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 opt-out
- 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