

CHAPTER

9

**Issues affecting dual-eligible
beneficiaries: CMS's financial
alignment demonstration and
the Medicare Savings Programs**

Issues affecting dual-eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Programs

Chapter summary

About 10 million people qualify for both Medicare and Medicaid and are known as dual-eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, home health care, physician services, durable medical equipment, and prescription drugs. The federal–state Medicaid program covers a variety of long-term services and supports (such as nursing home care or community-based care) and wraparound services, and it provides assistance with Medicare premiums and cost sharing.

Policymakers have long been concerned that dual-eligible beneficiaries may receive fragmented or ineffective care because they are generally in poorer health than other Medicare beneficiaries and must obtain care from two distinct programs, which can make coordinating their care more difficult. These concerns also reflect the high costs of caring for dual-eligible beneficiaries. In 2011, the most recent year of data available, dual eligibles represented about 20 percent of Medicare beneficiaries but accounted for about 35 percent of Medicare spending. For Medicaid, dual eligibles represented about 14 percent of enrollment and about 33 percent of total spending.

The Commission has examined numerous issues related to dual-eligible beneficiaries in recent years. This work organizes broadly into two areas of interest: (1) the development of new models of care that could improve quality

In this chapter

- Introduction
- Status report on the financial alignment demonstration
- Expanding the Medicare Savings Programs
- Conclusion

and reduce costs for dual eligibles and (2) the eligibility rules for these low-income beneficiaries and how their care is financed. This chapter continues our work in both areas by providing a status report on the “financial alignment” demonstration project, an initiative by CMS and states to test new models of care for dual eligibles, and by examining the potential cost of three illustrative scenarios for expanding the Medicare Savings Programs (MSPs), which are Medicaid programs that provide assistance with Medicare premiums and cost sharing to certain low-income Medicare beneficiaries.

Under the financial alignment initiative, CMS has approved 14 demonstrations in 13 states. CMS does not expect any additional states to join the demonstration. As of March 2016, 12 of the demonstrations were operational, and the other 2 are expected to start later this year. Most demonstrations will operate for five years. About 450,000 dual eligibles are currently enrolled, making this demonstration one of the largest that CMS has ever conducted related to dual eligibles.

Most demonstrations (11 of 14) are testing a “capitated” model, which uses health plans known as Medicare–Medicaid Plans (MMPs) to provide all Medicare benefits and all or most Medicaid benefits to dual eligibles. Enrollment in the MMPs has been much lower than some expected because many beneficiaries have declined to participate, or “opted out.” Based on interviews with stakeholders in several demonstration states, beneficiaries have opted out because they are satisfied with their existing care or are uncertain about how the demonstration would affect them. Stakeholders also agreed that provider resistance to the demonstration has contributed to the low participation rates.

Under the demonstration, states can “passively” (that is, automatically) enroll dual eligibles in MMPs to help ensure that the plans have enough enrollment to justify up-front investments in care coordination activities. Passive enrollment has helped generate sufficient enrollment for most MMPs, but our interviews found broad agreement that its use could be improved in the future. In particular, stakeholders said that passive enrollment should have been implemented more slowly to give MMPs more time to assess the health of new enrollees within the required time frames and that beneficiaries and providers needed to be better educated about the demonstration before passive enrollment began.

MMPs are distinctive because they are required to provide extensive care coordination for their enrollees, including individual health assessments, individual plans of care, and the use of interdisciplinary teams of providers. Several MMPs we interviewed said they have not been able to complete assessments for 20 percent to 30 percent of their enrollees, partly because of outdated contact information. More

broadly, MMPs vary in how they provide care coordination and are still trying to refine and improve their approaches.

As of now, there is no data available on the quality of care provided by MMPs or their ability to improve patterns of service use, such as reducing inpatient stays or nursing home placements. In our interviews, MMPs indicated that their efforts to reshape utilization patterns may not begin to pay off until the second or third year of the demonstration. More information will become available in the future as CMS releases preliminary evaluation reports on each demonstration.

MMPs are paid using a blended capitation rate that has separate components for Medicare Part A and Part B services, Part D drugs, and Medicaid benefits. Each component is risk adjusted to account for the beneficiary's health status. However, six MMPs have left the demonstration since it began, and some have cited inadequate payment rates as one factor. CMS recently increased the payment rate for Part A and Part B services, based on research that the existing risk adjustment model tends to underestimate costs for full-benefit dual eligibles.

Two states (Colorado and Washington) are testing a “managed fee-for-service” (FFS) model, under which the state provides additional care coordination for dual eligibles with FFS coverage in both programs. Interviews with stakeholders in Washington indicate that only 10 percent to 15 percent of those enrolled in its demonstration have used the additional care coordination services, in part because of difficulties with locating and engaging beneficiaries. CMS recently issued a preliminary report finding that Washington's demonstration had reduced Medicare spending by \$22 million (or 6 percent) in its first 18 months, but savings of that magnitude do not seem plausible given the low number of people served.

This chapter also summarizes MSP eligibility rules and assistance and examines the potential effects of expanding MSP eligibility under three illustrative scenarios. The scenarios highlight some of the key issues that policymakers would need to consider as part of an MSP expansion, such as the relationship between the eligibility rules for MSPs and those for the Part D low-income subsidy, how much Medicare cost-sharing assistance MSPs should provide (and in particular, whether states can continue to limit their payments for cost sharing), and whether MSPs should be federalized in some fashion. ■

Introduction

About 10 million people qualify for both Medicare and Medicaid and are known as dual-eligible beneficiaries. For these individuals, the federal Medicare program covers medical services such as hospital care, home health care, physician services, durable medical equipment, and prescription drugs. The federal–state Medicaid program covers a variety of long-term services and supports (LTSS), such as nursing home care and community-based care, and wraparound services, such as dental benefits and transportation. The program also provides assistance with Medicare premiums and, in some cases, cost sharing.

Policymakers have long been concerned that dual eligibles are vulnerable to receiving care that is fragmented or poorly coordinated. Medicare and Medicaid are separate programs—the first purely federal, the second largely operated by states with federal oversight and partial federal financing. Each program is complex, with its own distinct rules for eligibility, covered services, and administrative processes. Medicaid also differs from state to state because states have some flexibility in deciding which individuals and which benefits to cover. The two programs sometimes overlap in ways that are confusing for dual eligibles and providers. For example, Medicare and Medicaid have different rules for covering durable medical equipment and home health and different ways of processing grievances and appeals (Kruse and Philip 2015, Verdier et al. 2014).

More broadly, Medicare and Medicaid do not have strong financial incentives to engage in activities that might benefit the other program. For example, Medicaid covers long-term nursing home care, and Medicare covers inpatient care. States have relatively little incentive to reduce the use of inpatient care by nursing home residents because doing so increases Medicaid spending, while Medicare realizes savings when beneficiaries spend more time in the nursing home and less time in the hospital. Similarly, Medicare has little incentive to prevent dual eligibles from going into nursing homes, where Medicaid pays for most of their care.

How individuals become dual-eligible beneficiaries

Individuals must separately qualify for both Medicare and Medicaid coverage to become dual-eligible beneficiaries. Medicare is a national program, and its eligibility rules and benefits are the same in every state. Individuals typically qualify for coverage if they have a sufficient work history

and are either aged (65 or older) or have been disabled for at least 24 months, are a dependent or survivor of an aged or disabled beneficiary, or have end-stage renal disease. For those who qualify, Medicare covers a wide range of primary, acute, and post-acute services, as well as prescription drugs. Medicare also acts as the primary payer for any services that are covered by both programs.

Many dual-eligible beneficiaries qualify for Medicare because they are disabled. Based on linked Medicare–Medicaid eligibility data for 2011, about 41 percent of dual eligibles were under the age of 65, and 51 percent of dual eligibles originally qualified on the basis of disability (including beneficiaries who are now over age 65 but first qualified for Medicare because they were disabled). The corresponding figure for Medicare beneficiaries who are not dual eligibles is much lower: Only 17 percent originally qualified for Medicare because of disability (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2016).

Medicaid’s eligibility rules and benefits are more complex because states have some flexibility in deciding which individuals and which benefits to cover. Dual-eligible beneficiaries divide into two broad groups—“full benefit” and “partial benefit”—based on the Medicaid benefits they receive. Full-benefit dual-eligible beneficiaries qualify for the full range of Medicaid services covered in their state, which generally includes a broad array of primary and acute care services, nursing home care, and other long-term services and supports. In contrast, partial-benefit dual-eligible beneficiaries receive assistance only with Medicare premiums and, in most cases, assistance with cost sharing.

There were 9.9 million dual eligibles in 2014—7.1 million who were full benefit and 2.8 million who were partial benefit. Together, they represented about 20 percent of all Medicare beneficiaries.¹ Using linked Medicare–Medicaid eligibility data for 2011, we found that almost all full-benefit dual eligibles qualify for Medicaid in one of four ways:²

- **Eligibility for Supplemental Security Income (SSI) benefits.** The federal SSI program provides monthly cash payments to elderly and disabled individuals whose income is below about 75 percent of the federal poverty level. SSI recipients are automatically eligible for Medicaid in 41 states and the District of Columbia. The other nine states must allow SSI recipients to

**TABLE
9-1**

Service use and per user spending for full-benefit dual eligibles, 2011

	Percent using service	Per user spending for each service	Percent of	
			Total Medicare spending	Total Medicaid spending
Medicare-covered services				
Inpatient hospital	28%	\$18,708	28%	N/A
Skilled nursing facility	11	19,467	11	N/A
Home health	14	5,906	5	N/A
Other outpatient	94	5,904	30	N/A
Part D drugs	92	4,976	24	N/A
Medicaid-covered services				
Inpatient hospital	14	2,115	N/A	2%
Outpatient	87	2,390	N/A	12
Institutional LTSS	21	41,789	N/A	50
HCBS state plan	14	10,020	N/A	8
HCBS waiver	14	29,511	N/A	23

Note: N/A (not applicable), LTSS (long-term services and supports), HCBS (home- and community-based services). Figures are based on full-benefit dual eligibles who had fee-for-service coverage in both programs and do not include individuals with end-stage renal disease. (The dual eligibles who met these criteria represented about 63 percent of the overall total.) The figures for percentage of total spending do not sum to 100 because spending is shown only for selected services. Medicaid spending on inpatient hospital and outpatient services reflects payments for Medicare cost sharing and for services that Medicare does not cover, such as dental benefits. The percentage of dual eligibles using Medicaid-covered inpatient hospital services is lower than the corresponding percentage for Medicare-covered inpatient hospital services because some inpatient hospital services do not result in Medicaid spending. For example, the Medicare inpatient deductible may not apply, or states may not cover any of the deductible. A similar logic applies to outpatient services. "HCBS state plan" refers to services that states provide as a regular benefit under their Medicaid plan, such as home health or personal care. "HCBS waiver" refers to services that states only provide through waiver programs, such as those authorized under Section 1915(c) of the Social Security Act.

Source: Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2016.

“spend down” to Medicaid eligibility if needed, which means that they can qualify if their medical spending is high enough that their remaining income falls below an eligibility threshold set by the state. The SSI group accounts for about 49 percent of full-benefit dual eligibles.

- **Special income limit.** States can provide coverage to individuals who have income as high as 300 percent of the SSI benefit rate (or about 225 percent of the federal poverty level) and need the level of care provided in a nursing home. A total of 42 states and the District of Columbia use this eligibility pathway, which accounts for about 24 percent of full-benefit dual eligibles.
- **Poverty-related eligibility.** States can provide coverage to individuals who are either aged or disabled and

have income that exceeds the SSI eligibility limit but is below the federal poverty level. A total of 23 states and the District of Columbia use this eligibility pathway, which accounts for about 15 percent of full-benefit dual eligibles.

- **Medically needy program.** States can provide coverage to individuals who have higher income but also have high medical expenses. Under this pathway, individuals qualify for Medicaid by “spending down” their income on medical expenses until their remaining income falls below an eligibility threshold set by the state. A total of 33 states and the District of Columbia use this eligibility pathway, which accounts for about 12 percent of full-benefit dual eligibles.

Partial-benefit dual eligibles do not meet the eligibility criteria for full Medicaid benefits under any of the

pathways outlined above, but instead qualify for partial Medicaid benefits through the Medicare Savings Programs (MSPs), which require states to provide low-income Medicare beneficiaries assistance with Part A and Part B premiums and cost sharing. Under MSPs, beneficiaries with income below 135 percent of the federal poverty level receive assistance with the Part B premium, and individuals with income below 100 percent of the federal poverty level also receive assistance with Part A and Part B cost sharing (and the Part A premium, if necessary).

Characteristics of dual-eligible beneficiaries

Given the importance that factors such as disability, the need for nursing home care (or an equivalent level of care provided in the community), and high medical expenses play in becoming a dual-eligible beneficiary, it is not surprising that dual eligibles, as a group, tend to be in poorer health and have higher spending than other Medicare beneficiaries.

Dual eligibles are more likely than other Medicare beneficiaries to have three or more chronic conditions (19 percent vs. 9 percent) or be diagnosed with a mental illness (30 percent vs. 11 percent) (Congressional Budget Office 2013). Dual eligibles are also more likely to need help performing activities of daily living (ADLs), such as bathing or getting dressed.³ According to survey data, dual eligibles compared with other Medicare beneficiaries had higher rates of needing help with at least one ADL (55 percent vs. 26 percent) and needing help with three or more ADLs (32 percent vs. 9 percent) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2016).

About 18 percent of full-benefit dual eligibles have Alzheimer's disease or a related dementia. (That figure is higher—23 percent—for full-benefit dual eligibles who are over the age of 65.) In 2009, average Medicare and Medicaid spending for full-benefit dual eligibles with Alzheimer's disease or a related dementia was nearly twice as high as average spending for full-benefit dual eligibles who did not have those conditions (\$61,944 vs. \$29,185) (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2013).

Table 9-1 summarizes the major types of Medicare and Medicaid services used by full-benefit dual eligibles.⁴ (These figures are based on individuals who had fee-for-service (FFS) coverage in both programs in 2011 and exclude those with end-stage renal disease.⁵) For

Medicare, dual eligibles were more likely than other Medicare beneficiaries, who are not shown in the table, to have an inpatient stay (28 percent vs. 17 percent) and use post-acute services, such as skilled nursing facility care (11 percent vs. 4 percent) and home health care (14 percent vs. 9 percent). Furthermore, Medicare's average spending for those three services—when measured on a per user basis—was 21 percent to 32 percent higher for dual eligibles than for other beneficiaries, indicating that users who are dual eligibles receive more of a particular service, receive a more intensive level of care, or some combination of the two. Almost all dual eligibles used outpatient services and Part D-covered prescription drugs. Outpatient services (30 percent), inpatient hospital care (28 percent), and Part D drugs (24 percent) accounted for most of Medicare's total spending for dual eligibles.

Across all services, average Medicare spending for dual eligibles—measured on a per capita basis—was about \$17,960 in 2011, more than two times higher than the average spending of \$8,460 for other Medicare beneficiaries (data not shown).

As for Medicaid, spending on LTSS, which includes institutional forms of care as well as home- and community-based services, accounts for more than 80 percent of total program spending. However, less than half of dual eligibles use those services.⁶ For those who do, per user spending is high, particularly for institutional LTSS, such as nursing home care (\$41,789), or care provided through a home- and community-based services waiver program (\$29,511).

In aggregate, dual-eligible beneficiaries represented about 20 percent of Medicare enrollees in 2011 (the most recent year of linked Medicare and Medicaid enrollment and spending data available) but accounted for about 35 percent of total Medicare spending. They are costly for Medicaid as well, representing about 14 percent of enrollment and about 33 percent of total spending in that program.

Recent Commission work related to dual-eligible beneficiaries

The Commission has examined several issues in recent years that directly affect dual-eligible beneficiaries. Broadly speaking, the Commission's work has centered on two key areas of interest: (1) developing new models of care that could improve the quality of care and lower costs for dual eligibles and (2) assessing the eligibility rules and financing of care for dual eligibles.

New models of care

Given the challenges involved with coordinating Medicare and Medicaid services for dual-eligible beneficiaries, the Commission has a long-standing interest in developing new models of care, or expanding the use of existing models of care, that would give providers stronger incentives to coordinate care for dual eligibles. Several of these models involve the use of managed care.

In 2012, the Commission examined the Program of All-Inclusive Care for the Elderly (PACE), which serves individuals who are 55 or older and eligible for nursing home care. The program's goal is to keep people living in the community instead of long-term care facilities, and most enrollees are dual-eligible beneficiaries. The central feature of this model of care is the PACE provider, which is usually an adult day-care center that is staffed by an interdisciplinary team and provides therapy and medical services. For dual eligibles, Medicare and Medicaid make separate monthly capitation payments to the PACE provider, and the PACE provider can blend those payments and use them to deliver the full range of Medicare-covered and Medicaid-covered services. The program thus completely integrates the financing and delivery of Medicare and Medicaid benefits and gives PACE providers strong incentives to properly coordinate and manage care.

