

medicaid and the uninsured

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Financial Alignment Models for Dual Eligibles: An Update

Introduction

Nearly nine million dual eligibles, including 5.5 million low-income seniors and 3.4 million people with disabilities under age 65, receive both Medicare and Medicaid benefits.¹ Dual eligibles are a high cost, high need population, accounting for a disproportionate share of expenditures relative to their enrollment in both programs.² Recently, there has been increased interest on the federal and state levels in developing new service delivery and payment models in an effort to improve the quality of care and reduce costs for dual eligibles. In April, 2011, the Center for Medicare and Medicaid Services (CMS) announced the award of design contracts to 15 states to develop service delivery and payment models to integrate care for dual eligibles.³ Significant characteristics of the 15 states' initial design proposals are described in more detail in an earlier policy brief, which also provides background on dual eligibles and describes the challenges to integrating their care in existing Medicare and Medicaid financing models.⁴

As the design phase of the 15 demonstration contracts to integrate care for dual eligibles proceeds, CMS and the participating states have recognized that a "key component of better coordinating care for Medicare-Medicaid enrollees will be testing new payment and financing models to align the incentives between Medicare and Medicaid to support care improvements and lower costs."⁵ Consequently, in July, 2011, CMS released a State Medicaid Director letter containing preliminary guidance on opportunities to align Medicare and Medicaid financing for dual eligibles. These models would integrate Medicare and Medicaid benefits and align financing, unlike most existing arrangements that separately manage each program. CMS invited any interested state to submit a letter of intent to potentially test the proposed capitated or managed fee-for-service financial alignment models outlined in the State Medicaid Director Letter.⁶ On October 11, 2011, CMS announced that 37 states and the District of Columbia, including the 15 states previously selected for integrated care design contracts, have submitted letters of intent expressing possible interest in pursuing one or both of the new financial alignment models.⁷

This policy brief provides an update on financial alignment models for dual eligibles based on the new information in CMS's July, 2011 State Medicaid Director letter and the responding states' letters of intent. It describes CMS's two proposed models and the planning and design process and presents key points from the states' initial expressions of potential interest in testing these models.

CMS's State Medicaid Director Letter on Financial Alignment Models for Dual Eligibles

CMS's July, 2011 State Medicaid Director letter provides new guidance on two financial alignment models that CMS would like to test – a capitated model and a managed fee-for-service model – in states pursuing integrated programs for dual eligibles. The models target full duals, and beneficiaries currently in a Medicare Advantage plan, Medicaid managed care plan, or the Program of All-Inclusive Care for the Elderly (PACE) are able to participate if they disenroll from their existing program. The financial alignment demonstrations are open to all interested states, not only the 15 that were awarded integrated care design contracts. Through the financial alignment model demonstrations, CMS seeks to "improve beneficiary experiences and quality outcomes, while also reducing costs for" dual eligibles.⁸

Financial Alignment Models to Be Tested

The **capitated model** proposed by CMS involves a three-way contract between CMS, the state and participating health plans, in which plans would receive a prospective blended rate from Medicare and Medicaid for all primary, acute, behavioral health and long-term services and supports for full duals.⁹ CMS will provide the Medicare portion of the capitated payment to plans, and the state will provide the Medicaid portion. Eligible health plans include current Medicare Advantage or Medicaid managed care plans, as well as other entities that meet standards required by CMS and the state.¹⁰ CMS and the state will jointly select and monitor participating plans.¹¹ Under the capitated model, states are permitted to utilize “simplified and unified” rules, which will vary by state, in areas including but not limited to supplemental benefits, enrollment, appeals, auditing and marketing, coupled with “specific beneficiary safeguards” to be included in the contract.¹²

The capitated model described in the July, 2011 State Medicaid Director letter contains more specific guidance on some points than CMS provided in its Request for Proposals (RFP) for the duals integrated care design contracts. First, the State Medicaid Director letter provides that Medicare and Medicaid payment rates under the capitated model are intended to allow both CMS and the state to share savings, as compared to the lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area.¹³ The design contract RFP did not require states to share savings with CMS. Second, the capitated model described in the State Medicaid Director letter permits passive enrollment of duals with an opt-out available on a month-to-month basis.¹⁴ The design contract RFP did not specify whether enrollment should be voluntary, mandatory, or passive with an opt-out.

