An update on CMS's financial alignment demonstration for dual-eligible beneficiaries

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March 1, 2018

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Context for the financial alignment demonstration

- Demonstration is aimed at full-benefit dual eligibles – individuals who qualify for both Medicare and full Medicaid benefits
- Dual eligibles tend to be in poorer health and have above-average costs
- Vulnerable to receiving fragmented or poorly coordinated care
- Demonstration aims to improve quality of care and reduce costs in both programs

Obstacles to improving care and lowering costs for dual eligibles

- Dual eligibles often have diverse needs
- Medicare and Medicaid are both complex programs
- States have limited incentives to take actions that would lower Medicare spending
- Demonstration is latest in a series of efforts to improve Medicare-Medicaid integration

Demonstration is testing two new models of care

- Capitated model: Health plans provide both Medicare and Medicaid benefits
- Managed fee-for-service (FFS) model: States provide care coordination to dual eligibles with FFS Medicare and FFS Medicaid
- Both models allow states to benefit financially from Medicare savings
- This update focuses on the capitated model

State participation

- There are 14 demonstrations in 13 states
  - Capitated model (10 states): CA, IL, MA, MI, NY (2 demonstrations), OH, RI, SC, TX, VA
  - Managed FFS model (2 states): CO, WA
  - Alternate model: MN
- Length of most demonstrations has been extended from 3 years to 5 years
- CO & VA ended their demonstrations in 2017
- About 440K dual eligibles currently enrolled

Payment methodology for Medicare-Medicaid Plans (MMPs)

- MMPs receive separate capitation payments for Part A/B services, Part D, and Medicaid
- Payment rates are set administratively; MMPs do not bid like MA or Part D plans
- Part A/B and Medicaid rates are reduced to reflect expected savings
- Rates appear adequate following a 2016 increase in the Part A/B rates

MMP payment methodology includes a quality withhold

- CMS and state withhold a portion of Part A/B and Medicaid payments
- MMPs receive the withhold if they perform well on certain quality measures
- Quality withhold differs from MA quality bonus
  - Structured as a penalty instead of a bonus
  - Smaller in magnitude (1-3 percent vs. 5 percent)
  - Improvement counts for many measures
  - Plans can receive part of withhold

Beneficiary enrollment

- States can use passive enrollment but many beneficiaries have opted out or disenrolled
- Dual eligibles with higher risk scores have been more likely to opt out or disenroll
  - 40 percent of passively enrolled have opted out
  - Higher opt-out rates for certain subgroups
- Overall participation rate is 29 percent but figures for each state vary widely
- Total MMP enrollment has been stable since mid-2015

Health plan participation

- Most sponsors had prior experience in MA and/or Medicaid managed care
- The demonstration now has 50 MMPs; another 18 have dropped out
- Enrollment varies widely across plans
- Several plans that we interviewed said an MMP needs at least 5,000 to 7,500 enrollees to operate effectively

Challenges in conducting evaluations of the demonstration

- CMS plans to conduct annual evaluations of each demonstration
- Evaluations are taking much longer to finish than anticipated due to challenges obtaining the necessary data
- Annual reports for years 1 and 2 may not provide much insight due to implementation challenges

Care coordination and service use

- Care coordination model has 3 key elements
  - Initial health risk assessment
  - Individual care plan
  - Ongoing care coordination
- Completion rates for assessments are rising but MMPs cannot locate some enrollees
- No empirical data available on service use, but plans have said they are seeing declines in the use of inpatient care, EDs, and nursing homes

MMP quality appears to be improving but is lower than MA in some areas

- Patient experience: performance has improved or remained stable
  - Improvements in plan ratings, customer service, getting appointments quickly
- Clinical quality: some signs of improvement
- MMPs had mixed results on clinical quality compared to dual eligibles in MA plans
- Newer plans typically have lower quality than more experienced plans

Demonstrations using the managed FFS model

- CO and WA use Medicaid funded-entities to provide care coordination
- CMS found that WA's demonstration reduced Part A/B spending by $67 million over 2½ years, but savings appear too large relative to number served
- CMS found that CO's demonstration increased Part A/B spending

Future work and discussion

- Future work related to the demonstration
  - Explore use of MMP encounter data to analyze trends in hospital use
  - Additional site visits
  - Assess evaluations as they become available
- Possible topics for discussion
  - Other issues related to the demonstration where you would like more information
  - Future work on potential changes to the MA quality bonus program