Although research suggests that PACE improves the quality of care for its enrollees, the program has always been limited in scope, with about 33,000 Medicare beneficiaries currently enrolled. The Commission made a series of recommendations to broaden the use of PACE, including extending eligibility to people younger than 55, developing appropriate quality measures to enable PACE providers to participate in the Medicare Advantage (MA) quality bonus program, and establishing an outlier protection policy for new PACE providers that serve beneficiaries with unusually high costs (Medicare Payment Advisory Commission 2012b).⁷

In 2013, the Commission examined the role of MA special needs plans (SNPs), which can limit their enrollment to one of three specified groups: dual-eligible beneficiaries (in plans known as D-SNPs), beneficiaries who need the level of care provided in a long-term care institution (in plans known as I-SNPs), or beneficiaries with certain chronic conditions (in plans known as C-SNPs). Dual eligibles account for almost all enrollees in D-SNPs and a substantial share of those enrolled in I-SNPs and C-SNPs. At the time, SNPs were authorized

only through the end of 2014; the Congress has since authorized them through the end of 2018.

The Commission examined how well SNPs performed on quality measures compared with other MA plans and concluded that, in certain cases, SNPs were one way to better integrate care for beneficiaries with special health care needs. The Commission recommended that the Congress permanently reauthorize all I-SNPs, certain D-SNPs (those that are highly integrated with Medicaid), and certain C-SNPs (those that focus on certain chronic conditions—such as end-stage renal disease, HIV/AIDS, and severe mental illness—for which a distinct MA benefit package is most warranted). Authority would be allowed to expire for D-SNPs that did not integrate with Medicaid or C-SNPs that focused on other chronic conditions. The Commission also recommended letting MA plans enhance their benefit designs so that benefits could vary based on the medical needs of individuals with certain chronic or disabling conditions (Medicare Payment Advisory Commission 2013).

Eligibility rules and financing

In 2008, the Commission made recommendations that would increase the number of Medicare beneficiaries who are partial-benefit dual eligibles. The Commission examined beneficiaries' participation in MSPs, which provide assistance with Part A and Part B premiums and cost sharing, and the Part D low-income drug subsidy (LIS), which provides assistance with premiums and cost sharing for the Medicare prescription drug benefit. Although MSPs and the LIS provide valuable financial assistance, the research available at the time suggested that participation rates in the programs were relatively low, due to such factors as beneficiaries' lack of knowledge about the programs and the complexity of the application process.

The Commission concluded that participation rates would increase if MSP eligibility rules and application processes were better aligned with the LIS. The LIS has higher eligibility limits than MSPs, and the Commission recommended that the Congress raise the income and asset limits for MSPs to LIS levels. As part of this change, beneficiaries with income between 135 percent and 150 percent of the federal poverty level would become eligible for assistance with the Part B premium, but the cost of that assistance would be paid entirely by the federal government to minimize the impact on state Medicaid budgets.

The Commission also recommended that the Congress require the Social Security Administration, which determines LIS eligibility for most applicants, to also determine whether applicants are eligible for MSPs and enroll them in both programs if they qualify (Medicare Payment Advisory Commission 2008).

In 2012, the Commission recommended making a number of changes to Medicare's cost-sharing rules that could affect low-income Medicare beneficiaries. Those changes included placing an annual limit on beneficiary out-of-pocket spending, establishing a uniform deductible for Part A and Part B that would be higher than the current Part B deductible, replacing coinsurance with copayments that could vary by type of service and provider, and imposing an additional charge on premiums for supplemental insurance coverage, such as medigap plans. However, there would be no change in beneficiaries' aggregate cost-sharing liability. Since Medicaid pays for Part A and Part B cost sharing for many dual-eligible beneficiaries, those changes would increase Medicaid spending for some dual eligibles (such as those who use largely Part B services and would face a higher deductible) while reducing spending for other dual eligibles (such as those with high out-of-pocket spending) (Medicare Payment Advisory Commission 2012b).

Status report on the financial alignment demonstration

Since 2011, CMS has worked with states to conduct a financial alignment demonstration that tests new models of care for full-benefit dual-eligible beneficiaries. (Partial-benefit dual eligibles cannot participate in the demonstration.) These new models seek to improve the coordination of Medicare and Medicaid for dual eligibles, improve the quality of their care, and lower costs. Thirteen states are currently conducting or preparing to conduct demonstrations, and about 450,000 dual-eligible beneficiaries are enrolled in them. Collectively, they represent one of the largest demonstration projects that CMS has ever conducted related to dual eligibles.

For this report, we reviewed a wide range of CMS guidance related to the demonstration, made site visits to three states with demonstrations (California, Illinois, and Massachusetts), and conducted phone interviews with stakeholders in a fourth demonstration state (Washington). Our site visits and phone interviews took place between

November 2015 and February 2016. In all, we conducted over 40 interviews with a diverse range of stakeholders that included state Medicaid officials, executives and care coordination staff for health plans participating in the demonstration, several different kinds of providers, and beneficiary advocacy groups.

Development of the financial alignment demonstration

CMS began developing the financial alignment demonstration in April 2011, when it awarded 15 states up to \$1 million apiece to help them design new approaches for coordinating care for dual eligibles (Department of Health and Human Services 2011). A few months later, in July, CMS announced that states could test two models of care as part of the financial alignment demonstration—a *capitated* model and a *managed fee-for-service* model:

- Under the capitated model, a single managed care plan (known as a Medicare–Medicaid Plan, or MMP) provides the full range of Medicare and Medicaid benefits to dual eligibles. The MMP receives a blended Medicare–Medicaid payment rate that is reduced to reflect expected savings from the demonstration. This model builds on previous efforts to use managed care to better integrate Medicare and Medicaid, such as PACE and Medicare Advantage D–SNPs.⁸
- Under the managed FFS model, states provide greater care coordination to dual eligibles who are enrolled in both FFS Medicare and FFS Medicaid. States receive a retrospective performance payment from Medicare if expenditures for demonstration enrollees are below a target amount. This model builds on broader state efforts to improve the FFS delivery system that involve other reforms such as accountable care organizations and health homes (Centers for Medicare & Medicaid Services 2011).

Many states initially expressed interest in the financial alignment demonstration, but the number of states that are actually participating is much smaller. After CMS's announcement in 2011, a total of 37 states and the District of Columbia indicated their interest in participating, and 26 states ultimately submitted proposals to CMS (Medicaid and CHIP Payment and Access Commission 2015a).

As of March 2016, CMS had approved 14 demonstrations in 13 states. CMS does not expect to approve any more demonstrations; the other states that submitted proposals

The Commission's July 2012 letter to CMS about the financial alignment demonstration

In its letter to CMS, the Commission underscored its support for the goals of the financial alignment demonstration, noting that dual eligibles were often in poor health and vulnerable to receiving uncoordinated care. However, the Commission highlighted five key areas of concern about the demonstration, which at the time was still being developed:

1. **Scope of the demonstration**—At the time, CMS said it was interested in enrolling as many as 1 million to 2 million dual eligibles in the demonstration, which the Commission felt amounted to a program change instead of a true demonstration. The Commission believed that the two new models of care should be tested on a smaller scale before being used more broadly.
2. **Passive enrollment**—The Commission supported the demonstration's use of passive enrollment—that is, the automatic enrollment of beneficiaries—but suggested that it be accompanied by a number of beneficiary protections, such as allowing beneficiaries to opt out at multiple points in the process, conducting extensive outreach and education before passive enrollment, and assessing beneficiaries' care needs shortly after their enrollment.
3. **Plan requirements**—The Commission suggested that CMS use existing requirements for Medicare Advantage plans as a minimum standard for plans participating in the demonstration.
4. **Monitoring and evaluation**—The Commission suggested that CMS collect a core set of measures from all states to monitor access to care and quality, as well as a core set of outcome measures. The Commission also recommended that the evaluation of the demonstration should measure Medicare and Medicaid costs and savings separately, so that

policymakers would know where savings were actually achieved.

5. **Program costs and ensuring savings**—The Commission suggested that the demonstration first aim to improve quality and care coordination for dual eligibles, and only after that to reduce Medicare and Medicaid spending. For the participating managed care plans, CMS planned to lower the blended Medicare–Medicaid capitation rate so that the federal government and states would realize savings, and to use the same percentage to reduce both the Medicare and Medicaid components of the blended rate. The Commission disagreed with this approach, arguing that it was unlikely that both programs would see similar savings. The Commission also expressed concern that states might participate in the demonstration as a way to use Medicare funds to supplement Medicaid funds (Medicare Payment Advisory Commission 2012a).

Some elements of the demonstration as it has been implemented are in line with the Commission's comments, while others are not. The demonstration is much smaller than many observers expected because fewer states are participating, CMS reduced the size of the demonstrations in some states, and many beneficiaries have chosen to opt out. Nevertheless, the demonstration is still larger than needed to test its new models of care. The requirements for the demonstration in the areas of passive enrollment, plan requirements, and monitoring and evaluation are generally in line with the Commission's comments. However, the methodology that CMS is using to pay the health plans participating in the demonstration is generally not aligned with the Commission's comments. For example, CMS has continued to apply a uniform savings estimate to both the Medicare and Medicaid components of plan payment rates, rather than developing separate assumptions for each component. ■

have either formally withdrawn them or are no longer actively discussing them with CMS (Centers for Medicare & Medicaid Services 2016c). States that were initially interested in the demonstration but ultimately did not participate cited a number of reasons for their decision,

such as concerns about low payment rates for participating plans and less state flexibility than initially expected in designing the demonstration. A number of these states have chosen instead to pursue Medicare–Medicaid integration through the use of D–SNPs.

**TABLE
9-2**

Overview of the financial alignment demonstrations

State	Model type	Eligible population	MOU date	Start/end dates	March 2016 enrollment
California	Capitated	Aged and disabled	March 2013	April 2014 to 2017	127,349
Colorado	Managed FFS	Aged and disabled	February 2014	September 2014 to 2017	25,611
Illinois	Capitated	Aged and disabled	February 2013	March 2014 to 2017	49,171
Massachusetts	Capitated	Disabled only	August 2012	October 2013 to 2016	12,642
Michigan	Capitated	Aged and disabled	April 2014	March 2015 to 2018	34,684
Minnesota	Alternative	Aged only	September 2013	September 2013 to 2016	36,052
New York (1)	Capitated	Aged and disabled	August 2013	January 2015 to 2017	6,005
New York (2)	Capitated	Aged and disabled	November 2015	April 2016 to 2020	—
Ohio	Capitated	Aged and disabled	December 2012	May 2014 to 2017	63,112
Rhode Island	Capitated	Aged and disabled	July 2015	mid-2016 to 2018	—
South Carolina	Capitated	Aged only	October 2013	February 2015 to 2018	1,838
Texas	Capitated	Aged and disabled	May 2014	March 2015 to 2018	49,010
Virginia	Capitated	Aged and disabled	May 2013	April 2014 to 2017	28,249
Washington	Managed FFS	Aged and disabled	October 2012	April 2013 to 2016	21,870

Note: MOU (memorandum of understanding), FFS (fee-for-service). Enrollment figures for Washington are for December 2015. All states use additional eligibility criteria beyond age and disability. New York is conducting two distinct demonstrations: The first targets individuals who use certain kinds of long-term services and supports, while the second targets individuals with intellectual and developmental disabilities. All demonstrations are scheduled to end on December 31 of the indicated calendar year. End dates do not account for the optional two-year extension that CMS announced in July 2015.

Source: MedPAC analysis of state MOUs, CMS demonstration guidance, and Medicare Advantage enrollment data for March 2016; personal communication from L. Barnette at CMS.

In July 2012, after states had submitted their proposals but before CMS had approved any demonstrations, the Commission sent a letter to CMS outlining five key areas of concern with the demonstration (see text box).

Table 9-2 provides a high-level overview of the 14 demonstrations that CMS has approved. Most of them are testing the capitated model; only Colorado and Washington are testing the managed FFS model, while Minnesota is testing an alternative model.⁹ Most of the demonstrations are open to both disabled and aged dual eligibles, although one state (Massachusetts) is targeting only disabled beneficiaries, and two states (Minnesota and South Carolina) are targeting only aged beneficiaries.

CMS has approved each demonstration by signing a memorandum of understanding (MOU) with the state that summarizes the key parameters of the demonstration. The first MOU (Massachusetts) was signed in August

2012; the last (for New York’s second demonstration) was signed in November 2015 (Table 9-2). Most of the demonstrations started enrolling beneficiaries about a year after the signing of the MOU. As of March 2016, 12 of the 14 demonstrations were underway, with the last two (Rhode Island and New York’s second demonstration) expected to start later this year.

CMS initially planned for the demonstrations to last for three years, but announced in July 2015 that states could extend them for an additional two years.¹⁰ CMS offered the extension because the first detailed evaluations of the demonstrations will not be ready until the end of their second year, and states would need to start their planning process for fiscal years beyond the original three-year period before then (Centers for Medicare & Medicaid Services 2015f). All participating states expressed interest in the extension, but Virginia now plans to end its demonstration in 2017, as originally scheduled

(Gutman 2015a, Virginia Department of Medical Assistance Services 2015).¹¹ California may also end its demonstration in 2017 if it is not found to be cost effective (State of California 2016). CMS expects to approve the extensions later this year (Centers for Medicare & Medicaid Services 2016c).

About 450,000 dual eligibles were enrolled in the financial alignment demonstrations as of March 2016. California's demonstration is by far the largest, with almost 130,000 enrollees (about 30 percent of the national total), followed by Ohio, Illinois, and Texas.

Demonstrations using the capitated model

As shown in Table 9-2 (p. 273), nine states are currently working with CMS to test the capitated model, which relies on health plans to provide the full range of Medicare and Medicaid benefits to dual eligibles. About 372,000 dual eligibles were enrolled in those demonstrations in March 2016. Two more demonstrations using the model, in Rhode Island and New York, are planning to start later this year.

The centerpiece of the capitated model is the Medicare–Medicaid Plan (MMP), a health plan that provides all Medicare-covered and all or most Medicaid-covered services to dual eligibles. MMPs are required to provide a high level of care coordination for their enrollees; they receive a blended capitation rate that combines Medicare Part A, Part B, and Part D and Medicaid payments. CMS and the states hope that the integration of Medicare and Medicaid financing, combined with extensive requirements for care coordination, will lead to better care for dual eligibles and reduce Medicare and Medicaid spending.

This section covers eight key areas for the capitated demonstrations: beneficiary eligibility, health plan participation, beneficiary participation, the use of passive enrollment, care coordination, quality of care, service use, and payment adequacy. For this status report, we focus in particular on the use of passive enrollment and care coordination, two areas where we have enough information to offer some initial impressions. In many other areas, there is still relatively little information available.

Beneficiary eligibility

CMS has limited the financial alignment demonstration's eligibility to full-benefit dual eligibles—individuals who are eligible for both Medicare (Part A, Part B, and Part D) and full Medicaid benefits in their state. States can further

limit eligibility based on the particular needs of their demonstration, and all states testing the capitated model have done so. These additional eligibility criteria vary across states, but there are some common elements:

- Disabled (under 65) and aged (65 and older) beneficiaries both can enroll in most of the demonstrations. The exceptions are Massachusetts (disabled only) and South Carolina (aged only).
- Most demonstrations operate only in certain parts of the state. South Carolina has the only fully statewide demonstration for the capitated model.¹² The other states limit eligibility to certain counties or regions, usually around large metropolitan areas. For example, Texas is conducting its demonstration in six counties around Dallas, El Paso, Fort Worth, Houston, McAllen, and San Antonio.
- Beneficiaries enrolled in PACE cannot participate unless they first leave the PACE program. These individuals are already served by a program that fully integrates Medicare and Medicaid for dual eligibles.
- Six demonstrations do not allow beneficiaries to participate if they have other forms of health insurance coverage, such as employer-sponsored coverage.
- Seven demonstrations exclude beneficiaries enrolled in certain Medicaid home- and community-based waiver programs. The excluded waiver programs usually serve individuals with intellectual or developmental disabilities.
- Seven demonstrations restrict eligibility for individuals who qualify for Medicaid through “medically needy” programs for people with high medical expenses. Many of these individuals qualify for Medicaid for only a limited time.

As of March 2016, about 1.3 million dual eligibles were eligible to participate in the capitated demonstrations (Centers for Medicare & Medicaid Services 2016b).¹³ That number represents about 35 percent of the dual eligibles in the nine states testing the capitated model and between 15 percent and 20 percent of all dual eligibles in the country. While the size of the eligible population is in line with CMS's interest in enrolling up to 1 million to 2 million dual eligibles in the demonstration, enrollment has been much lower than some expected.

