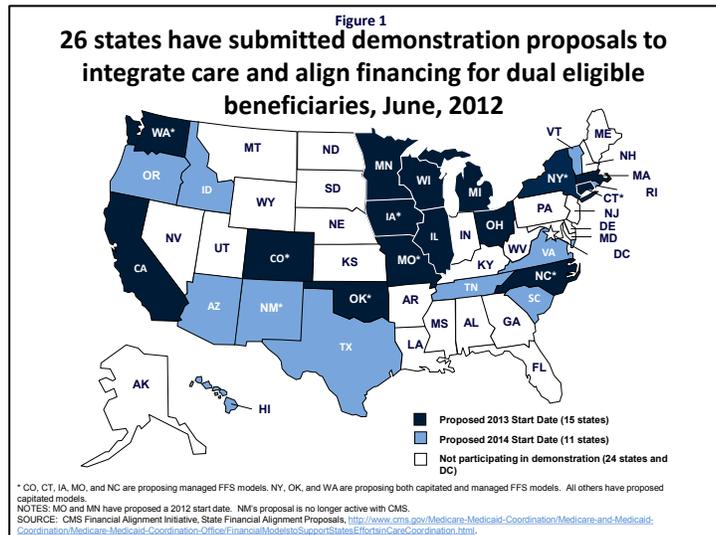


# medicaid and the uninsured

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## Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries

Over the last eighteen months, a number of states have been working with the Centers for Medicare and Medicaid Services (CMS) to develop payment and service delivery models to integrate care and align financing for beneficiaries who are dually eligible for both the Medicare and Medicaid programs. These efforts have resulted in proposals from 26 states to test these models (Figure 1).<sup>1</sup> CMS is presently reviewing the states' proposals to determine which will be implemented. This policy brief provides an overview of the proposed integrated care and financial alignment demonstrations for dual eligible beneficiaries and answers key questions about these new initiatives.



### Key Questions

#### 1. Who are the dual eligible beneficiaries?

Dual eligible beneficiaries receive both Medicare and Medicaid benefits.<sup>2</sup> They include over 9.1 million seniors and younger people with significant disabilities and are among the poorest and sickest beneficiaries covered by either program. Medicare is the primary payer for dual eligible beneficiaries and covers hospital, physician and post-acute services, diagnostic tests, and prescription drugs. Just over 7 million “full duals” receive Medicaid assistance with paying for their Medicare premiums and cost-sharing as well as services covered by Medicaid that Medicare does not cover, the most significant of which are long-term services and supports. The remaining 2 million “partial duals” receive Medicaid assistance with paying for their Medicare premiums and cost-sharing only.

#### 2. Why is CMS inviting states to test new integrated care and financial alignment models for dual eligible beneficiaries?

Medicare and Medicaid are separate programs, and the predominant existing delivery models typically involve little to no coordination among services. In addition, dual eligible beneficiaries account for a disproportionate share of spending in both programs, due to their poorer health status and resultant

higher use of services as compared to other program beneficiaries. The Affordable Care Act created two new offices within CMS that address these issues. The Medicare-Medicaid Coordination Office is charged with improving the integration of Medicare and Medicaid benefits for dual eligible beneficiaries. The Center for Medicare and Medicaid Innovation has new demonstration authority under § 1115A of the Social Security Act to test new payment and service delivery models that fully integrate care for dual eligible beneficiaries, among other areas.

### **3. What models does CMS propose testing?**

CMS has proposed two financial models to align Medicare and Medicaid benefits for dual eligible beneficiaries that it would like to test. One is a capitated model, which involves a three-way contract between CMS, the state, and participating health plans.<sup>3</sup> CMS and the state will jointly select and monitor participating plans. Plans will receive a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports. The Medicare and Medicaid payment rates under the capitated model are intended to allow both CMS and the state to share savings. The other is a managed fee-for-service model, which involves an agreement between CMS and the state in which the state will be responsible for dual eligible beneficiaries' care coordination and the delivery of fully integrated Medicare and Medicaid benefits. In return, the state will 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. In this model, providers will continue to be reimbursed on a fee-for-service basis by CMS for Medicare services and by the state for Medicaid services.

