires all MMC plans to offer a D-SNP, it could exclude smaller/local plans from the marketplace.
  - States could allow smaller/local MMC plans to operate without a D-SNP, but enrollees in those plans would not have the potential for aligned enrollment.
  - States can help small MMC plans launch a D-SNP and encourage enrollment by allowing/encouraging default enrollment, limiting competition in the plan's service areas, and/or allowing them to operate in more limited-service areas than larger plans (for example, if the state intends to require other D-SNPs to operate statewide).

MMC Re-Procurement Loss

- If a MMC plan **loses a re-procurement**, the affiliated D-SNP **can no longer operate** either; this can lead to **disruption for current enrollees.**
  - Enrollees in those exiting D-SNPs would need to **switch** D-SNPs, enroll in a regular Medicare Advantage plan, or enroll in fee-for-service Medicare.
    - If the circumstances meet the requirements at 42 CFR 422.60(g)(2) and approved by CMS, enrollees may be **passively enrolled** into another integrated D-SNP.
  - Parent companies of exiting D-SNPs may decide to operate **a regular Medicare Advantage plan** instead that FBDE enrollees may join (potentially undermining integration).
  - States may wish to consider including **provisions in MMC and D-SNP contracts** that address the potential for future disruptions of this sort.

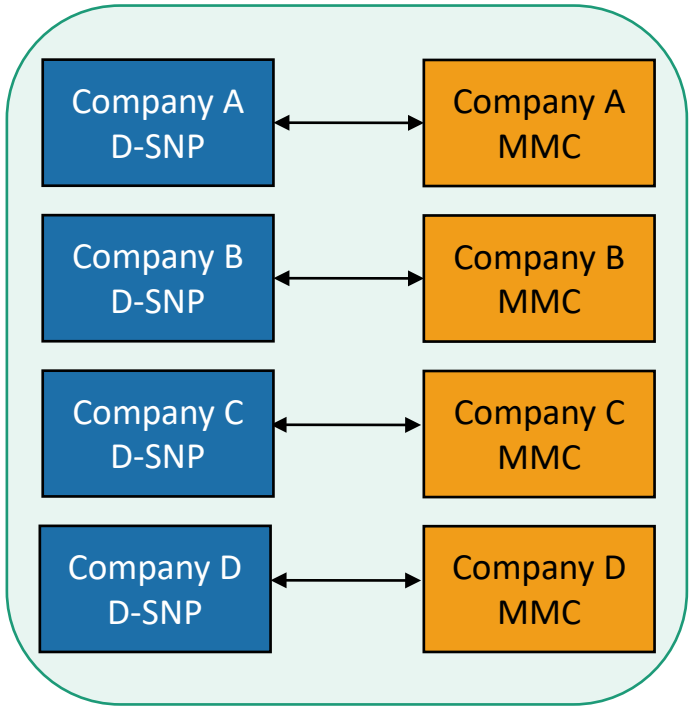


State Examples

Arizona's Approach: D-SNPs must have Affiliated MMC plans (and vice versa)

Relevant D-SNP contract language:

"AHCCCS shall execute an Agreement only when a (Medicare Advantage Organization) ***holds a companion AHCCCS program contract*** *that covers the requested county(ies) and AHCCCS population(s)."*

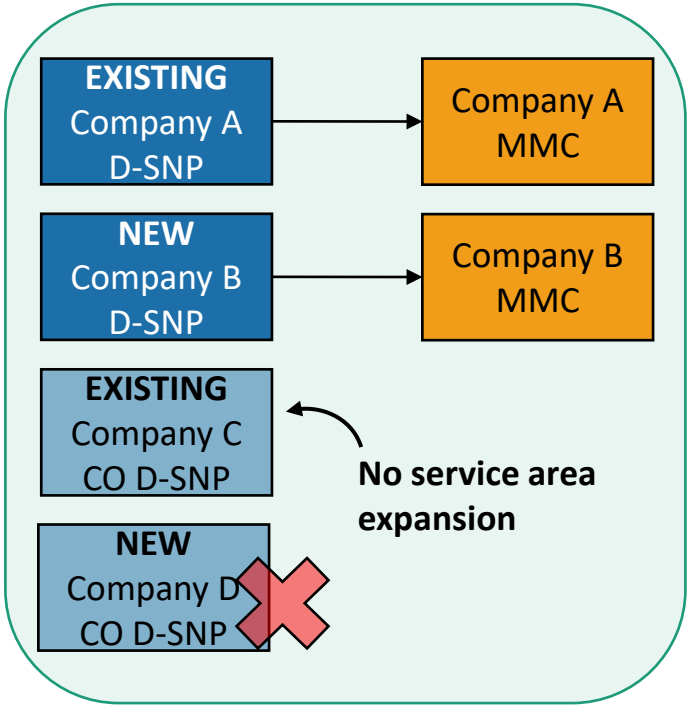


- MMC plan contracts also require MMC plans to operate a D-SNP.