Since eligibility for the demonstration uses both Medicare and Medicaid criteria, states have had to integrate their

**TABLE
9-3**

Largest MMP sponsors as of March 2016

Plan sponsor	Sponsor type	States	Enrollment	Percent of total
Molina	For profit	CA, IL, MI, OH, SC, TX	52,077	14.0%
Centene	For profit	CA, IL, MI, OH, SC, TX	48,338	13.0
Anthem	For profit	CA, TX, VA	36,251	9.7
Aetna	For profit	IL, MI, NY, OH	26,577	7.1
Inland Empire Health Plan	Nonprofit	CA	22,101	5.9
Orange County Health Authority	Nonprofit	CA	18,726	5.0
UnitedHealth Group	For profit	OH, TX	18,462	5.0
Humana	For profit	IL, VA	17,072	4.6
CareSource	Nonprofit	OH	16,076	4.3
Health Care Service Corporation	Nonprofit	IL	14,052	3.8
Total, top 10 sponsors			269,732	72.5

Note: MMP (Medicare–Medicaid Plan). The figures for Centene reflect its acquisition of Health Net, which took effect in March 2016. Anthem has announced plans to acquire Cigna (not shown in this table), and Aetna has announced plans to acquire Humana, but those acquisitions had not received regulatory approval as of the time of this report. If they were approved without any changes, the four largest sponsors would account for just over half of MMP enrollment. Components may not sum to totals due to rounding.

Source: Medicare Advantage enrollment data for March 2016.

enrollment systems with Medicare’s, which has often proven difficult (Chepaitis et al. 2015). Some stakeholders also raised this issue during our site visits, noting that MMPs and providers sometimes have had difficulty obtaining accurate enrollment information.

Health plan participation

As of March 2016, 60 MMPs were operating in the 9 states that had begun testing the capitated model. Two new MMPs intend to begin operating later this year—Rhode Island’s demonstration and New York’s second demonstration (both will use only one MMP). Six other MMPs have left the demonstration since it started—four in New York’s first demonstration and one apiece in Illinois and Massachusetts. The MMPs that left the demonstration either had very low enrollment or cited inadequate payment rates.

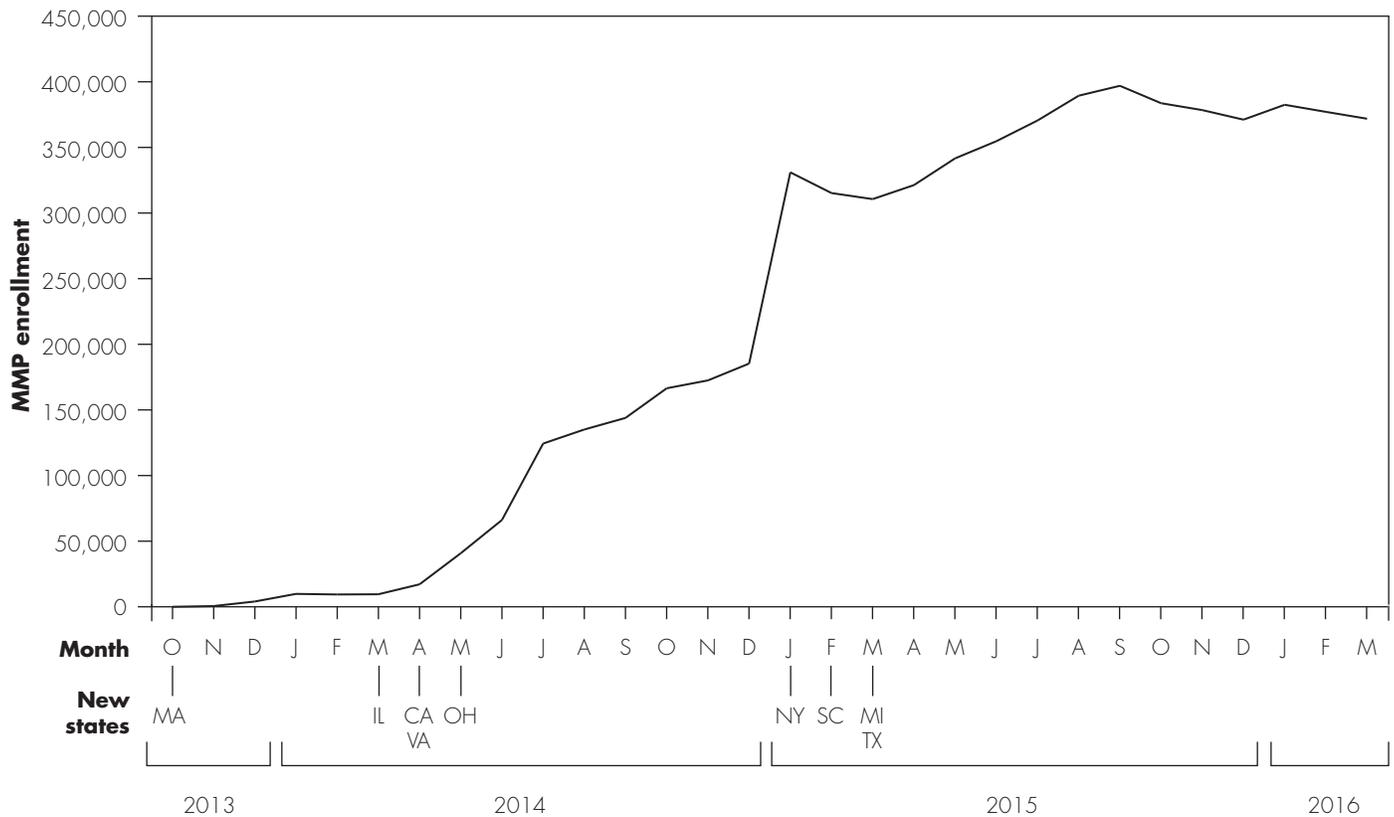
Each MMP signs a three-way contract with CMS and the state that specifies its requirements under the demonstration. States initially select the plans for the demonstration and can limit the number of plans that participate. Some states have chosen from among their Medicaid managed care plans, while others have issued a separate procurement. Plans must also satisfy CMS requirements and pass a readiness review that examines areas such as network adequacy, financial solvency, care-

management capabilities, and plan staffing for functions like customer service (Medicaid and CHIP Payment and Access Commission 2015a).

The number of MMPs in each state varies. All states currently have between 2 and 7 plans, except for California (10 plans) and New York (17 plans in its first demonstration). As noted earlier, many demonstrations are being conducted only in certain parts of the state, and many MMPs serve only part of the demonstration area. For example, Ohio is conducting its demonstration in seven regions. The state has five MMPs, but only two or three operate in each region.

Most MMPs are sponsored by organizations with prior experience in MA, Medicaid managed care, or both. One study found that 52 of the 67 MMPs in the demonstration had prior experience in MA, either by offering D–SNPs or regular MA plans.¹⁴ On the Medicaid side, 45 MMPs had prior experience serving dual eligibles in the state in some fashion (Weiser and Gold 2015). However, some of these MMPs did not have prior experience with LTSS, and some reported that working in that area has been challenging (Chepaitis et al. 2015).

A relatively small number of plan sponsors account for most MMP enrollment. Table 9-3 shows the 10 plan sponsors with the most MMP enrollees, as of March

FIGURE 9-1**Total MMP enrollment, by month, October 2013–March 2016**

Note: MMP (Medicare–Medicaid Plan).

Source: MedPAC analysis of monthly Medicare Advantage enrollment data from CMS.

2016. As a group, these sponsors account for over 70 percent of MMP enrollment. The four biggest sponsors—Molina, Centene, Anthem, and Aetna—are for-profit companies that offer MMPs in several states, and together they account for about 44 percent of MMP enrollment. Although the largest sponsors are primarily for-profit companies across all participating states, regional or local nonprofit MMPs have a significant presence in many individual states.

Beneficiary participation

Total enrollment in MMPs has grown gradually because the individual state demonstrations have started at different times and many have been implemented in stages (Figure 9-1). Overall enrollment has grown from about 4,000 at the end of 2013 (when there was 1 active demonstration), to 185,000 at the end of 2014 (5 active demonstrations), and to 370,000 at the end of 2015 (9 active

demonstrations). Total enrollment peaked in September 2015, at almost 400,000, and has declined somewhat since then. As of March 2016, about 372,000 beneficiaries were enrolled in MMPs.

Enrollment in MMPs has been much lower than many observers expected. When CMS first unveiled the demonstration in 2011, it was interested in enrolling up to 1 million to 2 million beneficiaries (Centers for Medicare & Medicaid Services 2011). Table 9-4 shows, as of March 2016, each state’s MMP enrollment, the number of beneficiaries eligible to participate in the demonstration, and MMP participation rate. Participation rates vary widely across states. Ohio has had the highest participation rate, at 68 percent, followed by five states—California, Illinois, Michigan, Texas, and Virginia—with participation rates of roughly 30 percent to 40 percent. On the low end, three states—Massachusetts, New York, and South

**TABLE
9-4**

MMP participation rates, March 2016

State	MMP enrollment	Eligible beneficiaries	Participation rate
California	127,349	424,000	30%
Illinois	49,171	154,000	32
Massachusetts	12,642	101,000	13
Michigan	34,684	105,000	33
New York	6,005	100,000	6
Ohio	63,112	93,000	68
South Carolina	1,838	50,000	4
Texas	49,010	165,000	30
Virginia	28,249	67,000	42
Total	372,060	1,259,000	30

Note: MMP (Medicare–Medicaid Plan). All of these demonstrations have completed their initial round of passive enrollment except New York and South Carolina. New York stopped using passive enrollment in December 2015, after it had attempted to passively enroll about 50,000 beneficiaries. South Carolina has used only voluntary enrollment so far and is planning to begin passive enrollment later this year. This table does not include Rhode Island’s demonstration or New York’s second demonstration, both starting later this year.

Source: Medicare Advantage enrollment data for March 2016, personal communication from L. Barnette at CMS.

Carolina—have participation rates below 15 percent.¹⁵ Across all participating states, only about 30 percent of eligible beneficiaries are enrolled in MMPs.

Participation rates for the MMPs have been relatively low because many beneficiaries have chosen not to participate. Under the demonstration, states can passively enroll dual eligibles in MMPs, but beneficiaries can “opt out” before their enrollment takes effect, and MMP enrollees can subsequently disenroll at any time.

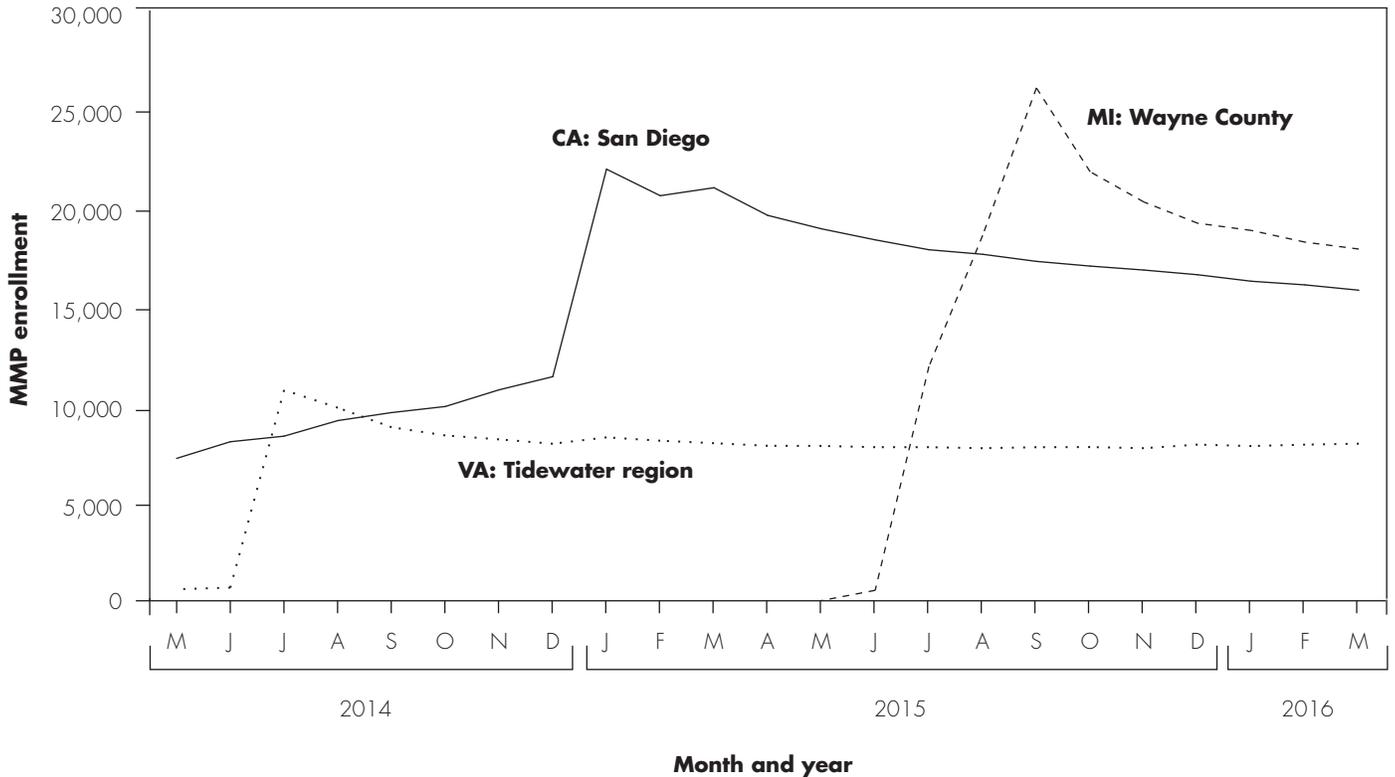
The three states we visited—California, Illinois, and Massachusetts—have experienced high opt-out rates. Stakeholders in those states said that beneficiaries declined to participate in the demonstration for a number of reasons:

- **Satisfaction with existing care.** Some beneficiaries are happy with their current providers and do not think that they will benefit by enrolling in an MMP. They are also concerned that enrolling in an MMP could threaten access to their current providers, such as specialists, who may not participate in the plans’ provider networks.
- **Fear of the unknown.** Many stakeholders indicated that beneficiaries often did not receive a clear explanation of the demonstration or how it would affect them. State educational materials

were sometimes difficult to understand and could prove unreliable. For example, many states had to delay the start of their demonstrations because of implementation challenges, which led to delays in expected enrollment dates. Stakeholders also said that explaining “care coordination” and its benefits for dual eligibles could be difficult. Given the uncertainties, many beneficiaries decided that opting out was the safer course of action.

- **Resistance from providers.** Stakeholders in these states indicated that some providers in their state opposed the demonstration and refused to participate in the MMPs’ provider networks or advised their dual-eligible patients not to participate.¹⁶ These states’ demonstrations largely involved moving FFS beneficiaries into managed care, and provider resistance seemed largely driven by a preference for the existing FFS system and an unwillingness to interact with managed care plans. The types of providers that resisted the demonstration varied across states but included primary care physicians, specialists, physicians in solo or small group practices, and nursing homes.

Although the high opt-out rates have received significant attention, disenrollment (leaving an MMP after being enrolled) has also been an issue. Many states have had

FIGURE 9-2**Attrition in MMP enrollment**

Note: MMP (Medicare–Medicaid Plan).

Source: MedPAC analysis of monthly Medicare Advantage enrollment data from CMS.

similar experiences. Figure 9-2 shows MMP enrollment in three regions that conducted passive enrollment at different times. Once passive enrollment has concluded, MMP enrollment often falls by roughly 10 percent to 30 percent in the following two to three months. After that, enrollment usually continues to decline, but at a slower rate. The decline in enrollment has stopped in some states (Illinois, Massachusetts, Ohio, and Virginia), and MMP enrollment there now appears to be stable. Other states continue to experience gradual declines in their MMP enrollment.

The variation in participation rates also appears to stem partly from structural differences among the individual state demonstrations. For example, Ohio’s high participation rate may be partly because the state effectively moved its dual eligibles into MMPs in two stages—first for Medicaid benefits and then for Medicare benefits. In the first stage, which took place in May 2014, the state required all dual eligibles in counties that

were part of the demonstration to enroll in managed care plans for their Medicaid benefits, including LTSS. In the second stage, which took place in January 2015, the state transferred these dual eligibles into companion MMPs offered by the same parent companies. This two-step process may have helped reduce resistance from LTSS providers to the demonstration (because they now had to operate in a managed care environment regardless) and may have given beneficiaries time to become more comfortable with managed care.

Conversely, the low participation rate in New York’s first demonstration may be partly due to requirements for care coordination that were unusually prescriptive. In particular, the demonstration required primary care physicians to complete training on the process that would be used to prepare each enrollee’s individual care plan, and it required all members of the interdisciplinary provider team (plus the enrollee) to participate in planning

meetings. These requirements were difficult for MMPs to administer and generated strong resistance from providers and high opt-out levels. To date, over 61,000 dual eligibles have opted out of the demonstration, and only about 6,000 were enrolled as of March 2016 (New York State Department of Health 2016). In response, the state suspended the use of passive enrollment in late 2015 and made a series of changes to give MMPs and providers greater flexibility in providing care coordination (New York State Department of Health 2015).