### **4. What is the process for designing and testing these models?**

In April, 2011, CMS awarded design contracts to 15 states to develop service delivery and payment models to integrate care for dual eligible beneficiaries.<sup>4</sup> In July, 2011, CMS expanded this initiative by releasing a State Medicaid Director letter outlining its proposed capitated and managed fee-for-service financial alignment models and inviting any interested state to submit a non-binding letter of intent to test either or both models.<sup>5</sup> In spring 2012, 26 states, including the 15 that received design contracts, submitted demonstration proposals to CMS (Figure 1). CMS is presently reviewing the states' proposals and working with selected states to develop memoranda of understanding (MOUs) to implement the demonstrations. The first MOU, for Massachusetts' demonstration, was released in late August, 2012.<sup>6</sup> The demonstrations will last for three years. The states' target implementation dates vary, with some states seeking to implement their demonstrations in late 2012 or in 2013, and other states seeking to implement in 2014 (Figure 1). The Secretary's § 1115A authority requires her to evaluate each model that is tested.<sup>7</sup> The law also authorizes the Secretary to expand the duration and scope of models, including on a nationwide basis, that are expected to reduce program spending without reducing the quality of care or improve patient care without increasing spending.

### **5. Which dual eligible beneficiaries will be included in the demonstrations?**

The financial alignment models target full dual eligible beneficiaries. CMS has stated that it plans to limit total participation in the demonstrations to no more than 2 million beneficiaries. Most states propose including all full dual eligible beneficiaries statewide in their demonstrations. Other states

propose limiting participation in their demonstrations by age, diagnosis or service use, and/or geographic area.

## **6. How will dual eligible beneficiaries be enrolled in the demonstrations?**

CMS has stated that it will allow states to passively enroll beneficiaries in the demonstrations as long as beneficiaries have the opportunity to opt out of the demonstration on a month to month basis. This means that beneficiaries would be placed in the demonstrations, and in the capitated model, enrolled in a managed care plan, unless they take action to disenroll. Beneficiaries could opt out of the demonstrations for their Medicare benefits but still may be required to enroll in managed care for their Medicaid benefits if their state has a waiver from CMS permitting the state to require Medicaid managed care participation. Nearly all the states propose passively enrolling beneficiaries in their demonstrations. CMS and the Administration for Community Living recently announced new grant funding for State Health Insurance Assistance Programs and Aging and Disability Resource Centers to provide options counseling for beneficiaries in states that will implement demonstrations.<sup>8</sup>

## **7. What benefits will the demonstrations include?**

CMS has stated that the demonstrations should provide integrated benefits packages that include all primary, acute, pharmacy, behavioral health, and long-term services and supports currently covered by Medicare and Medicaid. Demonstration health plans also may offer supplemental benefits that are not otherwise covered by Medicare or Medicaid. A few states propose including community health workers in their demonstration health plan integrated care teams to serve as peer navigators or assist beneficiaries with preventative care and health promotion efforts. Two states include provisions for independent coordinators for long-term services and supports.

## **8. What types of care coordination activities will the demonstrations provide?**

Most dual eligible beneficiaries currently receive their Medicare and Medicaid benefits on a fee-for-service basis. Section 1115A of the Social Security Act directs the Secretary to focus testing on payment and service delivery models that are expected to reduce program costs while preserving or enhancing the quality of care received by beneficiaries and models that also improve the coordination, quality and efficiency of care. The law includes a number of factors that CMS may consider when selecting models to test, including whether the model:

- includes a regular process for monitoring and updating patient care plans consistent with beneficiary needs and preferences;
- places beneficiaries, family members, and informal caregivers at the center of the care team;
- provides for in-person contact with beneficiaries;
- utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings;

- provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers;
- relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching;
- allows providers to share information with patients, caregivers and other providers on a real time basis.

## **9. How will the demonstrations affect the financing of Medicare and Medicaid services?**

CMS has stated that health plans in the capitated model will receive a prospective blended rate that includes payments from CMS for the Medicare portion of covered services and from the state for the Medicaid portion of covered services.<sup>9</sup> CMS has stated that it will not approve a demonstration unless the capitated rate provides upfront savings to both CMS and the state. CMS and the state will share program savings. CMS’s guidance also provides for an increasing quality withhold from the plans’ capitated rates, of one percent in year one, two percent in year two, and three percent in year three of the demonstration. Plans would earn back the withheld amount if they meet certain quality objectives.

