Updates on Managed Care for Dual Eligibles and Medicare Coordination Programs

NATIONAL CENTER ON LAW & ELDER RIGHTS

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Introduction

The Financial Alignment Initiative, a demonstration project testing models to integrate and coordinate Medicare and Medicaid services, enrolled its first beneficiaries in Massachusetts in 2013. Rollouts in 12 other states followed. This issue brief reviews where the demonstration stands today, looking at the design parameters, current timetables for operation of the demonstration, numbers of enrollees, and the extent of evaluation to date. It also discusses some best practices and responses to challenges that may have broader applicability within the Medicare and Medicaid programs.

Section 1: Background

The Affordable Care Act[1] directed the Department of Health and Human Services to create a new office focused exclusively on improving health care delivery and services for dual eligible beneficiaries, those individuals who are eligible for both Medicare and Medicaid.[2] The new entity, the Medicare-Medicaid Coordination Office (MMCO), is working with 13 states to develop integrated systems that better align Medicare and Medicaid benefits to deliver coordinated care and reduce costs. This effort, the Financial Alignment Initiative (FAI), is also referred to as the dual eligible demonstration and health plans participating in the demonstration are referred to as Medicare-Medicaid Plans (MMPs).

Three Model Types

Capitated model

The majority of FAI states are testing a capitated model that integrates Medicare and Medicaid payment and service delivery in one managed care plan or Medicare-Medicaid Plan (MMP). The idea is that the MMP is responsible for the delivery and coordination of all or most Medicare and Medicaid benefits including particularly long-term services and supports. The first FAI capitated model launched in Massachusetts in October 2013, and nine other states followed: California, Illinois, Michigan, New York, Ohio, South Carolina, Rhode Island, Texas, and Virginia. Virginia has decided to end its demonstration as of December 31, 2017.[3]

1 Pub. Law 111-148, Section 2602.

2 For more background, see *Financial Alignment Initiative for Medicare-Medicaid Enrollees*, available at innovation.cms.gov/initiatives/Financial-Alignment.

3 *Commonwealth Coordinated Care (CCC) Phase-Out Plan* (August 2017), available at dmasva.dmas.virginia.gov/Content_atchs/altc/Phase-Out Plan.pdf.

Fee-for-Service model

Two states are testing a managed fee-for-service model, Colorado and Washington. Under this model, states are eligible to receive savings if they develop initiatives that better align the delivery of care to dual eligibles to improve quality of care and reduce costs.[4] Colorado is ending its demonstration as of December 31, 2017.[5]

Administrative alignment model

Minnesota opted to only integrate its administrative functions within its current capitated delivery system.[6]

Target populations

The majority of states decided to broadly include both elderly and non-elderly dual eligibles in their demonstrations: Five states, however, decided to target a subset of the dual eligible population in their demonstrations. For example, Massachusetts limits its demonstration to non-elderly dual eligibles with disabilities.[7]

Geographic regions

The majority of states limited the demonstration to smaller geographic regions within their states. Only four states implemented their demonstrations statewide: Colorado, Minnesota, Rhode Island, and South Carolina.

Enrollment

All states opted to enroll eligible individuals into the demonstration through a process called passive enrollment. Eligible individuals received notices informing them about the program and providing them with the choice to either enroll or opt out of the program. If an individual did not affirmatively opt out of the program, the individual was enrolled into the demonstration by default. Participating states, with the exception of California and New York, have continued passive enrollment on an ongoing basis for individuals who become newly dually eligible.[8] Duals in all states can choose to enroll on a voluntary basis. Enrollment becomes effective the first day of the month following enrollment. Individuals have the right to change MMPs or leave the demonstration in any month; there is no lock-in period.

Current enrollment

Approximately 403,000 dual eligibles are enrolled in the capitated demonstration. This represents only 30% of the total 1.2 million duals eligible for the demonstration in participating states.[9] This is because significant numbers of duals decided not to participate in the program by either opting out when they initially received notices or disenrolling after having been enrolled.

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4 For more background, see *Managed Fee-For-Service Guidance*, (April 17, 2013), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMCO_MFFS_Guidance_4_17_13.pdf.

5 *Transition and Phase-Out Plan for the Accountable Care Collaborative Medicare-Medicaid Program* (June 15, 2017), available at colorado.gov/pacific/sites/default/files/Phase Out Plan for Public Comment.pdf.