Source: Arizona Medicare Advantage Organization Agreement, pg. 1 ,available at: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html;

New York's Approach: D-SNPs Must Operate an Integrated MMC Plan & Limits on Current CO D-SNPs

- Requires new D-SNPs to offer affiliated Medicaid plans by 2024.
- Not accepting new CO D-SNP applications in 2023 or later.
- Not allowing existing CO D-SNPs to expand their service areas.



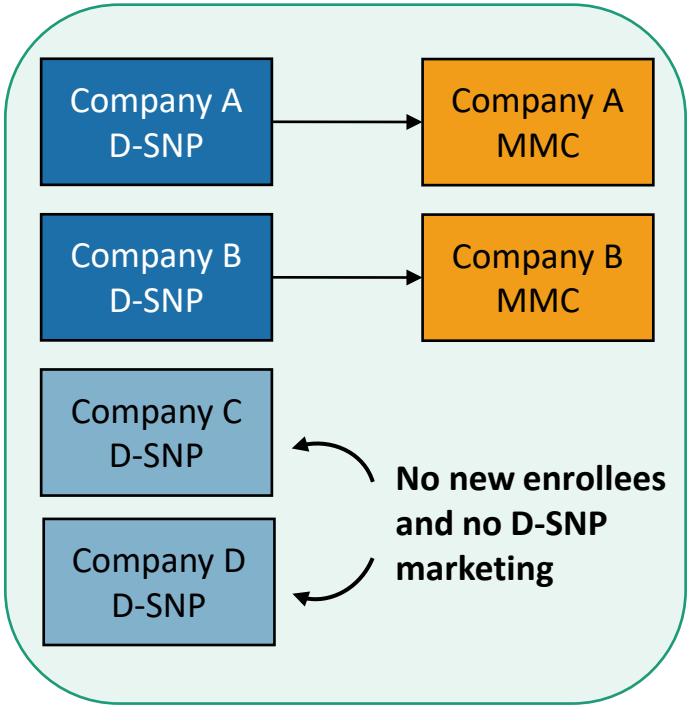
Source: New York State Medicaid Agency Contract, sections I. N and II.H. available at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2023/docs/cy2023_state_med_agency_cont.pdf

California's Approach: Limits on D-SNPs without Affiliated MMC Plans

- Prohibits D-SNPs without affiliated MMC plans from:
  - **enrolling new individuals** or
  - **marketing to prospective enrollees**.

Relevant Contract Language:

*"If D-SNP… is not affiliated with a Medi-Cal (Managed Care Plan) or a Subcontracted Delegate Health Plan…, **new enrollment is closed** in CY 2023 for that county, and D-SNP Contractor shall **not conduct any marketing** related to its D-SNP in that county."*



Source California D-SNP contract, Exhibit A, Attachment 1, Section 4.D. (not available online)

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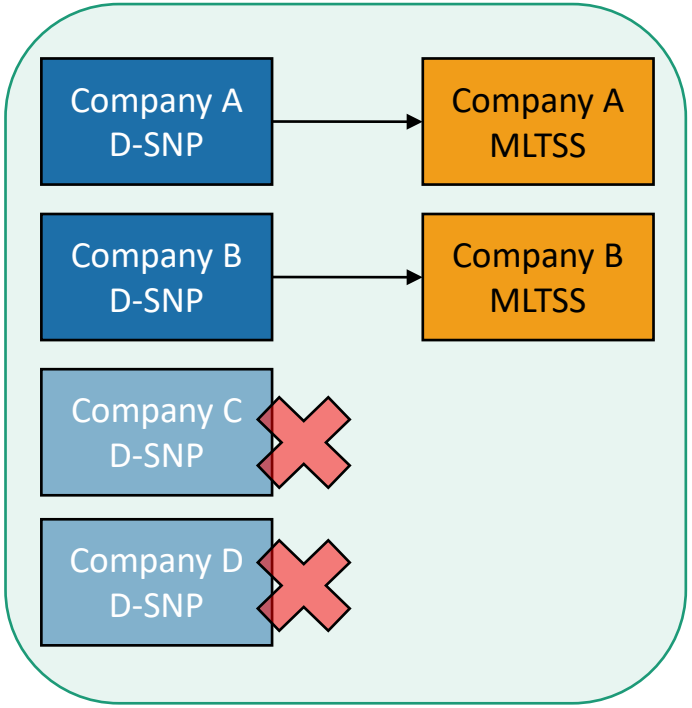
Indiana's Approach: Notification of Potential Selective Contracting in the Future

- Notifies its D-SNPs that the state may choose to only contract with D-SNPs that operate an affiliated MMC plan.