The **managed fee-for-service model** to be tested involves an agreement between CMS and the state in which the state would be responsible for full duals’ care coordination and the delivery of fully integrated Medicare and Medicaid benefits.¹⁵ Under the existing system, states are not responsible for administering Medicare benefits. The proposed managed fee-for-service model allows states to adopt care delivery systems available under the Affordable Care Act, such as accountable care organizations and Medicaid health homes, as well as existing Medicaid fee-for-service care coordination models, such as Primary Care Case Management. In return, the state would be eligible for a retrospective performance payment if a target level of Medicare savings, net of increased federal Medicaid costs, and specified quality thresholds are met, with final savings to be determined by CMS.¹⁶ Providers would continue to be reimbursed on a fee-for-service basis by CMS for Medicare services and by the state for Medicaid services.¹⁷ Under this model, states may be permitted flexibility to better align Medicare and Medicaid benefits and to target duals in a specific geographic area.¹⁸ Significant characteristics of the financial alignment models as proposed by CMS are summarized in Table 1.

**Table 1:
Significant Characteristics of CMS's Proposed Medicare-Medicaid Financial Alignment Models**

	Capitated Model	Managed Fee-for-Service Model
Parties	Contract between CMS, state, and participating health plans	Partnership agreement between CMS and state
Entity responsible for benefits delivery and care coordination	Health plan, either directly or by subcontracting with other qualified entities	State, either directly or by subcontracting with other qualified entities
Benefits package	All primary, acute, behavioral health, and long-term services and supports covered by Medicare and Medicaid	All primary, acute, behavioral health, and long-term services and supports covered by Medicare and Medicaid
Provider network adequacy	CMS, state, and plans to ensure beneficiary access to adequate network of medical and supportive services providers that are appropriate and competent for the population's needs	CMS and state will ensure beneficiary access to interdisciplinary teams of medical and supportive services providers
Benefits financing	Health plans to receive prospective blended capitated rate from CMS for Medicare portion of services and from state for Medicaid portion of services	Providers to be reimbursed fee-for-service by CMS for Medicare services and by state for Medicaid services
Shared savings arrangements between CMS and state	CMS and state to share savings, as compared to lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area	State will be eligible for retrospective performance payment if Medicare savings, net of increased federal Medicaid costs, and quality targets are met
Enrollment	Full duals. Passive enrollment permitted with opt-out available on month-to-month basis	Full duals. State may be allowed to target duals in specified geographic area; passive enrollment not addressed
Permissible modifications to program rules	Permits simplified and unified rules, which will vary by state, including but not limited to supplemental benefits, enrollment, appeals, auditing and marketing, with specific beneficiary safeguards	May permit state flexibility to better align benefits, with specific beneficiary safeguards
Data reporting requirements	State to report individual-level quality, cost, enrollment and utilization data; health plans to report encounter data and certain quality indicators	State to report individual-level quality, cost, enrollment and utilization data
Quality evaluation	CMS and state to jointly select and monitor plans; plans required to meet established quality thresholds	State must meet specified quality thresholds to be eligible for retrospective performance payment
Beneficiary input	Plans required to establish meaningful beneficiary input processes, which may include beneficiary participation on plan governing boards or beneficiary advisory boards	State shall demonstrate meaningful beneficiary participation in development and oversight of the model
Appeals system	CMS and state will develop unified set of requirements for plan complaints and internal appeals processes that incorporate relevant Medicare Advantage, Medicare part D and Medicaid managed care requirements. CMS and state will develop a single external appeals process using both Medicare and Medicaid requirements.	State must ensure beneficiary access to all Medicare and Medicaid grievance and appeal rights and assist beneficiaries in choosing which to pursue if both applicable
Target implementation	End of 2012	End of 2012