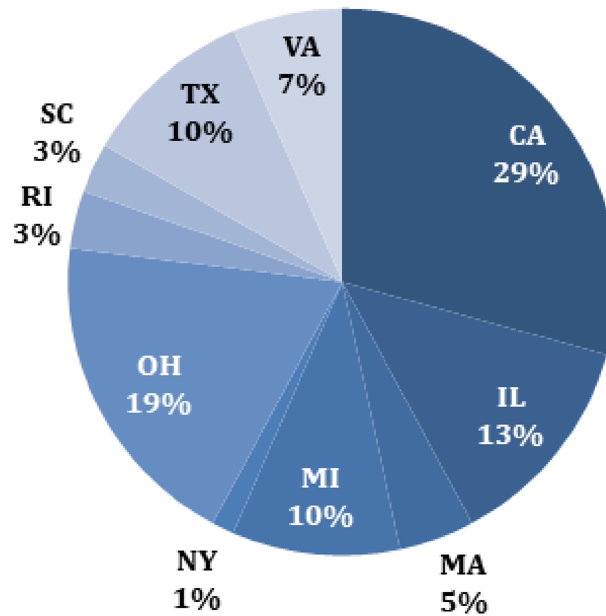
6 For more background, see *Minnesota's Demonstration to Integrate Care for Dual Eligibles*, available at dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573.

7 Massachusetts: non-elderly dual eligibles; Minnesota: elderly duals; New York: elder and non-elderly duals residing in a nursing facility or receiving nursing facility diversion and transition home and community-based waiver services or who require more than 120 hours of community-based LTSS; South Carolina: elderly duals living in community-based settings at enrollment; Texas: elderly and non-elderly duals who qualify for SSI or specific Medicaid home and community-based waiver services for seniors and adults with disabilities.

8 Illinois, Michigan, Ohio, South Carolina, and Texas conduct passive enrollment on a monthly basis; Massachusetts conducts passive enrollment on a quarterly basis; Rhode Island is conducting passive enrollment on an ad hoc basis; Virginia ended monthly passive enrollment in May 2017 in anticipation of ending its demonstration in December 2017.

9 Source: *Integrated Care Resource Center, Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2016 – August 2017*, available at integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_August_2017.pdf.

Current Enrollment in Capitated Model by State



Demonstration timeline

Initially, the demonstration was limited to a three-year period. In 2015, MMCO presented states with the option to extend their demonstrations from three to five years.[10] Massachusetts, Minnesota, and Washington as the first states to implement their demonstration were offered an additional two year extension to seven years.[11]

Demonstration Start and End Dates[12]

State	Start Date	End Date
California	April 2014	December 2019
Colorado	September 2014	December 2017
Illinois	March 2014	December 2019
Massachusetts	October 2013	December 2020
Michigan	March 2015	December 2020
Minnesota	September 2013	December 2020 (extension pending)
New York-FIDA	January 2015	December 2019 (extension pending)
New York FIDA IDD	April 2016	December 2020
Ohio	May 2014	December 2019
Rhode Island	July 2016	December 2020
South Carolina	February 2015	December 2018 (extension under discussion)
Texas	March 2015	December 2020
Virginia	April 2014	December 2017
Washington	July 2013	December 2020 (extension pending)

10 Centers for Medicare and Medicaid Services, *FA Extension Memo*, (July 16, 2015), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAExtensionMemo071615.pdf.

11 Centers for Medicare and Medicaid Services, *FA Extension Memo* (Jan. 19, 2017), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAExtensionMemo011917.pdf.

12 Data in this table was confirmed by the Medicare-Medicaid Coordination Office in an email dated Sept. 5, 2017.

Plans and benefits

There are currently 58 plans participating in the ten capitated demonstrations.[13] The MMPs offer most Medicare and Medicaid benefits including nursing facility care. MMPs also have the option to offer supplemental benefits like dental, home accommodations, and other services not covered by traditional Medicare and Medicaid. Most importantly, all plans are required to provide care coordination through case management and person-centered care planning.[14]

Section 2: Evaluations

The demonstrations are being evaluated through a number of different studies and reports. First, MMCO contracted with RTI International to monitor demonstration implementation and provide an evaluation of the demonstration's impact on the dual eligible population. RTI is tasked with both evaluating certain components of the demonstration across all the states and also with conducting state-specific evaluations. For example, RTI has released a state-specific reports on Washington's fee-for-service model, which demonstrate savings on health care spending and some promising trends with regard to care coordination and service use.[15]

Second, a number of federal agencies including the Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), and the Government Accountability Office (GAO) are also evaluating certain components of the duals demonstration.

Third, MMCO requires that all MMPs report on performance and quality measures and collects consumer experience through surveys.[16] Finally, some states are conducting their own evaluations. Below is a table of the federal-only evaluations and data to date.