Despite relatively low participation rates, overall MMP enrollment is still substantial at 372,000 beneficiaries and represents a noticeable shift from FFS to managed care for the dual-eligible population. For comparison, the number of full-benefit dual eligibles enrolled in MA plans, which are much more widely available, was about 1.7 million at the end of 2014, with 1.2 million enrolled in SNPs. Enrollment in MMPs is now much higher than in the other forms of managed care that significantly integrate Medicare and Medicaid: fully integrated dual-eligible (FIDE) SNPs (39 plans and about 123,000 enrollees in March 2016) and PACE plans (238 plans and about 35,000 enrollees).¹⁷ Enrollment in most demonstrations appears to be sufficient to properly test the capitated model, with the possible exception of New York, where many MMPs have very low enrollment.

The use of passive enrollment

As part of the capitated model, CMS allows states to use a passive enrollment process to enroll eligible beneficiaries in MMPs. With passive enrollment, states' enrollment of beneficiaries in MMPs is automatic, unless beneficiaries actively indicate that they do not want to enroll in an MMP, which is known as opting out. Beneficiaries who opt out keep their existing form of Medicare coverage.

The use of passive enrollment is a departure from Medicare's usual rules, where the FFS program is the default form of Part A and Part B coverage for new Medicare beneficiaries, and any subsequent changes, such as enrolling in a Medicare Advantage plan or Part D prescription drug plan, are voluntary. However, CMS uses passive enrollment under certain circumstances, most notably to assign certain beneficiaries who receive the Part D low-income subsidy to new prescription drug plans (see text box, pp. 280–281).

CMS authorized the use of passive enrollment in the demonstration to encourage health plans to participate and to ensure that there was enough enrollment to conduct a

robust evaluation. Many health plans believed that they would need to make significant upfront investments to provide the level of care coordination required for MMPs. CMS and the states were concerned that some plans would be unwilling to participate without some assurance that they would have enough enrollment to justify those initial investments. Passive enrollment would result in higher enrollment levels than a purely voluntary system, at least in the short term, and would help ensure that MMP enrollment would be sufficient.

The MMPs we visited largely confirmed these assertions. All indicated that they had made substantial investments to participate in the demonstration, such as developing new information technology systems and hiring and training care coordinators, often months before the demonstration started. Most indicated that passive enrollment was an important factor in their decision to participate in the demonstration.

The use of passive enrollment has been a key feature of the demonstration. Every state that is testing the capitated model has used it in some fashion, and passive enrollment has accounted for the vast majority of overall MMP enrollment.¹⁸

Requirements for MMPs to qualify for passive enrollment

Under the demonstration, MMPs must satisfy two key requirements before they can receive beneficiaries through passive enrollment. First, all states follow a “two-plan” rule that limits their use of passive enrollment to areas where at least two MMPs are operating. CMS requires states to follow this rule if they require Medicaid beneficiaries to enroll in managed care (four demonstration states currently do), but the other participating states have chosen to use it as well. This requirement is borrowed from the Medicaid program, where the two-plan rule is used to ensure that beneficiaries have some degree of choice when states require them to enroll in a Medicaid managed care plan. There are exceptions to the two-plan rule for rural areas and counties in California with a county organized health system (Centers for Medicare & Medicaid Services 2013d).¹⁹ Three demonstration regions—Michigan's Upper Peninsula (a rural area) and California's San Mateo County and Orange County (which have county organized health systems)—qualify for an exception and have used passive enrollment despite having only one MMP. All other demonstration regions are subject to the two-plan rule. States can only use voluntary, or “opt-in,” enrollment in regions that do not satisfy the two-plan rule. However,

Other uses of passive enrollment in Medicare and Medicaid

While the financial alignment demonstration has been noteworthy for its use of passive enrollment, Medicare and Medicaid regularly use passive (automatic) enrollment in other situations.

Medicare Part D

Since Medicare's prescription drug benefit does not have a fee-for-service option, CMS passively enrolls beneficiaries in stand-alone Part D plans in certain situations to ensure that they have prescription drug coverage. CMS categorizes some of these actions as "auto-enrollment" or "facilitated enrollment" instead of passive enrollment, but in each instance CMS selects a Part D plan for a beneficiary, and that selection takes effect unless the beneficiary takes some action to change it.

CMS most commonly uses passive enrollment for beneficiaries who qualify for Part D's low-income subsidy (LIS). All dual eligibles qualify automatically for the LIS. If beneficiaries do not select a Part D plan when they first qualify for the LIS, CMS randomly assigns them to a plan where the LIS fully covers the plan's Part D premium, known as a zero-premium plan. Part D also allows LIS beneficiaries to pick a new Part D plan at any time, with their selection taking effect the following month, or to opt out of passive enrollment entirely. This automatic enrollment is particularly important for dual eligibles who qualify for Medicaid before they qualify for Medicare. When those individuals qualify for Medicare, they lose their Medicaid drug coverage and must enroll in a Part D plan to maintain prescription drug coverage.

CMS also uses passive enrollment to ensure that LIS beneficiaries remain enrolled in zero-premium plans.

Part D plans qualify as zero-premium plans if their premiums are below a benchmark amount, and exactly which plans qualify changes from year to year because of changes in plans' Part D bids. If a plan's premium exceeds the benchmark by more than a minimal amount, LIS beneficiaries must pay the difference. When LIS beneficiaries are in plans that no longer qualify as zero-premium plans in the following year, CMS reassigns them at the start of the following year to another zero-premium plan to ensure that they do not have to start paying a premium. CMS does not reassign LIS beneficiaries who have selected a Part D plan on their own, including beneficiaries enrolled in Medicare Advantage plans that include drug coverage (Centers for Medicare & Medicaid Services 2015c). One study found that only 42 percent of LIS enrollees in 2010 had selected their own plan and that 90 percent of those who had been automatically reassigned accepted their new plan (Hoadley et al. 2015).

Finally, CMS uses passive enrollment when a plan's participation in Part D is terminating immediately and its enrollees' coverage would otherwise be disrupted. In these cases, CMS reassigns the beneficiaries in the terminating plan to a new plan and gives them a chance to pick a new plan.²⁰ CMS also reassigns beneficiaries when a Medicare Advantage (MA) plan that includes Part D coverage terminates immediately; the beneficiaries in that plan are either transferred to another MA plan with Part D coverage or placed in the fee-for-service (FFS) program and passively enrolled in a Part D plan.

Medicare Advantage

Health insurance companies typically offer plans in multiple lines of business, such as MA, commercial

(continued next page)

when an MMP plan sponsor also offers an MA plan or Medicaid managed care plan, states can transfer eligible beneficiaries from these plans to the sponsor's MMP—a process sometimes referred to as "crosswalking"—even if that is the only MMP available in an area.

Several states have had difficulty getting enough plans to participate in their demonstration projects, either because fewer plans agreed to participate at the outset or because

some MMPs have dropped out during the demonstration. Because of the two-plan rule, there have been several instances in which low plan participation has significantly limited states' ability to use passive enrollment:

- Illinois no longer uses passive enrollment in its Central Illinois region after one of the two MMPs there withdrew from the demonstration at the end of 2015.

Other uses of passive enrollment in Medicare and Medicaid (cont.)

insurance, or Medicaid managed care. Sponsors of MA plans may take individuals who have been enrolled in one of their non-Medicare health plans and passively enroll them in one of their MA plans when those individuals first become eligible for Medicare. This process is optional for plan sponsors and is known as “seamless conversion.” CMS requires sponsors to notify affected beneficiaries at least 60 days before they become eligible for Medicare and allow them to opt out of seamless conversion (Centers for Medicare & Medicaid Services 2014a). CMS has not indicated how many plan sponsors offer seamless conversion or how many beneficiaries are affected.

One-time opportunity for certain special needs plans

In 2006, a number of Medicaid managed care plans that served dual eligibles decided to begin offering special needs plans (SNPs) as well. CMS gave 42 SNPs in 13 states a one-time opportunity to passively enroll the dual eligibles from their Medicaid managed care plans in their new companion SNPs. Beneficiaries could opt out and stay enrolled in FFS Medicare, but most accepted their new coverage, which led to a substantial increase in SNP enrollment (Milligan and Woodcock 2008). CMS passively enrolled about 213,000 beneficiaries in SNPs through this process (Schmitz et al. 2008).

This use of passive enrollment in SNPs had mixed results. Implementation in many areas went relatively smoothly, but SNPs in Pennsylvania had problems coordinating Medicare and Medicaid benefits, which ultimately prompted a class-action lawsuit and a settlement stopping the use of passive enrollment in the state (Saucier et al. 2009). In California, opt-out rates varied significantly: Only one-third of beneficiaries

who were passively enrolled in San Mateo County chose to opt out, compared with about 80 percent of beneficiaries in Orange County (Gold et al. 2013).²¹

Medicaid

One notable difference between Medicare and Medicaid is that states can require many categories of Medicaid beneficiaries to enroll in a managed care plan in order to receive their Medicaid benefits. States that require beneficiaries to enroll in managed care must generally offer them a choice of at least two plans and passively enroll them in a plan if they do not pick one on their own. When states conduct these passive enrollments, they must try to maintain beneficiaries’ existing relationships with health care providers. In addition, when beneficiaries first enroll in Medicaid managed care, many states allow them to switch plans for any reason within a certain period of time. Once that period ends, many states have “lock-in” provisions that prevent beneficiaries from switching plans, usually for 6 to 12 months (Medicaid and CHIP Payment and Access Commission 2011).

In most states, mandatory enrollment in Medicaid managed care is now the norm for low-income children and adults who are not disabled or elderly. Medicaid prohibits states from requiring dual eligibles to enroll in managed care unless they obtain a waiver from CMS, and enrollment in Medicaid managed care has traditionally been lower for dual eligibles than for other Medicaid beneficiaries. However, the number of states that require dual eligibles to enroll in Medicaid managed care has grown significantly in recent years, particularly due to state interest in using managed care plans to deliver long-term services and supports (Saucier and Burwell 2015). ■

- Massachusetts originally planned to operate its demonstration throughout the state, but has been able to operate it in only 9 of the state’s 15 counties because of limited interest from health plans. Only four of those counties initially satisfied the two-plan requirement, which meant that the state could use passive enrollment for only about half of the eligible beneficiaries. One of the state’s three MMPs later withdrew from the demonstration in September 2015, and currently only two counties, with about 30 percent of the eligible beneficiaries, are eligible for passive enrollment (Barry et al. 2015, Massachusetts Executive Office of Health and Human Services 2015).
- Texas has not been able to use passive enrollment in Tarrant County (Fort Worth) because only one MMP has received approval to operate there. However, the

state has crosswalked beneficiaries into the MMP from the plan sponsor's Medicaid managed care plan.

- Virginia has been able to use passive enrollment only in parts of its Northern Virginia region because some areas there have only one MMP. One area that has not met the two-plan rule is Fairfax County, the state's most populous county and home to about 20 percent of the state's eligible beneficiaries.

Second, CMS has limited the extent to which parent organizations with poor performance in the Medicare Advantage or Part D programs can participate in the demonstrations. Parent organizations that are under any kind of Medicare enrollment or marketing sanction are prohibited from participating in the demonstrations; organizations that are sanctioned after the demonstration has already started cannot enroll any new members until the sanction has been lifted. Parent organizations that are considered outliers based on their past performance or designated "consistently low performing" in Medicare's star ratings for MA and Part D plans are allowed to participate in the demonstration, but they cannot receive passively enrolled beneficiaries while their low-performance designation remains in effect (Centers for Medicare & Medicaid Services 2013d). Both of these requirements delayed the start of the demonstration project in parts of California (Weiser and Gold 2015), and an MMP in Illinois was barred for a period of time from receiving passively enrolled beneficiaries.

Beneficiary protections Once states have a sufficient number of qualified MMPs and are able to conduct passive enrollment, they must meet a number of CMS requirements intended to limit disruptions to beneficiaries' coverage and ensure that affected beneficiaries are adequately informed about the coming changes in their Medicare and Medicaid coverage and their ability to opt out.

Certain groups of beneficiaries are exempt from passive enrollment and can participate in the demonstration only on a voluntary basis. The three major exemptions are:

- Beneficiaries enrolled in PACE, which provides Medicare and Medicaid benefits to frail individuals who are 55 or older and live in the community. PACE enrollees already receive fully integrated care and may not benefit from enrolling in an MMP.
- Beneficiaries with retiree health coverage from a former employer or union; these individuals may

inadvertently lose their retiree coverage if they enroll in an MMP.

- Beneficiaries who opt out of passive enrollment.

Some states exempt other groups from passive enrollment in their demonstration projects. In particular, states differ on using passive enrollment for beneficiaries in MA plans. Two states exclude all MA enrollees from passive enrollment, one state excludes only those enrolled in employer-sponsored MA plans, three states use passive enrollment only to crosswalk beneficiaries from MA plans to MMPs offered by the same plan sponsor, and three states include all MA enrollees in passive enrollment.

Under the passive enrollment process, states must send beneficiaries two advance notices. The first notice must be sent at least 60 days before enrollment takes effect. It tells beneficiaries that they will be enrolled in an MMP if they take no further action, indicates which MMP they will be enrolled in, and tells them how they can opt out. The second notice is a reminder and must be sent at least 30 days before enrollment takes effect. Beneficiaries can opt out by contacting the state or calling 1-800-MEDICARE and can opt out as late as the day before their enrollment is scheduled to take effect. Beneficiaries who opt out cannot be passively enrolled in an MMP at any other point during the demonstration, although they can later enroll voluntarily, as long as they remain eligible to participate (Centers for Medicare & Medicaid Services 2013b).²²

After beneficiaries have been passively enrolled, they can leave their MMP at any time, with their new coverage taking effect at the beginning of the next month. This is consistent with long-standing Medicare rules that allow dual eligibles to switch MA or Part D plans on a month-to-month basis. Beneficiaries can disenroll by enrolling in another MMP, an MA plan, or a stand-alone Part D plan. They can also disenroll without selecting a new form of Medicare coverage; if they do so, they are placed in FFS Medicare and passively enrolled in a stand-alone Part D plan. As for Medicaid, beneficiaries who disenroll are either returned to FFS Medicaid or are required to enroll in a Medicaid managed care plan, depending on the state.²³

Many stakeholders we interviewed said that some beneficiaries do not read the 60-day and 30-day notices and do not realize that they have been passively enrolled in an MMP until they visit their doctor or try to fill a prescription. At that point, some of these beneficiaries disenroll from the MMP, which may help explain the

initial drop in enrollment that many states experienced after conducting passive enrollment (Figure 9-2, p. 278).

States must also try to assign beneficiaries to the MMP that best meets their needs by using recent Medicare and Medicaid claims data to identify each beneficiary's key providers, such as a primary care physician, and assigning the beneficiary to the plan that includes those providers in its network (Centers for Medicare & Medicaid Services 2013b). However, stakeholders on our site visits indicated that this assignment process does not always work well. For example, states may have difficulty obtaining current claims data, and their information about which providers participate in each MMP's network can sometimes be incomplete or out of date. States also assign many beneficiaries to MMPs based on their primary care provider, but other providers, such as behavioral health providers or Medicaid personal care attendants, may be more important for certain groups of beneficiaries.

For the financial alignment demonstration, CMS has stated that beneficiaries can be passively enrolled only once each year, and that limit applies across both Part D plans and MMPs. States with demonstrations have thus had to coordinate their passive enrollment schedules with Part D's schedule, in which passive enrollments take effect in January. For example, a state that conducted passive enrollment for its MMPs in mid-2015 could not immediately enroll any beneficiaries that had been assigned to a new Part D plan in January 2015; the state would instead have had to wait until January 2016 before enrolling them in an MMP (Centers for Medicare & Medicaid Services 2013b).²⁴ While this requirement may reduce disruptions in coverage for affected beneficiaries, it can also limit states' ability to gradually enroll beneficiaries in their MMPs. As a result, some states had to make many of their passive enrollments effective in January, and this clustering can make it difficult for MMPs to complete health assessments for new enrollees in the required time frames.²⁵

Finally, all states use third-party brokers to process voluntary MMP enrollments. Unlike MA plans, plan sponsors cannot directly market to beneficiaries or enroll them in their MMPs. However, now that the demonstration's initial round of passive enrollment is largely over and many eligible beneficiaries have not enrolled, some stakeholders we interviewed were exploring new ways to inform beneficiaries about the demonstration. For example, companies that sponsor both a Medicaid managed care plan and an MMP could

send information about their MMP product to those enrolled in the Medicaid plan. One state was considering a nonbranded campaign (i.e., not specific to any particular MMP) that would advertise the benefits of the demonstration. Finally, some MMPs said they would like to be able to market directly to beneficiaries; they noted that beneficiaries often have very specific questions when deciding whether to enroll (for example, whether their doctors are in the plan's network) and that individual MMPs can best provide that information.