SOURCE: Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

Planning and Design Process for Testing Financial Alignment Models

The states' initial letters of intent to participate in CMS's financial alignment model demonstration are part of a "comprehensive planning and design process" in which CMS will collaborate with the interested states.¹⁹ After an initial discussion with CMS, participating states will continue or newly initiate stakeholder engagement processes before submitting demonstration proposals to CMS.²⁰ CMS "encourages and expects active and meaningful State engagement with stakeholders in both models," including providers, enrollees, their families, and consumer organizations that work with duals.²¹ Public notice is required prior to the submission of state proposals, which must demonstrate meaningful stakeholder engagement.²² CMS will then determine whether its standards and conditions are met and develop Memoranda of Understanding for implementation of the models.²³ Draft MOU templates for each model, which may be further modified by CMS, are included in the July, 2011 State Medicaid Director Letter. The required standards and conditions for the demonstrations will include beneficiary protections, such as access to a robust provider network and physically accessible services, the right to file an appeal, and access to culturally and linguistically appropriate services.²⁴ More detail about the standards and conditions that states must satisfy is provided in Text Box 1 below.

Text Box 1:

Standards and Conditions for State Participation in Financial Alignment Model Demonstrations

CMS will provide supplemental guidance setting out the standards and conditions for state participation in the financial alignment model demonstrations, which will include:

- Public notice and meaningful consumer and other stakeholder engagement
- Enrollment targets and related outreach initiatives
- Integrated care management across the full continuum of Medicare and Medicaid services, including primary, acute, behavioral health and long-term services and supports
- Certifiable estimates of expected savings
- Integrated beneficiary level claims data to inform program management and evaluation
- Adequate networks of medical and supportive services providers
- Monitoring and oversight infrastructure
- Quality measurement infrastructure
- Target implementation date by end of 2012

SOURCE: Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

CMS will require participating states to achieve certain quality standards. CMS is contracting with an independent evaluator to measure both the quality and cost impacts of the demonstrations.²⁵ In addition, states will be required to "collect and provide individual-level quality, cost, enrollment and utilization data for the purposes of comparing the effects of these models across sub-groups of Medicare-Medicaid enrollees, including those that

participate in the integrated model being tested and those that do not.”²⁶ In addition, health plans in the proposed capitated model will be required to “provide encounter data in a common format that will facilitate evaluation and an improved understanding of the beneficiary experience in the plan” and to “report on certain established quality indicators.”²⁷

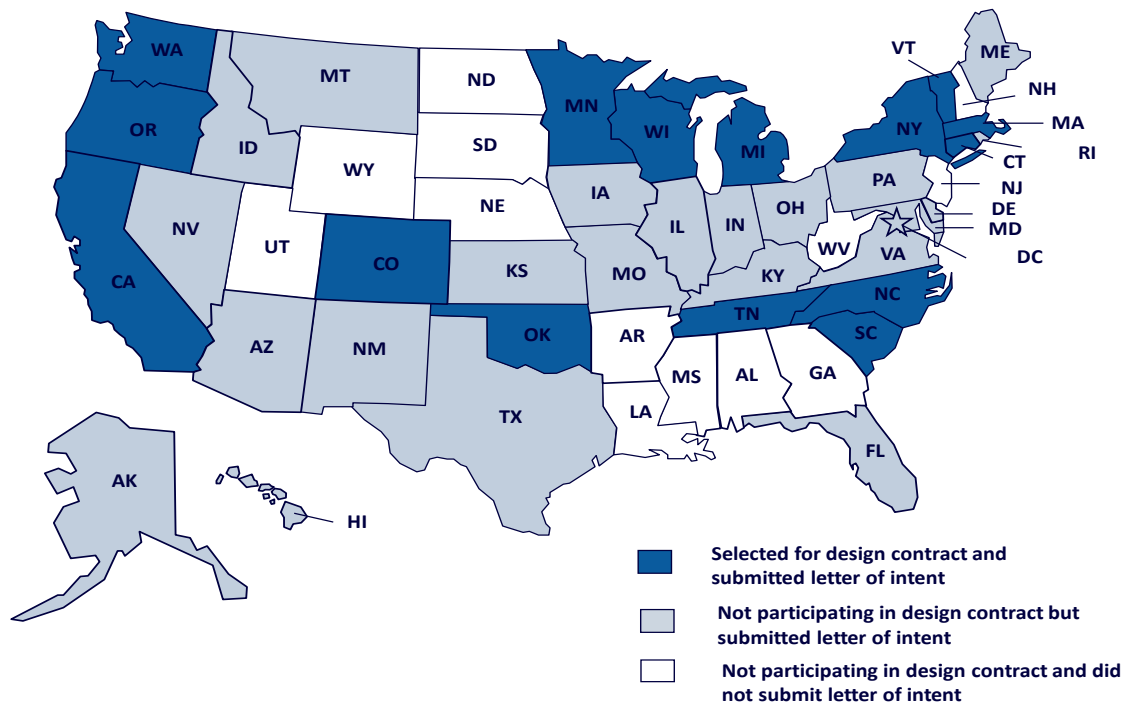
CMS’s target implementation date for the financial alignment model demonstrations is 2012, and selected demonstrations will last no more than three years.²⁸ For states that will not be ready to implement demonstrations in 2012, CMS will “collaborate in other ways to improve quality and cost of care” for dual eligibles in interested states.²⁹ In addition to the assistance available to states from the Medicare-Medicaid Coordination Office, the new Integrated Care Resource Center, a joint technical assistance project of CMS, the Medicare-Medicaid Coordination Office and the Center for Medicaid, CHIP, and Survey & Certification, also is available to help states learn about best practices to integrate care for high cost, high need beneficiaries, including dual eligibles.³⁰

