

CMS demonstrations for dual-eligible beneficiaries

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Context for today's presentation

Prior Commission work on dual-eligibles

- Data analysis
- Site visits to integrated care programs
- June 2012 report chapter
 - Analysis of PACE program and Commission recommendations to improve PACE
 - Analysis of D-SNPs' quality of care and payments
- Today's presentation
 - Focus on CMS demonstrations on dual-eligibles

Overview of CMS financial alignment demonstrations

- Two models to be tested
 - Capitated model
 - 3-way contract between CMS, a state, and a health plan
 - Managed FFS model
 - States finance care coordination and can share in Medicare savings if they meet quality thresholds
- Process for states implementing capitated model effective January 1, 2013
 - Spring: States post proposals for comment on their websites and submit proposals to CMS; CMS posts proposals for comment
 - June: Plans that want to participate submit benefit packages
 - July 30th: Target date for completion of plan selection
 - September 20th: Deadline for signing three-way contracts



Summary of issues

- Medicare payment methodology
 - Calculation of capitation rates and savings from rates
 - Risk-adjustment methodology
 - Flexibility to use Medicare funds on non-clinical services
- Evaluation methodology
- Timing and process of the demonstrations

- Scope of the demonstrations
- Passive enrollment with optout
- Plan requirements and plan selection
- Shared savings with states and beneficiaries



Scope of the demonstrations

- Some states are proposing to enroll all or most dual-eligibles in the state into the demonstration
- Issues:
 - Are the programs demonstrations if most or all dual-eligibles are enrolled?
 - Do plans have the capacity and experience to cover Medicare and Medicaid benefits for large numbers of dual-eligibles?



Passive enrollment with opt-out

 Capitated model demonstrations likely to include passive enrollment with opt-out

Issues:

- Will beneficiaries be given prior notification before they are passively enrolled and how much time after enrollment will they have to opt-out?
- How will beneficiaries be assigned to a plan?
- Will plans be required to contact beneficiaries within a certain period after enrollment?



Plan requirements under capitated model

- CMS' "preferred requirement standards" appear to be negotiable with states. These include:
 - Medicare benefit package
 - Part D
 - Medicare network adequacy
 - Administrative requirements (appeals process, marketing)

Issue:

Should some or all Medicare standards be non-negotiable?



Plan selection process for capitated model

- Plans will be selected through a joint CMS-state process. Plans also have to qualify through each state's specific selection process.
- Issues:
 - What kinds of plans will be eligible for participation (SNPs, Medicaid managed care plans)?
 - Should all plans be eligible for passive enrollment?



How should savings be allocated?

- Shared savings methodology under capitated model:
 - The Medicare and Medicaid capitation rates will be reduced to account for upfront savings
 - CMS works with each state to estimate a savings percentage off a combined Medicare and Medicaid spending baseline
 - Medicare and the state split the savings based on the proportion that each program contributes to the baseline

Issues:

- Should savings be allocated this way?
- Should CMS publish the savings estimate methodology and which services the savings were derived from?
- Will the capitation rates be sufficient to provide Medicare and Medicaid services?
- Should the beneficiary benefit from the savings?



Summary for Commission discussion

- Scope of the demonstrations
- Passive enrollment with opt-out
- Plan requirements and plan selection
- Shared savings with states and beneficiaries