How states have used passive enrollment Except for the beneficiary protections described above, states have considerable flexibility in deciding how to conduct passive enrollment. CMS has urged states to phase in the use of passive enrollment, and most have done so, using a variety of approaches (Centers for Medicare & Medicaid Services 2013b). Some states with multiple demonstration regions have started passive enrollment at different times for each region, depending on when the MMPs there were ready. Many states have conducted passive enrollment over several months, splitting their dual eligibles into cohorts using variables like birth month, zip codes, Medicaid case numbers, or Medicaid renewal dates. Some states have also distinguished dual eligibles based on their LTSS use, with LTSS users often being enrolled later. Some states have numeric limits on the number of dual eligibles that can be passively enrolled in a plan in a given month, while other states factor in each plan's capacity to accept new enrollees. Many states have used some combination of these approaches.

One key issue is whether states passively enroll beneficiaries who first become dual eligibles after the start of the demonstration. The composition of the dual-eligible population changes noticeably over time, largely because dual eligibles are typically in poorer health than other Medicare beneficiaries and are more likely to die in a given year. For example, we identified beneficiaries who were dual eligibles in January 2011, using national data, and followed them over time. The share of the cohort that was still both alive and dually eligible declined to 86 percent after one year, 79 percent after two years, and 72 percent after three years. Among the 28 percent that were no longer dual eligibles after three years, 20 percent had died, 3 percent had switched from being full-benefit dual eligibles to partial-benefit dual eligibles, and 5 percent were no longer eligible for Medicaid.

When states have conducted passive enrollment, they have initially limited their efforts to beneficiaries who

were eligible for the demonstration at the time it started. Since mortality rates for the dual-eligible population are relatively high, this one-time approach will likely result in declining MMP enrollment over time (even if there were no disenrollment, which has not been the case), unless the declines are offset by growth in voluntary MMP enrollment. States can passively enroll beneficiaries who have newly become dual eligibles but must navigate some operational challenges before doing so.²⁶ However, using passive enrollment on an ongoing basis can help stabilize MMP enrollment. Three states (Illinois, Ohio, and Virginia) currently conduct passive enrollment each month for their new dual eligibles, and MMP enrollment in those states appears to be stable. Two other states (Michigan and Texas) are planning to begin passively enrolling their new dual eligibles later this year.

Perspectives from site visits Most (but not all) of the stakeholders we interviewed on our site visits supported the use of passive enrollment, and some MMPs said that passive enrollment had been an important factor in their decision to participate in the demonstration. However, stakeholders broadly agreed that its implementation had been problematic, and they had numerous suggestions for how it could be better used in the future.

Although the three states we visited conducted passive enrollment in stages, the most common sentiment was that passive enrollment should have been implemented more slowly. MMPs had difficulty contacting a significant number of enrollees and struggled to meet their deadlines for completing initial health assessments for all enrollees. (In this respect, the low participation rates have been beneficial, by relieving some of the workload for the MMPs.) Stakeholders suggested passively enrolling beneficiaries in smaller monthly increments or separating each “wave” of passive enrollment by a month or two to give MMPs time to contact and assess new enrollees. In this regard, CMS could make it easier for states to stretch out the implementation of passive enrollment by modifying its policy that beneficiaries cannot be passively enrolled in both a stand-alone Part D plan and an MMP in the same year.

Stakeholders also frequently said that passive enrollment should have been preceded by a more robust outreach and education campaign, for both beneficiaries and providers. States often sent numerous mailings about the demonstration to beneficiaries before passive enrollment, but those materials were sometimes difficult to understand (many states have revised their mailings during the

demonstration) and sometimes turned out to be inaccurate, particularly when states had to delay the start of their demonstrations. One stakeholder indicated that face-to-face outreach efforts, such as presentations in nursing homes, would be most effective, especially if state officials and MMP representatives both participated.

Some stakeholders, mainly from MMPs, said that states should be allowed to use “lock-in periods” that limit when beneficiaries can disenroll. States often have lock-in periods for their Medicaid managed care plans, and about half of the states testing the capitated model had some sort of lock-in period in their original demonstration proposal. The MA and Part D programs also have lock-in periods; most beneficiaries can leave their plan only during the annual open enrollment period. However, CMS has always allowed dual eligibles to leave MA and Part D plans at any time and decided to apply the same policy to MMPs. Stakeholders argued that lock-in periods could help compensate for poor beneficiary outreach and education by giving beneficiaries sufficient time to become familiar with the MMP and its benefits. In concept, a lock-in period could be used for all beneficiaries who are passively enrolled (eliminating their ability to opt out) or applied only once beneficiaries are actually enrolled in an MMP. The stakeholders who supported the use of lock-in periods appeared to be primarily interested in the latter, more limited approach.

Care coordination

Under the demonstration, MMPs are required to provide extensive care coordination to their enrollees, which CMS and states hope will improve their quality of care and reduce spending relative to the FFS Medicare and Medicaid programs.

Key elements of the MMP care coordination model The care coordination requirements for MMPs have three key elements: the completion of an initial health assessment for all enrollees, the development of individual plans of care by interdisciplinary teams of providers, and the use of care coordinators to help dual eligibles obtain and manage their care.²⁷

All beneficiaries must receive an initial health assessment when they first enroll in an MMP. The assessment is supposed to be comprehensive, covering such areas as physical health, behavioral health, ability to perform activities of daily living, and cognitive status (Medicaid and CHIP Payment and Access Commission 2015a). Each state has its own deadlines for completing the assessments;

in the states we visited, they generally had to be completed within two to three months of enrollment. MMPs must also periodically update their assessments, usually at least once a year.

MMPs must also develop individual care plans for each enrollee, based in part on the results of the initial health assessment. Like the assessment, the care plan is intended to be comprehensive and cover the full range of a beneficiary's care needs. The plan must be formulated by an interdisciplinary team: Each state has its own membership requirements, but the teams normally include the enrollee's care coordinator, primary care physician, LTSS providers, relevant specialists (such as behavioral health providers), as well as the enrollee.²⁸

Finally, MMPs are required to assign a care coordinator to each enrollee. The care coordinator often takes the lead in developing an enrollee's care plan and provides ongoing help in finding and obtaining necessary care (Medicaid and CHIP Payment and Access Commission 2015a).

Findings from site visits Based on our site visits to California, Illinois, and Massachusetts, care coordination is very much a work in progress. Many MMPs we interviewed had confronted similar challenges in trying to coordinate care for their enrollees, but each had developed a care coordination model that was unique in some respects, even among MMPs in the same state. Plans were also continuing to develop and refine their care coordination models as they gained more experience with their enrollees.

Most MMPs, as well as many other stakeholders, said that the completion of the initial health assessments had been a significant challenge. Part of the problem was the sheer number of new enrollees who needed assessments. Despite state efforts to phase in passive enrollment, many MMPs still had months in which they received more than a thousand new enrollees, often followed a month later by another wave of passive enrollment. Some MMPs also found it difficult to staff properly for the assessments because the share of beneficiaries who opted out varied from one wave of passive enrollment to the next (so while the state may have included the same number of beneficiaries in each wave, the number who ultimately enrolled varied).

The MMPs we interviewed also said that the enrollee contact information they received from the state was often outdated and that it had been very difficult to contact some enrollees to conduct their assessments. (Several

MMPs, in different states, indicated that 20 percent to 30 percent of their enrollees had been unreachable.) Plans have sometimes taken unorthodox measures to locate enrollees, such as asking pharmacies where enrollees had filled prescriptions for contact information, sending care coordinators to the hospital when they learned that enrollees were in the emergency room, or going to enrollees' last known addresses and asking people in the community for any information on their whereabouts.

MMPs have largely used nurses to complete the assessments because they require clinical expertise. The assessments are either done in person, usually at the enrollee's home or a doctor's office, or over the phone, depending on the beneficiary's health needs. Some plans have used in-house staff to conduct the assessments, while other plans have used outside contractors to conduct most of them (with some plans turning to contractors only after they realized that they needed additional help to complete the assessments on time). Even where plans use in-house staff for the assessments, the person who conducts the assessment is usually different from the care coordinator.

Each MMP we interviewed said that it had made significant investments to get ready for the demonstration. Most plans had hired dozens of care coordinators; CMS has estimated that the MMPs with active enrollment as of the end of 2014 had hired about 2,500 care coordinators in all (Centers for Medicare & Medicaid Services 2015f). Plans often hired coordinators several months before the start of the demonstration to train them. Many plans had also made changes to their information technology systems; for example, they modified their electronic health record systems to accommodate LTSS providers and better track interactions between care coordinators and enrollees.

Most care coordinators have backgrounds in social work, with plans using more highly trained staff (such as nurse practitioners, licensed clinical social workers, or mental health counselors) to provide additional expertise when needed. The care coordinators are usually assigned to the enrollees in a specified geographic region, and their caseloads vary depending on the health needs of the enrollees.²⁹ The coordinators we interviewed spent most of their time either on the phone (making appointments for beneficiaries, answering questions from beneficiaries, helping beneficiaries obtain approval for services such as durable medical equipment, and so on) or meeting with beneficiaries in person (for example, checking on beneficiaries' living arrangements or accompanying them

Caring for dual eligibles with behavioral health needs

Dual-eligible beneficiaries are much more likely than other Medicare beneficiaries to have a behavioral health condition, meaning some form of mental illness or substance abuse disorder. Researchers use different methods to identify beneficiaries with behavioral health conditions, so prevalence estimates vary. As one example, the Congressional Budget Office found that in 2009, 30 percent of dual eligibles had been diagnosed with a mental illness, compared with 11 percent of Medicare-only beneficiaries (Congressional Budget Office 2013). Since so many dual eligibles have behavioral health needs, we asked stakeholders during our site visits about the challenges involved with caring for this population.

The Medicare–Medicaid Plans (MMPs) we interviewed recognized the importance of behavioral health care under the financial alignment demonstration. As part of the demonstration, most plans had hired staff that specializes in behavioral health; these individuals often helped to oversee the work of the care coordinators and

the development of individual care plans for enrollees with behavioral health conditions. Some MMPs had also contracted with community mental health providers to furnish care coordination for plan enrollees, particularly those considered high risk. Some plans said that it had been harder to complete the initial health assessments for enrollees with behavioral health needs and that it was particularly important for care coordinators to develop trusting relationships with these enrollees to be effective. Plans also noted that some beneficiaries with behavioral health conditions are either homeless or lack stable housing arrangements and that finding adequate housing was often the biggest challenge for their care coordinators.

Several stakeholders said that there was a general shortage of providers of outpatient mental health services in their areas and that this shortage made it more difficult for MMPs to reduce inpatient admissions related to behavioral health. Some stakeholders hoped that the MMPs would provide a

(continued next page)

to appointments). Often, care coordinators also spent time helping beneficiaries obtain assistance from a range of social service programs, such as those providing housing assistance.

Some plans found it difficult to hire or retain care coordinators, especially in the early stages of the demonstration when other MMPs in the area were also staffing up. (In one case, an MMP lost all its care coordinators after the state delayed the start of the demonstration and the coordinators had nothing to do. The plan later had to hire an entirely new group of care coordinators.) Many plans try to hire people from local social service agencies because their employees have experience working with disabled and aged individuals and are familiar with the various social services available in the community.

Depending on the plan, care coordinators can be direct employees of the plan, employees of one of the plan's subcontractors, or a mix of the two. Most care coordinators in Massachusetts and Illinois worked directly

for the MMP, while most in California were employed by plan subcontractors.³⁰ However, these arrangements were evolving as plans gained experience and tested new approaches. We saw movement in both directions: One plan that largely used internal employees as care coordinators was experimenting with using primary care practices and social service agencies to provide care coordination, while another plan that largely relied on subcontractors was considering moving some care coordination in-house, particularly for high-risk or high-cost beneficiaries.

All MMPs that we interviewed tried to focus their care coordination efforts on enrollees with the greatest care needs. (The text box describes some of the specific challenges involved with one particularly important subset of dual eligibles—those with behavioral health conditions.) Some states were more prescriptive than others in this area. For example, Illinois requires its MMPs to classify beneficiaries receiving home- or community-based LTSS as either medium or high risk, but MMPs appeared to have a fair amount of latitude in classifying enrollees. High-risk

Caring for dual eligibles with behavioral health needs (cont.)

new source of funding for outpatient mental health providers and help support them. We interviewed one mental health provider who reported being able to hire more staff as a result of the demonstration.

Behavioral health has been a particularly important issue in Massachusetts, which has the only demonstration limited to beneficiaries with disabilities. One of the state's MMPs has gone to unusual lengths to expand the availability of care outside of inpatient hospitals by opening and operating two crisis stabilization centers. The centers provide 24-hour care to enrollees who have behavioral health needs that are not acute enough to require inpatient hospital care. The centers are staffed by a combination of psychiatric nurse practitioners, licensed clinical social workers, and nurse managers and provide counseling and addiction treatment. The plan says that the cost of caring for beneficiaries in the centers is much lower than the cost of inpatient care (\$600 per day vs. \$1,100 per day) (McCluskey 2015a). Some stakeholders

also said that peer specialists—individuals who have personal experience managing their own behavioral health conditions—provide an effective way to engage enrollees with behavioral health needs, but they are in short supply because they take time to train.

Multiple stakeholders also said that it had been challenging to provide care coordination and use interdisciplinary teams of providers for beneficiaries with behavioral health needs while also adhering to federal laws and regulations (particularly those in Title 42, Part 2, of the Code of Federal Regulations) that limit the disclosure of patient information related to substance abuse. Stakeholders in Los Angeles have responded by developing a universal consent form that authorizes the disclosure of enrollees' patient information and will be used by all MMPs and providers in the city. There was widespread agreement that the form will make it easier to coordinate care for these beneficiaries while still providing adequate privacy safeguards. ■

enrollees receive the most extensive care coordination, such as regular calls from their care coordinators and in-person meetings or assistance. Care coordination for low-risk enrollees is much more limited; in one MMP, low-risk enrollees receive calls only periodically (less than monthly) from their care coordinators and have little or no in-person contact. MMPs said that they provide greater care coordination as needed (for example, after an inpatient stay), but some beneficiary advocates said that plans' efforts to classify enrollees were not always accurate and that some enrollees who were considered low risk would benefit from greater care coordination.

In each state we visited, beneficiary advocates and providers reported some level of confusion about the MMPs' care coordination efforts. Some beneficiaries did not know who their care coordinators were or how to contact them, which could be partly due to turnover among care coordinators. The responsiveness of the individual care coordinators also appeared to vary. LTSS providers that had coordinated care for enrollees before the demonstration as part of Medicaid home- and community-

based waiver programs were also uncertain about their role once MMPs became the locus for care coordination.

Quality of care

Improving the quality of care for dual eligibles is one of the primary goals of the demonstration. MMPs are required to collect and report the same quality data as MA plans. CMS and the states also require MMPs to regularly submit a wide range of additional quality data as part of their efforts to oversee the demonstration and evaluate its impact. Some requirements are modeled after the MA and Part D programs (dealing with issues like grievances, coverage determinations and reconsiderations, and pharmacy access), while others were developed specifically for MMPs.

The MMP-specific measures are a mix of process and structure measures (such as completing health assessments and reassessments on time and establishing a consumer advisory board) and utilization measures (such as emergency room visits related to behavioral health and diversion of beneficiaries from nursing homes) (Centers

for Medicare & Medicaid Services 2015g). CMS and states use these measures partly to determine MMP payment rates. Quality data are not yet available for MMPs, but CMS plans to release this information when it becomes available.

In November 2015, CMS announced plans to develop a star rating system for MMPs. This rating system will differ from the one used for MA plans because MMPs provide a much broader range of services. CMS tentatively proposed that ratings for MMPs be based on their performance in six areas: The provision of LTSS and management of chronic conditions would each count for 25 percent of the rating; prevention, safety of care, member experience, and plan performance on administrative measures would each count for 12.5 percent of the rating.

CMS does not plan to have the rating system ready until after the end of the demonstration, but has begun working on it now in case the demonstration succeeds and the use of the capitated model is expanded. CMS noted that there is a shortage of accepted quality measures for LTSS, in particular, and that the time frame for developing them “is likely to be long” (Centers for Medicare & Medicaid Services 2015h). Other observers have also noted the current lack of quality measures for LTSS and argued that it will be difficult to compare performance across MMPs without them (Zainulbhai et al. 2014).

Service use

We chose California, Illinois, and Massachusetts for our site visits because they were among the first states to begin their demonstrations. At the time of our visits, the Massachusetts demonstration had been underway for about 2 years; Illinois and California, about 18 months. We hoped that this experience would enable stakeholders to provide insights into whether MMPs have been able to better manage service use and improve the quality of care for dual eligibles. However, the representatives from the MMPs that we interviewed said that it was unrealistic to expect plans to produce savings in the first few years of the demonstration. Other stakeholders had the same view, and the plans themselves said that they had not yet seen noticeable changes in service use for their enrollees. The plans said that several factors made savings unlikely in the near term, such as the gradual implementation of passive enrollment, the challenges that many plans faced in completing the initial health assessments, and continuity-of-care requirements.³¹ More broadly, most MMP enrollees had come from the FFS environment, and plan representatives said they would need time to build

relationships with the enrollees before they could modify certain enrollee behaviors, such as using emergency rooms to obtain primary care.