Initial State Interest in Testing Financial Alignment Models for Dual Eligibles

Thirty-eight states, including all 15 states that were awarded design contracts and the District of Columbia, submitted letters of intent expressing potential interest in testing one or both of the financial alignment models proposed in CMS’s July, 2011 State Medicaid Director letter. The states’ letters of intent are non-binding, and not all of the states that submitted letters of intent ultimately may participate in the demonstration. Figure 1 illustrates state interest in the financial alignment models, including the states previously selected for design contracts and the states that submitted letters of intent to test CMS’s proposed models.

Figure 1

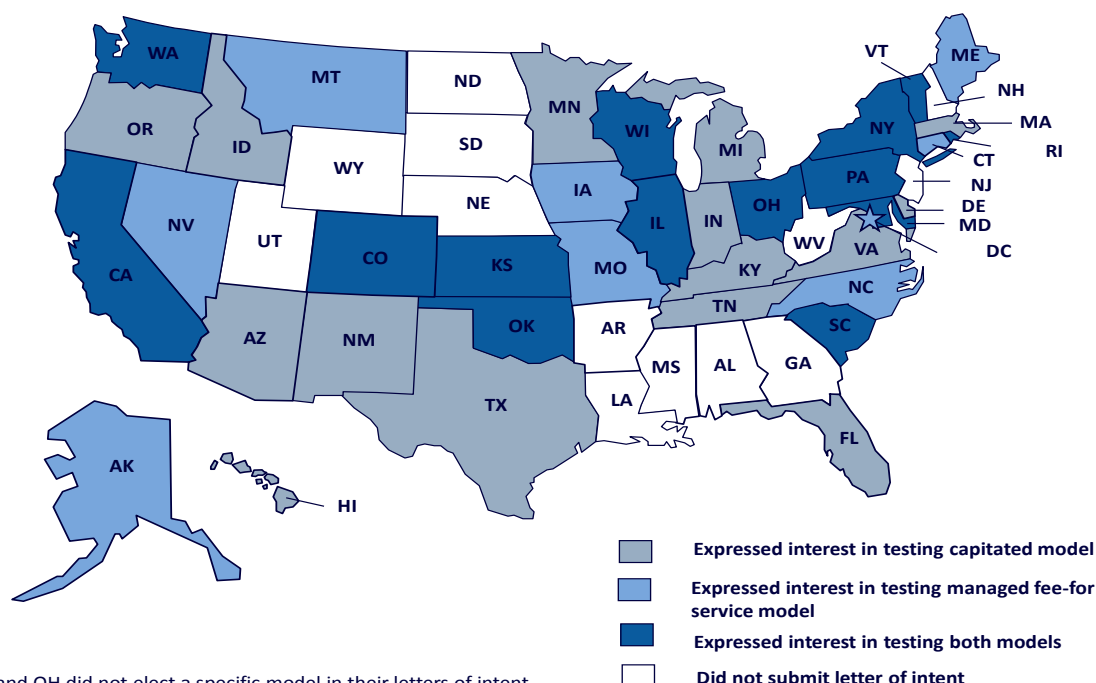
State Interest in Testing Financial Alignment Models for Dual Eligibles by Type of Demonstration



Of the 38 letters of intent, 15 states expressed potential interest in the capitated model (with 2 states each submitting 2 different proposals for the capitated model), 9 states expressed potential interest in the managed fee-for-service model, and 14 states expressed potential interest in both models (including 2 states that did not elect a specific model in their letters of intent). Figure 2 illustrates state interest in testing CMS’s proposed financial alignment models by type of model, and Table 2 summarizes the model(s) that each state would like to test.