Relevant Contract Language:

*"The state may ultimately **choose to limit D-SNP marketplace participation** with an expectation that only contractors with the same parent company as a Medicaid Managed Care Entity (MCE) that is awarded an MLTSS contract would continue to operate in the state post-MLTSS implementation. The state views this potential requirement as the best way to ensure sufficient and sustainable alignment and integration between Medicaid and Medicare in a MLTSS system into the future."*

If implemented as planned:



MLTSS: Managed long-term services and supports

Source: Indiana Professional Services Contract, Exhibit 1, Section 1.E, available at: https://www.in.gov/medicaid/partners/files/IN-SMAC-2022.pdf

Key Steps in Implementing Selective Contracting

Early Planning Phase

- Consider **meeting with the CMS Medicare-Medicaid Coordination Office (MMCO) and ICRC** to discuss the state's selective contracting options. For example:
  - Selectively contracting with D-SNPs,
  - Selectively contracting with MMC plans,
  - Considerations when planning selective contracting, and
  - State readiness for implementing selective contracting.
- To request a technical assistance call with MMCO and ICRC, contact ICRC at integratedcareresourcecenter@chcs.org.

Early Planning Phase, *Continued*

- Examine the state's **current D-SNP and MMC landscape** to assess readiness for selective contracting. For example:
  - Identify the types of D-SNPs and MMC plans already operating and the parent companies responsible for those plans.
  - Confirm that the state enrolls FBDE individuals in MMC.
  - Determine how many dually eligible D-SNP enrollees are already enrolled in an MMC plan through the same parent company.
  - Confirm that the state has the federal MMC authority(ies) needed to implement selective contracting with MMC plans, if applicable.
  - Identify the benefits that are (or will be) carved in or out of the relevant MMC program, such as behavioral health and LTSS.

ICRC can help state Medicaid agencies analyze your D-SNP and MMC landscape – to request assistance, email integratedcareresourcecenter@chcs.org

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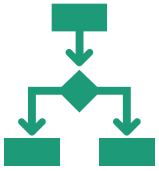
Early Planning Phase, *Continued*

- **Engage internal and external entities with interest in the new or existing integrated care program** to discuss and elicit feedback on the state's selective contracting plans
  - Examples of interested "internal" state entities may include the governor's office, state budget office, key divisions within the state Medicaid agency, other state agencies, and/or legislators.
  - Examples of interested "external" entities may include health plans, providers, beneficiaries, and beneficiary advocacy groups or community-based organizations that serve dually eligible populations.



- **Make high-level decisions** regarding the state's selective contracting goals and structure. For example:
  - Does the state plan to selectively contract with D-SNPs only, or with D-SNPs *and* MMC plans?
  - What federal authority (e.g., an 1115 demonstration) does the state plan to use to selectively contract with MMC plans, if applicable?

Planning Phase

- Select and work with CMS to implement an **appropriate MMC authority** for selectively contracting with MMC plans. As noted previously, federal MMC authorities that allow for selective contracting include:
  - 1115 demonstration,
  - 1932(a) state plan amendment, or
  - 1915(b) waiver.

- Develop reasonable **timelines** for achieving the state's selective contracting goals, considering:
  - MMC contracting and implementation start dates,
  - D-SNP contracting cycles,
  - Plan readiness to offer affiliated plans, and
  - State staff capacity to design and oversee the process.

Planning Phase, *Continued*

- Include **future selective contracting expectations** in D-SNP and MMC contracts in years preceding the selective contracting year to alert existing plans to the state's selective contracting goals.

- Develop and issue RFP(s) and **model D-SNP and MMC contract(s)** for the selective contracting year that specify the state's selective contracting requirements.

- Identify and consider how to address potential service area/provider network adequacy challenges, such as unaligned Medicare/Medicaid access standards and capacity issues in **rural areas.**

Implementation and Evaluation Phase

- **Implement selective contracting** by:
  - Selecting D-SNPs and MMC plans.
  - Finalizing D-SNP and MMC contracts.
  - Conducting readiness reviews with MMC plans.
  - Monitoring the degree to which selective contracting improves outcomes for dually eligible individuals, such as:
    - Improved transitions between hospitals and post-acute settings,
    - Streamlined state oversight of MMC plans and D-SNPs, and/or
    - Improved experiences of care among dually eligible D-SNP enrollees.
  - Applying any lessons learned in state processes and future contracts with D-SNPs and MMC plans.

Questions?

About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org