The delivery of LTSS appeared to have been a particular challenge for many MMPs we interviewed. Most had little prior experience managing these services and had to acquaint themselves with entirely new types of providers and services. In the early stages of the demonstration, the delivery of LTSS seemed to differ little from the prior FFS Medicaid system, with plans often deferring to the judgment of LTSS providers about which services were appropriate. However, as the MMPs gained experience, they began to take a more active role in LTSS delivery (for example, reviewing care needs for enrollees who had been approved for skilled nursing visits).

As part of the demonstration, MMPs have flexibility to experiment with new forms of service delivery and care coordination. For example, one MMP was testing the idea of paying monthly stipends to enrollees’ personal care attendants in return for regular updates on the enrollees’ overall health and functioning, while another MMP opened a pair of crisis stabilization centers to serve enrollees with behavioral health needs (see text box, pp. 286–287).

However, this flexibility has limits. Several stakeholders said that help with housing was the most pressing need for some MMP enrollees, but that plans generally could not use their funds for permanent housing assistance. Instead, care coordinators tried to help these enrollees obtain housing through existing social service programs.

CMS intends to examine changes in beneficiaries’ service use as part of its overall evaluation of the demonstration, which is expected to include annual reports and a final report for each state. However, no annual reports have yet been released for states testing the capitated model.

Payment adequacy

Under the capitated model, MMPs provide all Part A, Part B, and Part D benefits to their enrollees, as well as all or most of the state’s Medicaid-covered services.³² MMPs are accordingly paid a monthly capitation rate with three distinct components: one for Medicare Part A and Part B services, one for Part D drugs, and one for Medicaid services. However, the payment methodology for MMPs differs from those used in the MA and Part D programs in several respects.

For Part A and Part B benefits, MMPs are paid using a county-level base rate that is adjusted for differences in

beneficiaries' health status. CMS determines the base rate using historical FFS and MA spending data for beneficiaries who meet the demonstration's eligibility criteria. In most states, the eligible population was largely enrolled in FFS Medicare before the demonstration, so the base rate is primarily based on historical FFS experience. The base rates are also standardized to reflect costs for a beneficiary of average health status and are updated annually based on FFS per capita spending growth. Unlike MA plans, MMPs do not submit bids for the cost of providing Part A and Part B benefits. CMS adjusts for differences in beneficiaries' health status using the hierarchical condition category (HCC) risk adjustment model that Medicare uses to pay MA plans.³³

MMPs also do not submit bids for the cost of providing Part D drugs. Instead, CMS pays MMPs based on the national average bid for all Part D plans. Like Part D plans, MMPs receive a capitated direct subsidy payment as well as prospective payments for estimated reinsurance costs for beneficiaries with high drug costs and for beneficiary cost sharing covered by the Part D LIS, which all dual eligibles receive. The direct subsidy payment is adjusted for differences in beneficiaries' health status using the prescription drug HCC risk adjustment model used for Part D plans.

For Medicaid benefits, each state determines its own payment rates, subject to CMS approval. The rates include both federal and state Medicaid spending and typically vary based on beneficiaries' use of LTSS. Medicaid rates are typically highest for beneficiaries in nursing homes and lowest for those not receiving any LTSS, with rates for beneficiaries receiving home- and community-based LTSS somewhere in between.

CMS and states also make two other adjustments to produce the final MMP payment rates. Both adjustments apply only to the Part A and Part B and Medicaid components. First, part of the payment rate is withheld (known as the "quality withhold") and later paid to the plan if it performs sufficiently well on a range of quality measures, such as completing initial health assessments on time. For almost all states, the quality withhold equals 1 percent of the rate in the first year of the demonstration, 2 percent in the second year, and 3 percent in the third year. Second, rates are reduced by a certain percentage to reflect savings that CMS and states assume MMPs will be able to produce under the demonstration (Centers for Medicare & Medicaid Services 2013a). The savings percentages vary by state but are generally around 1 percent in the first year of the

demonstration, 2 percent in the second year, and 3 percent to 5 percent in the third year (Medicaid and CHIP Payment and Access Commission 2015a).

CMS has made a number of changes to its payment methodology during the demonstration. Most notably, the agency increased payment rates for 2016 for the Part A and Part B component based on an analysis that found that the HCC risk adjustment model underestimated costs for full-benefit dual eligibles (Centers for Medicare & Medicaid Services 2015i). The increase is between 5 percent and 10 percent for most MMPs. CMS has also raised Part A and Part B and Medicaid payment rates for MMPs in Massachusetts and Virginia by reducing some of the savings percentages and quality withholds. Finally, CMS increased certain Part D payments for MMPs in Massachusetts (Centers for Medicare & Medicaid Services 2016b).³⁴

Stakeholder views on the adequacy of the payment rates varied greatly among states. Some MMPs in Massachusetts have experienced substantial financial losses, which stakeholders attributed to the challenges of serving a population that is composed entirely of disabled beneficiaries and, in their view, often has unmet needs. These difficulties led one MMP to leave the demonstration at the end of September 2015 and prompted CMS and the state to increase payment rates (Gutman 2015b, McCluskey 2015b). In our interviews, stakeholders said that the initial savings assumptions had proven unrealistic, and they believed that the higher rates would help stabilize the demonstration's financing.

In contrast, stakeholders in Chicago and Los Angeles did not express any significant concerns about the payment rates. One MMP said that it had lost money so far on the demonstration but did not find that surprising given the challenges of developing a new and complex managed care product. Another MMP indicated that it had managed to break even so far. Stakeholders appreciated CMS's plans to increase payment rates for Part A and Part B services and generally believed that the higher savings assumed to occur later in the demonstration were achievable.

Demonstrations using the managed fee-for-service model

Unlike the capitated model, which relies on managed care plans to improve care and reduce costs, the managed FFS model aims to achieve those goals by providing greater care coordination in an FFS environment. Two states—

Colorado and Washington—are testing the managed FFS model, and about 47,000 dual eligibles were enrolled in their demonstrations as of March 2016 (Table 9-2, p. 273). Both demonstrations are part of broader state efforts to provide more care coordination in FFS Medicaid.

Under the managed FFS model, the state passively enrolls dual eligibles that have both FFS Medicare and FFS Medicaid in a Medicaid-funded entity that is responsible for providing care coordination. (In Colorado, the entities are called Regional Care Collaborative Organizations. In Washington, they are called health homes.) Beneficiaries can receive care coordination services from the entity, but their participation is entirely optional, and they remain enrolled in FFS Medicare and FFS Medicaid regardless.

At the end of each year, the state can receive a “performance payment” if the demonstration produces savings for the federal government. CMS calculates the savings by comparing Part A and Part B spending for beneficiaries in the demonstration with an estimate of how much Medicare would have spent without the demonstration. Savings must be at least 2 percent for the state to receive a performance payment (to guard against random variation in program spending), and CMS deducts any additional Medicaid costs when calculating the overall federal savings. The state’s performance payment equals 30 percent to 50 percent of the federal savings, depending on the state’s performance on certain quality measures.

Findings on the demonstration in Washington State

In Washington State, dual-eligible beneficiaries are eligible for the demonstration if they have one chronic condition and are at risk of developing another (which is one of Medicaid’s eligibility criteria for health homes). They must also be considered high risk based on an analysis of their Medicare and Medicaid claims, and the subset of dual eligibles who have been enrolled in the demonstration have substantially higher average risk scores than the broader population of dual eligibles who meet only the chronic condition criteria (2.4 vs. 2.0) (Walsh et al. 2016). The demonstration operates in all parts of the state except two counties around Seattle.³⁵

Under the demonstration, the state approves “lead organizations” in six regions to oversee the delivery of care coordination. There can be multiple lead organizations in a region. The lead organizations are a mix of health insurers, provider-sponsored consortia, and area agencies on aging. The lead organizations, in turn, contract with care

coordination organizations (CCOs), which are responsible for most of the ground-level care coordination.³⁶ CCOs are typically entities such as area agencies on aging, mental health clinics, and community health centers. CCOs contact beneficiaries who have been passively enrolled in the demonstration, develop individual care plans known as health action plans (HAPs), and provide ongoing care coordination.

The stakeholders that we interviewed said that only 10 percent to 15 percent of the dual eligibles who had been assigned to a health home had completed a HAP, which is the first care coordination service that the state pays for under the demonstration. As a result, the number of people who actually receive care coordination is much lower than the enrollment figures for the demonstration might suggest. (Beneficiaries are considered enrollees once the state has referred them to the lead organizations.) The completion rate varies widely across CCOs, ranging from 15 percent to 80 percent for one lead organization. The completion rate can also vary significantly over time for the same CCO.

As with the capitated model, stakeholders in Washington reported that they often had difficulty contacting enrollees, partly due to outdated contact information from the state. Even when CCOs had good contact information, many beneficiaries were unfamiliar with the program and saw little or no benefit in participating. Some stakeholders also said that the number of new enrollees they received had varied significantly from month to month, which made it difficult for CCOs to staff appropriately and could contribute to the low participation rate.

Several stakeholders from lead organizations and CCOs also expressed concern with the adequacy of the payment rates for care coordination. The state makes three types of payments under the demonstration: a one-time initial payment of \$253 for the completion of a HAP, followed by monthly rates of either \$173 for intensive care coordination or \$68 for low-level care coordination.³⁷ Stakeholders were particularly concerned that the initial payment was not made until a HAP was completed, which they argued did not adequately compensate CCOs for the time they spend dealing with beneficiaries who do not complete a HAP. It was unclear whether the state’s payment methodology was a factor in the low participation rate.

In January, CMS released a report that estimated that the demonstration reduced Medicare spending by 6 percent in its first 18 months of operation (July 2013 to December 2014) and generated about \$22 million in savings. CMS

produced its estimate by comparing per capita spending growth for the enrollees in the demonstration (7 percent) with the growth for a comparison group of dual eligibles in Arkansas, Georgia, and West Virginia (13 percent). The report notes that its findings are preliminary and do not account for any changes in Medicaid spending. CMS plans to update the savings estimate using more rigorous analytic methods as part of its final evaluation of the demonstration (Walsh et al. 2016). While we understand that the report is preliminary, we do not think that savings of that magnitude are plausible because the number of people who actually received care coordination during that period was relatively small (about 1,700) and they received care coordination for a relatively short amount of time (about 5 months, on average).

Expanding the Medicare Savings Programs

Eligibility rules and the financing of care for dual-eligible beneficiaries have been abiding concerns for policymakers. Changes in these areas offer another way to correct or lessen some of the programmatic shortcomings that dual eligibles face. Such changes are not mutually exclusive with changes to models of care. One area of focus has been the Medicare Savings Programs (MSPs).

MSPs play an important role in defining which Medicare beneficiaries can become dual eligibles and what benefits Medicaid is required to provide to them. Under MSPs, Medicaid requires states to provide assistance with Medicare Part A and Part B premiums and cost sharing to four categories of low-income Medicare beneficiaries. Each category is considered a distinct MSP. Although the Part D LIS provides analogous assistance with Part D premiums and cost sharing, the LIS is part of the Medicare drug benefit and is not considered an MSP.

Eligibility and benefits

MSPs require individuals to have both limited income and limited assets to qualify for benefits. States are required to exclude certain items when calculating an individual's income and assets, and eligibility is determined based on the remaining "countable" income and assets. For example, countable income does not include the first \$20 in monthly income (such as wages or Social Security benefits) or half of any earned income, and countable assets do not include the value of a primary residence.³⁸ The Part D LIS uses similar rules.

The eligibility rules and benefits for the three primary MSPs are summarized in Table 9-5 (p. 292), which includes information for the Part D LIS for comparison.³⁹ Taken together, the MSP and LIS eligibility rules divide low-income Medicare beneficiaries into four categories based on income levels: up to 100 percent of the federal poverty level, between 100 percent and 120 percent of the federal poverty level, between 120 percent and 135 percent of the federal poverty level, and between 135 percent and 150 percent of the federal poverty level. The three MSP categories use the same asset limit (\$7,280 for an individual in 2016), while the Part D LIS has a higher asset limit (\$13,640 for an individual in 2016). The level of assistance provided varies across these groups:

- **Beneficiaries with income up to 100 percent of the federal poverty level**—These beneficiaries are eligible for the qualified Medicare beneficiary (QMB) program, which has the most generous benefits of any MSP and covers Part A and Part B premiums, deductibles, and coinsurance. The cost of QMB benefits are paid for by the federal government and the states, with their respective shares determined by the federal Medicaid match rate.⁴⁰ QMBs are also the largest MSP category: In 2014, about 6.5 million beneficiaries—12 percent of all Medicare beneficiaries—were enrolled in the QMB program (Table 9-6, p. 293). Under the Part D LIS, most beneficiaries in this income range do not pay a Part D premium or deductible and pay nominal copayments (in 2016, \$1.20 for generic drugs and \$3.60 for brand-name drugs).
- **Beneficiaries with income between 100 percent and 120 percent of the federal poverty level**—These beneficiaries are eligible for the specified low-income Medicare beneficiary (SLMB) program, which covers the Part B premium. Like the QMB program, the costs of these benefits are paid for by the federal government and the states, with their respective shares determined by the federal Medicaid match rate. SLMBs are the second-largest MSP category: In 2014, about 1.2 million beneficiaries (2 percent of all Medicare beneficiaries) were SLMBs (Table 9-6, p. 293). Under the Part D LIS, most beneficiaries in this income range do not pay a Part D premium or deductible and pay reduced copayments (in 2016, \$2.95 for generic drugs and \$7.40 for brand-name drugs).

**TABLE
9-5**

Medicare premium and cost-sharing assistance, by beneficiary income, 2016

	Income			
	Up to 100% FPL	100-120% FPL	120-135% FPL	135-150% FPL ^a
Income limit	Up to \$11,880	\$11,880 to \$14,260	\$14,260 to \$16,040	\$16,040 to \$17,820
Medicare Part A and Part B				
MSP category	QMB	SLMB	QI	Not covered
Part A premium	X			
Part B premium	X	X	X	
Deductibles	X			
Coinsurance	X			
Asset limit	\$7,280	\$7,280	\$7,280	
Financing	Federal/state	Federal/state	Federal	
Medicare Part D LIS				
Premium	X	X	X	X ^b
Deductible ^c	X	X	X	X
Copayments	X	X	X	X
Asset limit	\$13,640	\$13,640	\$13,640	\$13,640
Financing	Federal	Federal	Federal	Federal

Note: FPL (federal poverty level), MSP (Medicare Savings Program), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), LIS (low-income drug subsidy). Income and asset limits are for an unmarried individual; couples are subject to higher limits. Most Medicare beneficiaries do not pay the Part A premium because they have worked at least 40 quarters and paid Medicare taxes while working (or are the dependent or survivor of such a person). The table does not include the qualified disabled working individual MSP category or other full-benefit dual-eligible beneficiaries who are not eligible for one of the MSPs.

^a Some Medicare beneficiaries with income above 135 percent of the federal poverty level can meet their state's eligibility rules for full Medicaid benefits. These beneficiaries are not enrolled in the MSPs, however, because they do not meet the MSP eligibility criteria. States may cover Medicare cost sharing for these beneficiaries, but they are not required to do so.

^b These beneficiaries receive a partial Part D premium subsidy based on a sliding scale.

^c Beneficiaries who have income below 135 percent of the federal poverty level and assets between the MSP limit and the LIS limit, as well as all beneficiaries with income between 135 and 150 percent of the federal poverty level, receive a reduced deductible.

Source: Centers for Medicare & Medicaid Services 2016a, Centers for Medicare & Medicaid Services 2016d, Centers for Medicare & Medicaid Services 2015b, Centers for Medicare & Medicaid Services 2014b, Office of the Assistant Secretary for Planning and Evaluation 2016b.

- **Beneficiaries with income between 120 percent and 135 percent of the federal poverty level**—These beneficiaries are eligible for the qualifying individual (QI) program, which, like the SLMB program, covers the Part B premium. Aside from the higher eligibility limit, the only difference between the QI and SLMB programs is their method of financing. The costs of the QI program are paid for entirely by the federal government from the Part B trust fund, and the total amount of federal funding for each state is subject to an annual cap. QIs are the smallest of the three MSP categories: In 2014, about 500,000 beneficiaries—1 percent of all Medicare beneficiaries—were enrolled in the QI program (Table 9-6). Under the Part D LIS,

most beneficiaries in this income range do not pay a Part D premium or deductible and pay reduced copayments (in 2016, \$2.95 for generic drugs and \$7.40 for brand-name drugs).

- **Beneficiaries with income between 135 percent and 150 percent of the federal poverty level**—These beneficiaries are not eligible for MSPs but are eligible for the Part D LIS. These beneficiaries get a partial Part D premium subsidy based on a sliding scale, a reduced deductible (\$74 in 2016, instead of \$360), reduced coinsurance up to the out-of-pocket (OOP) threshold (the lower of 15 percent coinsurance or the plan's copayment), and reduced copayments after

the OOP threshold (in 2016, \$2.95 for generic drugs, \$7.40 for brand-name drugs).