Figure 2

State Interest in Testing Financial Alignment Models for Dual Eligibles by Type of Model



The states’ letters of intent are very brief documents expressing their potential initial interest, and thus it is difficult to analyze in detail many aspects of the proposals to date. Of the states that addressed which benefits would be encompassed in their proposed financial alignment model demonstrations, nearly all indicated that they planned to include all Medicare and Medicaid benefits. This is consistent with CMS’s concept of an “integrated program,” defined in the State Medicaid Director letter as one that “encompasses all the medical, behavioral health, and long-term services and supports needed by an individual eligible for both Medicare and Medicaid,” in which an “individual has a seamless care experience,” and where “one entity is accountable for the full continuum of care for the Medicare-Medicaid enrollee.”³¹ Similarly, of the states that addressed the geographic area in which their financial alignment model would be tested, most indicated that their demonstration would be statewide, with others electing to pilot or phase-in the demonstration in limited areas of the state. Of the states that indicated the target population for their demonstrations, most proposed including all full duals statewide, while some states proposed focusing on a subset of full duals, such as those with serious mental illness or other chronic conditions. Some of the states, including the 15 selected for the design contracts, described more completely developed proposals and indicated that they are committed to pursuing the financial alignment demonstration, while others are at a much earlier stage of development. Some states are not certain that they will participate in

the financial alignment models demonstration, and several indicated that they are seeking input from CMS as they determine which financial alignment model to test, which population to target, and other aspects of the demonstration. A few states also requested additional flexibility to deviate from the structure of CMS's proposed models.

Conclusion

While the letters of intent are non-binding expressions of initial interest, and not all states may ultimately pursue a financial alignment demonstration, the number of submissions, representing 37 states and the District of Columbia, demonstrates significant interest among the states in integrating care for dual eligibles. There are a number of key issues related to financing and beneficiary rights and protections to consider as the dual eligibles integrated care demonstration and financial alignment models testing move forward. These issues are discussed in an earlier policy brief, Kaiser Commission on Medicaid and the Uninsured, "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS," Aug. 2011, available at <http://www.kff.org/Medicaid/8215.cfm>.

The financial alignment model demonstrations, along with the 15 states awarded design contracts to develop service delivery and payment models that integrate care for duals, have the potential to improve the efficiency and quality of care for dual eligibles and possibly reduce costs over the long-term. However, there is a need to also ensure that the Medicare and Medicaid benefits to which the dual eligible population is entitled are not compromised in the financial models being tested. Monitoring is necessary to assess whether payments are appropriately calculated and whether the new financial models provide measureable improvements in the quality of care. At the same time, the current fiscal climate and state budgetary pressures could affect states' administrative capacity to devote sufficient resources to effectively develop, and if approved, execute and manage these projects, while also working to implement other aspects of health reform. As the financial alignment models are further developed, tested, and evaluated, ongoing efforts are needed to examine the extent to which dual eligibles are protected and to ensure that states are afforded appropriate support and are able to devote adequate time and resources to their efforts to work with CMS to improve the integration of the Medicare and Medicaid programs for this very vulnerable population.

This policy brief was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The author thanks Foundation colleagues Tricia Neuman and Gretchen Jacobson for their helpful review and comments.