## **10. How will the demonstrations be monitored and evaluated?**

The law requires the Secretary to evaluate the demonstrations. The evaluation must analyze the quality of care provided, including patient level outcomes and “patient-centeredness criteria,” and changes in Medicare and Medicaid spending. A few states propose conducting their own evaluations of their demonstrations as well. In the capitated model, CMS and the state will jointly monitor participating health plans, which will be required to meet established quality thresholds. The specific quality measures and plan oversight requirements are to be determined in the MOU between CMS and the state and the three-way contract between CMS, the state, and the plan.

### **Looking Ahead**

The integrated care and financial alignment demonstrations for dual eligible beneficiaries offer the potential opportunity to improve care coordination, lower program costs, and achieve outcomes such as the increased use of home and community-based services instead of institutionalization. At the same time, dual eligible beneficiaries’ high care needs increase their vulnerability when care delivery systems are changed. As the demonstrations proceed, careful attention must be paid to how beneficiaries will be notified about and enrolled in these new models, how beneficiaries’ continuity of care with their current providers and services will be preserved during transitions, what the sources of program savings will be, how beneficiary access to medically necessary services will be ensured, how beneficiary rights will be protected, how demonstration plans and providers will accommodate the needs of beneficiaries with disabilities, and how the demonstrations will be overseen and evaluated to monitor quality and costs.

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## Endnotes

<sup>1</sup> For a summary of the 26 states' proposals to CMS, see Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS* (Oct. 2012), available at <http://www.kff.org/Medicaid/8369.cfm>. NM's proposal is no longer active with CMS. See CMS, Medicare-Medicaid Coordination Office, Financial Alignment Initiative, available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html> (noting that only active proposals are listed).

<sup>2</sup> For additional background on the dual eligible population, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicaid/7846.cfm>; Kaiser Family Foundation, *Medicare's Role for Dual Eligible Beneficiaries* (April 2012), available at <http://www.kff.org/medicare/8138.cfm>.

<sup>3</sup> For a summary of CMS's guidance on the capitated financial alignment model, see Kaiser Commission on Medicaid and the Uninsured, *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees* (April 2012), available at <http://www.kff.org/medicaid/8290.cfm>.

<sup>4</sup> For background on the state design contract proposals, see 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>.

<sup>5</sup> For background on the states' letters of intent, see Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Models for Dual Eligibles: An Update* (Nov. 2011), available at <http://www.kff.org/medicaid/8260.cfm>.

<sup>6</sup> For a summary of the memorandum of understanding between CMS and Massachusetts, see Kaiser Commission on Medicaid and the Uninsured, *Massachusetts' Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries* (Oct. 2012), available at <http://www.kff.org/Medicaid/8291.cfm>.

<sup>7</sup> For a summary of CMS's § 1115A demonstration authority, see Kaiser Commission on Medicaid and the Uninsured, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS*, Appendix A (Oct. 2012), available at <http://www.kff.org/Medicaid/8369.cfm>.

<sup>8</sup> U.S. Dep't of Health & Human Servs., CMS, Administration for Comm'y Living, *ACA State Health Insurance Assistance Program and Aging and Disability Resource Center Options Counseling for Medicare-Medicaid Individuals in States with Approved Financial Alignment Models* (Aug. 23, 2012), available at [http://www.aoa.gov/aoaroot/grants/funding/docs/2012/SHIP\\_ADRC\\_Duals\\_FOA\\_FINAL8\\_22\\_2012.pdf](http://www.aoa.gov/aoaroot/grants/funding/docs/2012/SHIP_ADRC_Duals_FOA_FINAL8_22_2012.pdf).

<sup>9</sup> State Medicaid spending qualifies for federal matching funds based upon the state's Federal Medical Assistance Percentage (FMAP). For more information about the FMAP, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (Sept. 2012), available at <http://www.kff.org/medicaid/8352.cfm>.

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