Medicaid allows states to disregard larger amounts of income or assets when they determine eligibility for the MSPs. States that use more generous income or asset disregards effectively have more generous eligibility rules. In 2010, two states and the District of Columbia had higher income limits than the federal standards, and nine states and the District of Columbia had higher asset limits (Kaiser Commission on Medicaid and the Uninsured 2010). For example, Connecticut and Maine use additional income disregards to raise the eligibility limit for the QMB program, which is normally 100 percent of the federal poverty level, to 200 percent and 140 percent, respectively, and both states disregard all assets when determining MSP eligibility (Medicare Payment Advisory Commission 2014).

In addition to the MSPs, states have separate eligibility rules for full Medicaid benefits, which include coverage of Medicare wraparound services and LTSS, such as nursing home care and community-based care. The eligibility rules for MSP benefits differ from the eligibility rules for full Medicaid benefits; as a result, some individuals are eligible for MSP benefits only, some qualify for both MSP and full Medicaid benefits, and some are eligible for full Medicaid benefits only. In 2014, 1.3 million enrollees in the QMB program and about 900,000 enrollees in the SLMB program were eligible only for MSP benefits and are sometimes known as QMB-only or SLMB-only enrollees. The remaining QMB and SLMB enrollees (about 5.2 million and 250,000 people, respectively) also qualified for full Medicaid benefits and are sometimes known as QMB-plus or SLMB-plus beneficiaries. Another 1.7 million Medicare beneficiaries were not eligible for MSPs but received full Medicaid benefits.⁴¹

Participation rates and application process

Medicare beneficiaries must apply with their state's Medicaid office to become eligible for MSP benefits, and many beneficiaries who are eligible for benefits do not enroll. The low participation rates have been attributed to such factors as complex eligibility rules and a lack of awareness that the programs exist (Medicare Payment Advisory Commission 2008).⁴²

Under current law, all dual-eligible beneficiaries, including those enrolled in the MSPs, are automatically enrolled in the Part D LIS. All other Medicare beneficiaries must apply for LIS coverage and can do so through their Medicaid program or through the Social Security

**TABLE
9-6**

Medicare beneficiaries enrolled in the MSPs, 2014

MSP category	Number of beneficiaries (in millions)	Percent of all Medicare beneficiaries
QMB	6.5	12%
SLMB	1.2	2
QI	0.5	1

Note: MSP (Medicare Savings Program), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual). The table includes fee-for-service and Medicare Advantage enrollees.

Source: MedPAC analysis of July 2014 enrollment data.

Administration (SSA). In practice, almost all beneficiaries who apply for LIS coverage do so through the SSA, which is familiar to virtually all beneficiaries through their dealings with the Social Security program and does not have Medicaid's welfare stigma. Although beneficiaries who qualify for an MSP are automatically enrolled in the LIS, the reverse is not true, even though many LIS enrollees likely also qualify for MSP benefits (Medicare Payment Advisory Commission 2008).

State payment of Medicare cost sharing for QMBs

As noted above, the QMB program covers all deductibles, copayments, and coinsurance for Part A and Part B services. However, states have considerable flexibility in determining how much of that cost sharing they actually cover because of a provision in the Balanced Budget Act of 1997 (BBA) that gave states the option of using their Medicaid rates, which are often lower than Medicare rates, to determine the amount of cost sharing they will pay for QMBs.⁴³

As an example, consider a beneficiary who is enrolled in the QMB program, has already met the Part B deductible, and has an office visit with her physician. If Medicare's payment rate for the visit were \$100, Medicare would pay \$80 to the provider and the state would be responsible for \$20 in coinsurance. The state has the option of using Medicare rates to determine its cost-sharing payment. Under this approach, which is sometimes called a "full-payment" policy, the state would pay the entire \$20 in coinsurance.

However, the state could instead choose to base its cost-sharing payment on the lower of the Medicare rate or the state’s Medicaid rate for the same service. Under this approach, which is sometimes called a “lesser-of” policy, if the Medicaid rate was \$85, the state would only pay the difference between that amount and Medicare’s payment of \$80, which would result in the state paying \$5 of the coinsurance. If the state’s Medicaid rate for the service was less than \$80, the state would not pay any of the coinsurance. When states do not pay the full amount of Medicare cost sharing, Medicaid prohibits providers from billing the beneficiary for the remaining unpaid amount. As a result, while lesser-of policies reduce Medicaid spending, they also reduce overall payments for providers who serve QMBs.

States can use a full-payment policy for certain services and a lesser-of policy for other services, and they can adopt other approaches as well, such as paying a fixed percentage of Medicare cost sharing (Centers for Medicare & Medicaid Services 2015a, Medicaid and CHIP Payment and Access Commission 2013).

Most states use lesser-of policies for at least some services. The Medicaid and CHIP Payment and Access Commission (MACPAC) examined state policies on payment of cost sharing for QMBs for four major types of service—inpatient hospital, outpatient hospital, skilled nursing facility, and physician services—and found that 45 states and the District of Columbia used a lesser-of policy in 2015 for at least 1 type of service (Medicaid and CHIP Payment and Access Commission 2015d). The number of states that use lesser-of policies grew rapidly in the late 1990s after BBA was enacted (Medicaid and CHIP Payment and Access Commission 2013).

Recent research suggests that lesser-of policies reduce access to care for QMBs. MACPAC estimated the share of Medicare cost sharing that states paid for certain outpatient services that can serve as indicators of access to care (office-based and outpatient evaluation and management services, preventive services, services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs), and psychotherapy services) and examined how utilization rates for QMBs compared with rates for Medicare-only beneficiaries across states. MACPAC found that when states paid a larger share of the Medicare cost sharing, QMBs were more likely to receive office-based and outpatient evaluation and management services, preventive services, and psychotherapy services, and less likely to receive services from an FQHC or

RHC. These findings suggest that lesser-of policies make it more difficult for QMBs to obtain care in traditional office-based settings and increase their reliance on safety-net providers (Medicaid and CHIP Payment and Access Commission 2015c).

CMS recently conducted a similar analysis, with broadly similar results. CMS also studied the impact of lesser-of policies on the use of inpatient hospital services and skilled nursing facility (SNF) care and found that lesser-of policies had no significant impact on inpatient hospital use and ambiguous results for SNF care (Centers for Medicare & Medicaid Services 2015a).

CMS has also found that providers in states with lesser-of policies sometimes bill QMBs for their unpaid cost sharing, even though Medicare and Medicaid both prohibit this practice. Many QMBs appear to pay these bills from their providers, either because they are unaware that Medicaid protects them from being balance-billed in this way or because they do not want to endanger their relationship with the provider (Centers for Medicare & Medicaid Services 2015a, Centers for Medicare & Medicaid Services 2013e).

Illustrative scenarios for expanding MSPs

A variety of researchers, policymakers, and beneficiary advocates have expressed interest over the years in expanding MSPs—by making additional beneficiaries eligible for the programs, by providing more generous benefits (such as extending coverage of Part A and Part B cost sharing to some beneficiaries with income above the federal poverty level), by federalizing MSPs in some fashion, or by employing a combination of these strategies.

Supporters make several arguments in favor of expanding MSPs. They contend that “near-poor” Medicare beneficiaries—those with income somewhere between 100 percent and 200 percent of the federal poverty level—spend a relatively large share of their income, on average, on health care costs (Families USA 2014). They cite evidence that states’ use of lesser-of policies has reduced access to care for QMBs and that some providers appear to bill QMBs for unpaid cost sharing, despite the statutory prohibition against doing so (Burke and Prindiville 2011). They also argue that federalizing MSPs would lead more beneficiaries to participate in the programs and provide budgetary relief to states (Moon et al. 1996).

Given the numerous policy issues that would need to be addressed, proposals to expand MSPs would vary significantly in their budgetary and programmatic effects. To demonstrate the range of possible outcomes, the Commission developed three illustrative scenarios for expanding MSPs and used analyses prepared by the Urban Institute to estimate their potential costs.⁴⁴ These costs should be viewed as approximations and not a substitute for the budgetary estimates that the Congressional Budget Office prepares for the Congress as part of the legislative process.

The three illustrative scenarios are listed in order from least to most expensive:

- **Scenario 1—Raise eligibility for the QI program to 150 percent of the federal poverty level.** This scenario is a reprise of the Commission’s recommendation from 2008. The eligibility limit for the QI program, which provides assistance with the Part B premium, would be raised from the current 135 percent of the federal poverty level to 150 percent. The QI program would continue to be funded entirely by the federal government, but its annual funding cap would be increased to reflect its higher eligibility limit.
- **Scenario 2—Raise eligibility for the QMB program to 150 percent of the federal poverty level.** This scenario would increase the eligibility limit for the QMB program—which provides assistance with Part A and Part B premiums and cost sharing—from the current 100 percent of the federal poverty level to 150 percent. The SLMB and QI programs would be eliminated. Like the existing program, the expanded QMB program would be funded jointly by the federal government and the states based on regular Medicaid match rates. States would remain able to use lesser-of policies to limit their spending on Medicare cost sharing.
- **Scenario 3—Raise eligibility for the QMB program to 150 percent of the federal poverty level and federalize the program.** As with the second scenario, the eligibility limit for the QMB program would be increased from the current 100 percent of the federal poverty level to 150 percent, and the SLMB and QI programs would be eliminated. However, the QMB program would be federalized and become part of the Medicare program, which would pay the full amount of any cost sharing for QMBs. As part of this scenario, states would be required to make maintenance-of-

effort payments based on their historical spending on MSP benefits.

Each scenario outlined above would also make two related changes to MSPs. First, the asset limit for the MSPs would be increased to match the level used for the Part D LIS. Second, since the MSP and LIS eligibility criteria would be aligned, the Social Security Administration would be required to determine eligibility for both programs at the same time and would enroll applicants in both programs if they were eligible.

The effects of each scenario on MSP participation, federal spending, and state spending are shown in Table 9-7 (p. 296). The participation figures are for 2012. The estimated costs are for 2016 to 2025; the Commission generated these figures by adjusting the estimated 2012 costs for expected growth in Medicare enrollment and per capita spending, using data from the 2015 Medicare Trustees’ report.

Under current law, about 17.6 million Medicare beneficiaries are eligible for MSPs. (This figure does not include beneficiaries whose income is low enough to qualify for MSPs but whose assets exceed the limits.) This number would increase under all three scenarios because the MSP income and asset limits would be raised to the higher Part D LIS levels.

Enrollment in MSPs would increase by about 2 million beneficiaries under all three scenarios, from 9.1 million under current law to between 11.0 and 11.5 million. The higher enrollment would be due largely to beneficiaries who are now enrolled only in the LIS but also would qualify to be automatically enrolled in an MSP. Medicare enrollment data indicates that about 1.4 million people enrolled in the LIS are not in an MSP.

MSP participation rates are assumed to rise also, from the current rate of 51 percent to 56 percent under the first scenario and to 59 percent under the second and third scenarios.⁴⁵ Participation rates for the second and third scenarios would be higher because beneficiaries with income between 100 percent and 150 percent of the federal poverty level would be eligible for more generous benefits (assistance with Part A and Part B cost sharing, in addition to the Part B premium), and thus more eligible beneficiaries would enroll.

The estimated 10-year federal cost of the 3 scenarios would vary significantly, ranging from \$38 billion for the first scenario to \$74 billion for the second scenario

**TABLE
9-7**

Illustrative scenarios for expanding the MSPs

	Current	Scenario		
		1	2	3
Eligibility limits (as percent of federal poverty level)				
Part B premiums	135%	150%	150%	150%
Part A and Part B cost sharing*	100%	100%	150%	150%
Are MSPs federalized?	QI only	QI only	No	Yes
Eligible beneficiaries, 2012 (in millions)	17.6	19.6	19.6	19.6
Total enrollees, 2012 (in millions)	9.1	11.0	11.5	11.5
Current MSP enrollees		9.1	9.1	9.1
Current LIS-only enrollees		1.4	1.4	1.4
Truly new enrollees		0.5	1.0	1.0
Participation rate	51%	56%	59%	59%
Estimated cost, 2016–2025 (in billions)				
Federal		\$38	\$74	\$296
State		\$8	\$38	\$0
Total		\$46	\$111	\$296
Breakdown of federal costs, 2016–2025 (in billions)				
Current MSP enrollees		\$0	\$10	\$162
Current LIS-only enrollees		\$19	\$23	\$61
Truly new enrollees		\$19	\$41	\$73

Note: MSP (Medicare Savings Program), QI (qualifying individual), LIS (low-income subsidy). All scenarios assume that the MSP asset limit would be raised to the limit used for the Part D LIS and that the Social Security Administration would be required to screen LIS applicants for MSP eligibility as well. The Social Security Administration would also enroll those who qualify in both programs. Scenario 3 assumes that Medicare pays the full amount of cost sharing for MSP enrollees and that states would be required to make maintenance-of-effort payments. Components may not sum to totals due to rounding.
* Includes coverage of Part A premiums for beneficiaries who do not qualify for premium-free Part A coverage.

Source: MedPAC analysis of estimates prepared by the Urban Institute.

and \$296 billion for the third scenario. The variation in the expected cost of the three scenarios is due largely to differences in how each scenario provides assistance with Part A and Part B cost sharing. (All three scenarios extend assistance with the Part B premium to beneficiaries with income between 135 percent and 150 percent of the federal poverty level.) The first scenario (raise the income level for QI eligibility) does not expand eligibility for assistance with cost sharing, although some of the LIS enrollees who would become automatically eligible for MSP benefits would receive assistance with cost sharing. In contrast, the second scenario (raise the income level for QMB eligibility) expands assistance with cost sharing to

beneficiaries with income between 100 percent and 150 percent of the federal poverty level. However, states would still be able to use lesser-of policies to limit how much cost sharing they cover, which would reduce the expected cost. The third scenario (raise the income level for QMB eligibility and federalize the program) is the most expensive because it both expands eligibility for assistance with cost sharing to 150 percent of the federal poverty level and requires Medicare to pay the full amount of any cost sharing for those enrolled in MSPs. In aggregate, the analyses prepared by the Urban Institute indicate that states pay only about 35 percent of the cost-sharing liability for QMBs now. The difference in the cost of the

second and third scenarios is largely due to Medicare's liability for the 65 percent of cost sharing that states do not cover. (As shown in Table 9-7, a majority of the costs for the third scenario are for existing rather than new MSP enrollees.) The additional costs to Medicare under the third scenario would be partly offset by lower spending on bad-debt payments; those savings are included in the estimate for the third scenario.⁴⁶

The impact on state budgets would also vary significantly, depending on the scenario. Under the first, expanding QI eligibility, the cost to the states would total about \$8 billion over 10 years. While the cost of the assistance with the Part B premium for beneficiaries with income between 135 percent and 150 percent of the federal poverty level would be paid entirely by the federal government, states would still see higher Medicaid costs because some LIS enrollees would become automatically eligible for QMB or SLMB benefits, which are partly financed by states. Under the second scenario, expanding QMB eligibility, the cost to the states would total about \$38 billion over 10 years because states would bear part of the cost for the additional MSP benefits provided to beneficiaries with income between 100 percent and 150 percent of the federal poverty level. Under the third scenario, expanding QMB eligibility and federalizing the program, the impact for states would be negligible. States would ordinarily see significant savings from federalizing MSPs, but under this scenario, states would be required to make maintenance-of-effort payments to the federal government that equal what the states would have spent on MSPs under current law, which would largely eliminate any savings for states.⁴⁷ Without a maintenance-of-effort requirement, federal costs under the third scenario would be much higher.

The amount of cost sharing that states currently pay for QMBs varies considerably, and the maintenance-of-effort requirement under the third scenario would create inequities across states. Health care providers and beneficiaries in states that currently pay a relatively small percentage of the cost sharing for QMBs would benefit more under this scenario. The providers in those states would see a larger increase in their overall revenues (once Medicare started covering the cost sharing that states currently do not pay), and the QMBs themselves would see a bigger improvement in their access to care, while the states' maintenance-of-effort payments would be relatively limited. Conversely, states that now pay a larger percentage of the cost sharing for QMBs would benefit less: the additional revenues for providers in those

states would be smaller, as would any improvements in access to care for the QMBs themselves, and the states' maintenance-of-effort payments would be larger.

To illustrate how the third scenario's impact could vary by state, consider two states that had similar cost-sharing liability in 2012 for their QMBs—\$105 million and \$98 million, respectively. The first state paid about 36 percent of its cost-sharing liability (or \$37 million), and the state's share of those payments, based on its Medicaid match rate, was about \$14 million. In contrast, the second state paid about 71 percent of its cost-sharing liability (\$70 million), and the state's share of those payments was about \$22 million. Under the third scenario, providers in both states would now be fully paid for the cost sharing; the additional revenue would be about \$68 million in the first state and about \$28 million in the second state. However, the first state would have to make smaller maintenance-of-effort payments (\$14 million vs. \$22 million).

