



*Advising the Congress on Medicare issues*

# Status report on CMS's financial alignment demonstration for dual-eligible beneficiaries

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# Context for the financial alignment demonstration

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- Demonstration is aimed at full-benefit dual eligibles – those 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 align Medicare and Medicaid to improve quality of care and reduce costs in both programs

# Demonstration is testing two new models of care

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- Capitated model
  - Relies on managed care plans to provide all Medicare and Medicaid benefits
  - Plan receives a blended capitation rate
- Managed fee-for-service (FFS) model
  - State provides care coordination to dual eligibles with FFS Medicare and FFS Medicaid
  - State receives a retrospective performance payment if it reduces federal Medicare and Medicaid spending

# State participation

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- CMS has approved 14 demonstrations in 13 states; no more expected
  - 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
- All demonstrations have started except RI
- Demonstration originally planned to last 3 years; CMS has offered a 2-year extension
- About 450K dual eligibles currently enrolled

# Demonstrations using the capitated model

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- Each state sets its own eligibility criteria
  - Most states cover both disabled and aged dual eligibles
  - Demonstrations are usually limited to certain counties
- Participating health plans are known as Medicare-Medicaid Plans (MMPs)
  - 61 MMPs now participating
  - Most sponsors had prior experience in Medicare Advantage and/or Medicaid managed care

# Enrollment in MMPs has been lower than expected

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- Participation rate is 30 percent across all states, but varies from state to state
- States can use passive enrollment, but many beneficiaries have opted out or disenrolled
  - Satisfaction with existing care
  - Lack of information about demonstration
  - Resistance from providers
- Stakeholders said passive enrollment should have been done more slowly and more robust outreach was needed

# MMPs required to provide extensive care coordination

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- Care coordination model has 3 key elements
  - Initial health risk assessment
  - Individual care plan
  - Ongoing care coordination
- Plans have been unable to locate many enrollees (30 percent in some cases)
- Level of care coordination varies depending on enrollees' health needs
  - High-risk: frequent contact, in-person interaction
  - Low-risk: monthly or quarterly phone calls only

# Challenges in caring for beneficiaries with behavioral health conditions

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- Dual eligibles are much more likely to have a behavioral health condition
- Stakeholders reported several challenges in caring for this population
  - Particularly important for care coordinators to develop trusting relationships
  - Lack of adequate/stable housing
  - Shortage of outpatient treatment options
  - Providing interdisciplinary care while adhering to federal rules that restrict sharing of patient info



# Impact of MMPs on service use and quality of care is unclear

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- MMPs that we interviewed had yet to see significant changes in service use
- Many plans said they would need 2-3 years to begin modifying utilization patterns
- CMS is collecting quality data for plans but it is not yet public
- Lack of measures for LTSS will hamper ability to fully assess quality of care

# Payment methodology for MMPs

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- Capitation rate has separate Part A/B, Part D, and Medicaid components
- MMPs do not submit bids
- Part A/B rate is based on historical costs, with same risk adjustment used for MA plans
- Part A/B and Medicaid rates are reduced for quality withhold and assumed savings
- CMS plans to raise Part A/B payments after finding that current risk-adjustment model underestimates costs for full dual eligibles

# Demonstrations using the managed FFS model

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- CO and WA use Medicaid funded-entities to provide care coordination
- Beneficiaries are not required to participate
- Only 10–15 percent of WA enrollees are using care coordination services; many have been hard to locate
- CMS has found that WA's demonstration has reduced Medicare spending, but savings appear too large relative to number served

# Plans for future work

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- Compare MMP enrollees to beneficiaries who either opted out or later disenrolled
- Make additional site visits to monitor service use, access to care, and care coordination
- Examine payment methodology for Part A/B services
- Assess usefulness of quality data when it becomes available

# Discussion

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- Use of passive enrollment
- Process for selecting and paying MMPs if they become permanent
- Performance payments under MFFS model
- Potential implications for MA special needs plans