Table 2: State Interest in Financial Alignment Models for Dual Eligibles as of October, 2011

State	Awarded Duals Integration Design Contract	Submitted Letter of Intent	Interest in Capitated Model	Interest in Managed Fee-for-Service Model
Alabama				
Alaska		X		X
Arizona		X	X	
Arkansas				
California	X	X	X	X ¹
Colorado	X	X	X	X
Connecticut	X	X		X
Delaware		X	X	
District of Columbia		X		X
Florida		X	X	
Georgia				
Hawaii		X	X	
Idaho		X	X	
Illinois		X	X	X
Indiana		X	X ²	
Iowa		X		X
Kansas		X	X ³	X ³
Kentucky		X	X	
Louisiana				
Maine		X		X
Maryland		X	X	X
Massachusetts	X	X	X ²	
Michigan	X	X	X	
Minnesota	X	X	X	
Mississippi				
Missouri		X		X
Montana		X		X
Nebraska				
Nevada		X		X
New Hampshire				
New Jersey				
New Mexico		X	X	
New York	X	X	X	X
North Carolina	X	X		X
North Dakota				
Ohio		X	X ³	X ³
Oklahoma	X	X	X	X
Oregon	X	X	X	
Pennsylvania		X	X	X
Rhode Island		X	X	X
South Carolina	X	X	X	X
South Dakota				
Tennessee	X	X	X	
Texas		X	X	
Utah				
Vermont	X	X	X	X ¹
Virginia		X	X	
Washington	X	X	X	X
West Virginia				
Wisconsin	X	X	X	X
Wyoming				
TOTAL:	15	38	29	23

SOURCE: Based on Kaiser Commission on Medicaid and the Uninsured’s review of the states’ letters of intent. Letters of intent are available directly from the states; contact information is available at CMS, “States Submitting Letters of Intent – Financial Alignment Models,” Oct. 2011, <https://www.cms.gov/medicare-medicare-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf>.

1 State intends to pursue capitated model first and managed fee-for-service in the future (CA) or if impediments emerge with capitated model (VT).

2 State’s letter of intent contains two different proposals for capitated model.

3 State’s letter of intent does not specify which model state would like to pursue.

Endnotes

- ¹ Kaiser Commission on Medicaid and the Uninsured, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” May 2011, available at <http://www.kff.org/medicaid/4091.cfm>.
- ² *Id.*; Kaiser Family Foundation Program on Medicare Policy, “The Role of Medicare for the People Dually Eligible for Medicare and Medicaid,” Jan. 2011, available at <http://www.kff.org/medicare/8138.cfm>.
- ³ CMS Office of Public Affairs, “15 States Win Contracts to Develop New Ways to Coordinate Care for People with Medicare and Medicaid,” April 14, 2011, available at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3929&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>
- ⁴ Kaiser Commission on Medicaid and the Uninsured, “Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS,” Aug. 2011, available at <http://www.kff.org/Medicaid/8215.cfm>.
- ⁵ CMS, “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees: Frequently Asked Questions,” available at <https://www.cms.gov/medicare-medicare-coordination/Downloads/CMSFinancialModelsFrequentlyAskedQuestions.pdf>.
- ⁶ Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ⁷ CMS, “States Submitting Letters of Intent – Financial Alignment Models,” Oct. 2011, available at <https://www.cms.gov/medicare-medicare-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf>.
- ⁸ *Id.*
- ⁹ Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ¹⁰ *Id.*
- ¹¹ Draft Template Memorandum of Understanding for Capitated Model, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ¹² *Id.*
- ¹³ *Id.*
- ¹⁴ *Id.*
- ¹⁵ Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ¹⁶ Draft Memorandum of Understanding Template for Managed FFS Model, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ¹⁷ *Id.*
- ¹⁸ *Id.*
- ¹⁹ CMS, “States Submitting Letters of Intent – Financial Alignment Models,” Oct., 2011, available at <https://www.cms.gov/medicare-medicare-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf>.
- ²⁰ Email announcement from Melanie Bella, Update: Duals Financial Alignment Model Demonstration Letters of Intent, Oct. 11, 2011.
- ²¹ Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.
- ²² Email announcement from Melanie Bella, Update: Duals Financial Alignment Model Demonstration Letters of Intent, Oct. 11, 2011.
- ²³ *Id.*
- ²⁴ CMS, “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees: Frequently Asked Questions,” available at <https://www.cms.gov/medicare-medicare-coordination/Downloads/CMSFinancialModelsFrequentlyAskedQuestions.pdf>.
- ²⁵ *Id.*
- ²⁶ *Id.*
- ²⁷ *Id.*
- ²⁸ *Id.*
- ²⁹ *Id.*
- ³⁰ See <http://www.integratedcareresourcecenter.com/Default.aspx>.
- ³¹ Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011, available at http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

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