Conclusion

The financial alignment demonstration is one the largest demonstrations that CMS has ever conducted related to dual eligibles and will have a significant impact on dual eligibles, the federal government, and the states, regardless of its ultimate success or failure. The demonstrations in most states are now well underway. While enrollment has been much lower than anticipated, it is nonetheless substantial and should be sufficient to test the capitated and managed FFS models.

The implementation of the demonstration has consistently proven to be more difficult than first expected, and our site visits to three states suggest that these challenges continue. The MMP representatives that we interviewed widely agreed that at least one to two years would be needed to begin reshaping their enrollees' patterns of care and that the expected savings from the demonstration were unrealistic, at least initially. Correspondingly, many stakeholders viewed improving the quality of care for dual eligibles as the primary goal of the demonstration. Plans are still developing their care coordination models and revising them as they gain more experience under the demonstration.

Given these continuing challenges, the results from the demonstration at the end of its original three-year lifespan could be less definitive than policymakers would like. We support CMS's offer to extend the

demonstration for another two years and hope that most states agree to it because the additional time may yield valuable information about the ultimate effectiveness of the two models. The Commission continues to support the overall goals of the demonstration—although we remain concerned about its ultimate impact on Medicare spending—and will monitor its progress with interest. In particular, we will continue to monitor the development of the demonstration’s care coordination models and their impact on the quality of care received by dual eligibles.

As for MSPs, they are a good example of the challenges that policymakers confront in deciding what roles Medicare and Medicaid should play in caring for dual-eligible beneficiaries. Although MSPs play an important role in protecting low-income Medicare beneficiaries against high out-of-pocket spending on premiums and cost sharing, participation is relatively low, in part because

the MSP eligibility rules differ from those used by the Part D LIS and the two programs use separate enrollment processes. Since MSPs are part of Medicaid, states play an important role in paying for their costs, but their ability to use lesser-of policies to limit spending on cost sharing for QMBs ultimately reduces payments to the health care providers that serve QMBs and could impede access to care.

Policymakers could expand MSPs in a variety of ways, and the three illustrative scenarios we examined suggest that the resulting impact on beneficiaries, federal spending, and state spending would depend on the approach used. The scenarios we examined suggest that efforts to expand or federalize MSPs would affect a relatively small number of Medicare beneficiaries, could result in substantial new federal costs, and would have an uneven impact across states. ■

Endnotes

- 1 Annual enrollment figures for dual-eligible beneficiaries are usually calculated using one of two methods: (1) a “point-in-time” method that counts all beneficiaries who were dual eligibles at a specific point during the year or (2) an “ever-enrolled” method that counts all beneficiaries who were dual eligibles at any point during the year. The two methods produce somewhat different results because some individuals are dual eligibles for only part of the year. (There are also individuals who are full-benefit dual eligibles for part of the year and partial-benefit dual eligibles for part of the year. Those individuals are counted in both categories under the ever-enrolled method unless some sort of hierarchy is applied, such as assigning them to their most recent type of dual eligibility.) The 20 percent figure is based on the ever-enrolled method; the point-in-time figure would be a few percentage points lower.
- 2 The descriptions of the Medicaid eligibility categories and the number of states using them are based on work done by the Medicaid and CHIP Payment and Access Commission (Medicaid and CHIP Payment and Access Commission 2015b, Medicaid and CHIP Payment and Access Commission 2013).
- 3 Other ADLs include eating, using the toilet, personal hygiene, and transferring (being able to move from one setting to another, such as getting in and out of a chair). Most states require Medicaid beneficiaries to need help with two or three ADLs to qualify for nursing home care or community-based forms of long-term care.
- 4 The rest of the figures in this section are taken from the data book on dual-eligible beneficiaries that the Commission produced with the Medicaid and CHIP Access and Payment Commission (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2016).
- 5 About 63 percent of all full-benefit dual eligibles in 2011 met these criteria. The share of dual eligibles enrolled in FFS has likely declined since then due to growth in the number of dual eligibles enrolled in various forms of managed care (Medicare Advantage plans, Medicaid managed care, or Medicare–Medicaid Plans under the financial alignment demonstration).
- 6 The service categories in Table 9-1 (p. 268) are not mutually exclusive; some beneficiaries used more than one type of service. About 44 percent of full-benefit dual eligibles used at least one type of LTSS.
- 7 The Commission also found that Medicare payments to PACE plans were 17 percent higher than FFS spending on comparable beneficiaries and recommended that PACE plans be paid using the standard MA payment system. In November 2015, the Congress enacted legislation that authorizes CMS to test the use of PACE on people younger than 55.
- 8 PACE serves individuals who live in the community but are at risk of entering a nursing home and fully integrates Medicare and Medicaid financing. D–SNPs must have a contract with the state to coordinate Medicare and Medicaid benefits for their enrollees, but the degree to which they integrate the two programs varies widely and is generally much lower than the degree of integration provided by MMPs.
- 9 Since the late 1990s, Minnesota has operated a program known as Minnesota Senior Health Options (MSHO) that uses health plans to integrate Medicare and Medicaid for beneficiaries who are 65 or older. MSHO plans contract with the state as Medicaid managed care plans and with CMS as D–SNPs. Under the demonstration, the state will test new ways to integrate Medicare and Medicaid administrative functions in its MSHO plans (for example, in areas such as beneficiary notices and appeals). The MSHO program is otherwise unchanged (Centers for Medicare & Medicaid Services 2013c).
- 10 New York’s second demonstration is scheduled to last for four years. CMS and the state signed the MOU for this demonstration after CMS’s July 2015 announcement, and its end date implicitly reflects an extension.
- 11 Virginia will enroll all Medicaid beneficiaries who use long-term services and supports in managed LTSS (MLTSS) plans starting in 2017. The state has decided to use the MLTSS plans as its platform for integrating Medicare and Medicaid and will require the sponsors of the MLTSS plans to offer companion Medicare D–SNP products also. The dual eligibles in the demonstration will be moved into MLTSS plans once the demonstration ends. CMS has not indicated what will happen to their Medicare coverage—they could be passively enrolled in the companion D–SNPs on a one-time basis (see text box, pp. 280–281) or placed in FFS Medicare. The role of D–SNPs in integrating Medicare and Medicaid for dual eligibles is a broader question that policymakers may want to consider based on the results of the demonstrations using the capitated model.
- 12 Although the demonstration is statewide, no MMPs are currently operating in 5 of the state’s 46 counties because they have not been able to meet network adequacy requirements in those areas. Rhode Island’s demonstration, expected to start later this year, will also be statewide.
- 13 This figure does not include Rhode Island’s demonstration or New York’s second demonstration, which had not started

as of March 2016. About 30,000 and 20,000 dual eligibles, respectively, will be eligible for those demonstrations (Centers for Medicare & Medicaid Services 2015d, Centers for Medicare & Medicaid Services 2015e).

- 14 The 67 MMPs examined in the study are the 60 plans that are still participating in the demonstration, the 6 plans that left the demonstration after it started, and 1 plan in New York that dropped out of the demonstration before any beneficiaries were enrolled.
- 15 South Carolina has not yet conducted passive enrollment in its demonstration. Its participation rate is likely to increase once that occurs later this year.
- 16 There have been numerous reports of provider resistance in other states also.
- 17 The figures for the FIDE SNPs include the plans in the Minnesota Senior Health Options program, which are part of the alternative model that the state is testing in the financial alignment demonstration.
- 18 South Carolina has used voluntary enrollment only since launching its demonstration in February 2015, but it plans to conduct passive enrollment in 2016. Rhode Island will launch its demonstration later this year and plans to use passive enrollment for some beneficiaries. As noted earlier, New York used passive enrollment during the initial year of its first demonstration but stopped using it in December 2015. The state will not use passive enrollment in its second demonstration, scheduled to begin later this year.
- 19 California lets its counties decide how to use managed care to serve residents who are enrolled in the state's Medicaid program, known as Medi-Cal. Counties can choose one of six models. Under one model, the county creates and runs its own health plan, which is known as a county organized health system (COHS), and all Medi-Cal beneficiaries in the county receive services through the COHS (California Department of Health Care Services 2014).
- 20 For example, CMS took these steps when it terminated its Part D contract with Fox Insurance Company in 2010 (Centers for Medicare & Medicaid Services 2010).
- 21 California's experience with its demonstration project has echoed that earlier episode: MMP participation rates in February 2016 were 77 percent in San Mateo County and 47 percent in Orange County (California Department of Health Care Services 2016). Provider resistance to managed care appears to have been a significant factor in both 2006 and the current demonstration, particularly in Orange County.
- 22 Some states provide additional notices. For example, California sends beneficiaries an initial notice 90 days before their passive enrollment will take effect, followed by the required 60-day and 30-day notices (California Department of Health Care Services 2016).
- 23 Four demonstration states—California, Ohio, New York, and Texas—currently require dual eligibles to enroll in managed care for their Medicaid benefits, including LTSS. These states typically contract with the same insurers for their MMPs and their Medicaid plans. As a result, beneficiaries who disenroll from MMPs in these states are usually enrolled in a Medicaid managed care plan sponsored by the same company.
- 24 In some situations, this requirement might work the other way and lead states to passively enroll beneficiaries sooner than they would otherwise. For example, if a state initially plans to passively enroll beneficiaries in an MMP in February or March of a given year and determines that some of those beneficiaries will be assigned to a new Part D plan in January of that year, it can either move up the MMP enrollment to January (to trump the Part D reassignment) or delay the MMP enrollment until the following January.
- 25 This issue has been more significant for some demonstrations than others. The number of passive enrollments in Part D is determined by the year-to-year change in plans that qualify to offer zero-premium plans to beneficiaries who receive the low-income subsidy. The extent of the year-to-year change varies over time and across states. For example, if the lineup of zero-premium plans in a particular state changed little from 2014 to 2015, the number of Part D enrollees who were assigned to new plans in January 2015 would be relatively low, and the state would have more flexibility to passively enroll beneficiaries in its MMPs during 2015.
- 26 For example, states must develop the ability to process passive enrollments more than two months before beneficiaries actually gain dual eligibility to supersede CMS actions to passively enroll those beneficiaries in Part D plans. States must also develop systems that can communicate with the Social Security Administration so that they can identify which disabled Medicaid beneficiaries also receive Social Security disability benefits and will become eligible for Medicare after a two-year waiting period.
- 27 Some states use different names for these elements, such as “care manager” or “case manager” instead of “care coordinator.”
- 28 The MMPs are not required to pay providers for the time they spend engaged in this activity. Some MMPs that we interviewed during our site visits indicated that low participation by primary care physicians had been an obstacle to developing individual care plans and that the MMPs had started paying physicians to participate.

- 29 Caseloads varied widely across the MMPs we interviewed, ranging from about 50 (all high-risk enrollees) to about 500 (all low-risk enrollees). However, most care coordinators appeared to have caseloads of 75 to 125 enrollees.
- 30 Managed care plans in California often make capitated payments of their own to large physician groups that assume risk for providing services to plan enrollees. This arrangement is sometimes referred to as “subcapitation” or the “delegated model.” The MMPs we interviewed in California use the delegated model for many services and contract with the delegated entity to provide much of the care coordination.
- 31 All demonstrations require MMPs to allow new enrollees to use their existing providers for a certain period of time, even if the providers are not in the MMP’s provider network. This transition period often lasts for at least 90 days and, in some cases, can last for 6 months or a year (Musumeci 2014).
- 32 Several states have “carved out” certain benefits from the demonstration and continue to provide them through FFS arrangements (Medicaid and CHIP Payment and Access Commission 2015a). For example, California has carved out certain services for beneficiaries with serious behavioral health needs.
- 33 Since 2010, CMS has applied an across-the-board reduction to HCC risk scores to compensate for the higher reporting of diagnoses for MA enrollees compared with those in FFS. This reduction is often referred to as the “coding intensity adjustment” and equals 5.41 percent in 2016. This adjustment also applies to MMPs but is being phased in over time and will not be fully implemented until the second or third year of the demonstration.
- 34 CMS increased its prospective payments for reinsurance for beneficiaries with high drug costs and for cost sharing covered by the LIS. Both types of payments are estimated amounts and are later adjusted based on plans’ actual experience, so this change does not increase overall program spending. The MMPs that we interviewed in Massachusetts indicated that their costs for reinsurance and LIS cost sharing had been much higher than the initial payment rates. Although CMS reimburses plans for any additional costs in these areas, this reconciliation does not take place until the following year, and this delay led to cash-flow problems for the MMPs.
- 35 The state originally planned to conduct a second demonstration in King and Snohomish counties using the capitated model. The state signed an MOU with CMS in November 2013 for the second demonstration but later canceled it when one of the two health plans that had agreed to participate decided to drop out.
- 36 The distinction between lead organizations and CCOs can quickly get confusing because each lead organization may contract with multiple CCOs, each CCO may contract with multiple lead organizations, and some entities serve as lead organizations in some regions and as CCOs in other regions.
- 37 Health homes must first complete a HAP before they can bill the state for providing intensive or low-level care coordination. In addition, the state makes payments for intensive or low-level care coordination only for months in which the beneficiary received care coordination services.
- 38 Medicaid requires states to determine the countable income and assets of MSP applicants using the same rules as the Supplemental Security Income program.
- 39 The fourth MSP category is the qualified disabled working individual (QDWI) program, which requires Medicaid to pay the Part A premium for certain disabled individuals who have income below 200 percent of the federal poverty level but are no longer eligible for Medicare Part A because they have returned to work. In 2014, fewer than 100 people were enrolled in the QDWI program.
- 40 The federal Medicaid match rate, known as the federal medical assistance percentage, or FMAP, determines what share of Medicaid spending is paid by the federal government. The FMAP varies from state to state and is determined by a formula that compares each state’s per capita income with the national average. States with higher per capita income have lower FMAPs and vice versa, although each state’s FMAP cannot be lower than 50 percent or higher than 83 percent. FMAPs for fiscal year 2016 range from 50 percent in 13 states to 74.17 percent in Mississippi (Office of the Assistant Secretary for Planning and Evaluation 2016a).
- 41 Many of those 1.7 million beneficiaries either require long-term care and reside in nursing homes or live in the community and have high medical expenses. States have the option of covering Medicare cost sharing for these beneficiaries, but Medicaid does not require them to do so. States can also cover the Part B premium for these beneficiaries, but they can receive federal Medicaid matching funds only for beneficiaries who receive some sort of cash assistance payment, such as a state supplementary payment (Medicaid and CHIP Payment and Access Commission 2015c).
- 42 Researchers have found it challenging to estimate participation rates for the MSPs because doing so requires detailed information about the income and assets of low-income individuals (to determine which individuals are eligible) and their Medicaid enrollment status (to determine which individuals are already enrolled in the MSPs). Researchers usually base their estimates on statistical surveys such as the Medicare Current Beneficiary Survey or the Survey of Income and Program Participation, but each survey has limitations.

- 43 The Congress first required states to cover QMBs in 1988. CMS, then known as the Health Care Financing Administration, issued guidance in 1991 that allowed states to use Medicaid rates to determine their obligation to pay cost sharing for QMBs. However, health care providers filed multiple lawsuits on the issue, arguing that the statutory language for the QMB program required states to use Medicare rates. Federal courts had issued mixed rulings on the issue, and the Congress resolved the disagreement by explicitly giving states the authority to use Medicaid rates (Medicaid and CHIP Payment and Access Commission 2013).
- 44 The Urban Institute used data from the American Community Survey, the Survey of Income and Program Participation, and the Medicare Beneficiary Summary File to produce its analyses.
- 45 These participation rates are higher than the ones included in the Commission’s March 2008 report, which stated that participation rates for the QMB and SLMB programs were about 33 percent and 13 percent, respectively. These figures come from a 2004 study by the Congressional Budget Office (CBO) that examined the impact of the recently enacted Medicare drug benefit (Congressional Budget Office 2004). The CBO figures do not include full-benefit dual eligibles and thus cannot be directly compared with the figures shown here (which do include them) and are also now somewhat dated.
- 46 Medicare currently makes payments to most institutional providers (such as hospitals and skilled nursing facilities) that cover a portion of their Medicare “bad debt,” which is cost sharing not paid by FFS enrollees. This bad debt includes amounts that providers cannot collect because states do not pay the full amount of cost sharing for QMBs. Since under the third scenario Medicare would pay the full amount of any cost sharing for beneficiaries with income below 150 percent of the federal poverty level, Medicare payments to providers for bad debt would decrease.
- 47 These payments would be similar in nature to the so-called clawback payments that states make as part of the Medicare Part D drug benefit. The creation of the Part D program shifted the responsibility for providing drug coverage for dual-eligible beneficiaries from Medicaid to Medicare and thus lowered state Medicaid spending. However, states are required to make payments to the federal government that are equal to 75 percent of their estimated Medicaid savings, thus allowing the federal government to “claw back” most of the states’ savings.

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