Demonstration Evaluation

RTI Reports*

Report	Date
Report on Early Implementation of Demonstrations under the Financial Alignment Initiative	October 2015
Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration	July 2016
Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare	September 2016
Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative	March 2017
Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative	March 2017
Issue Brief: Special Populations Enrolled in Demonstrations under the Financial Alignment Initiative	March 2017

* All RTI evaluations, including state-specific reports not listed here, are available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html.

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13 Integrated Care Resource Center, *Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2016 – August 2017*, available at integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_August_2017.pdf.

14 For additional information on person-centered planning requirements, see, *Guidance to States Using 1115 Demonstrations or 1915(b) and Medicaid Managed Long Term Services and Supports*, codified in 42 CFR § 438.208, available at medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf.

15 RTI, *Report for Washington Managed Fee-For-Service, Final Demonstration Year 1 and Preliminary Year 2 Medicare Savings Estimates: Medicare and Medicaid Financial Alignment* (July 2017), available at innovation.cms.gov/Files/reports/fai-wa-finalyr1prelimyr2.pdf; RTI, Financial Alignment Initiative Annual Report: Washington Health Homes MFFS Demonstration (July 2016), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalResults.pdf.

16 *Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements* (FY 2017), available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2017CoreReportingRequirements121616.pdf. Each state has additional state-specific reporting requirements.

Federal Agency Reports	
Experiences with Financial Alignment Initiative Demonstration Projects in Three States (MACPAC)	May 2015
Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries (GAO)	December 2015
Issues affecting dual-eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Programs (MedPAC)	June 2016

MMP Data	
2017 MMP Performance Data (for 2015)	June 2017
Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results from the 2016 CAHPS Survey	July 2017

Section 3: Learnings and Best Practices

Though evaluation is ongoing, the dual eligible demonstration already has provided much learning on challenges and best practices. Our observations on some innovations that we believe have been most effective and could provide valuable models for other programs include:

Communications

Over the course of the demonstration, there was real progress in designing clearer and simpler consumer communications. Consumer testing proved important.[17] Some innovative consumer outreach, such as Cal MediConnecToons, and OneCare videos were developed. In California, several counties established communications workgroups composed of advocates, providers, and managed care plans who collaborated in creating fact sheets on the program to supplement and complement materials produced by the state. Because three-way agreements required that the more expansive of state or federal translation requirements apply, beneficiaries with limited proficiency in English in many states received more information about the Medicare portion of their benefit than they had ever had in the past. Multi-lingual websites and outreach materials[18] also made the program more accessible.

Ombuds

All demonstration states had a dedicated ombuds to assist beneficiaries in navigating the new system and to identify systemic issues. In some states, the ombuds is the long-term care ombudsman;[19] in others it is an advocacy organization or group of advocacy of advocacy organizations.[20] Our experience is that with both models the ombuds has been effective in tracking and untangling systemic issues particularly as, over time, they develop strong working relationships with plans and state officials.[21]

17 This was particularly true in California where initial enrollment forms caused confusion but extensively tested revisions fared better. RTI, *Report on Early Implementation of Demonstrations under the Financial Alignment Initiative*, (October 2015) ("Early Implementation"), at pp. 27-28, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.

18 *Cal MediConnect Beneficiary Toolkit*, available at calduals.org/learn-more-resources/toolkits/beneficiary-toolkit/.

19 One example is the Long-term Care Ombudsman in Virginia, see elderrightsva.org/ccc.htm.

20 One example is ICAN in New York, see health.ny.gov/health_care/medicaid/redesign/fida/ican.htm.

21 Note however that beneficiaries interviewed in focus groups showed low awareness of the program. RTI, *Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative* (March 2017), at pp. 32-33, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.

Stakeholder engagement

The level of stakeholder engagement in the demonstration has been greater than in most state and federal programs. As an example, the Massachusetts' Implementation Council,[22] which includes beneficiaries, representatives of community-based organizations, providers and trade associations meets regularly and is a particularly strong model of an organized group of stakeholders who have been effective in shaping the program in meaningful ways.[23]

Delivery of services

Much learning is taking place in how to address the complex needs of the dual eligible population. Areas of particular challenge where significant experimentation is taking place include:

- *Integration of behavioral health:* Dual eligibles have a disproportionately high need for behavioral health services, much of it unmet. A great deal is being learned in the demonstration about how to better integrate behavioral health. Plans are bringing more behavioral health professionals into care teams.[24] Silos have been an especially difficult issue with behavioral health and coordination with existing provider organizations has required significant work on both sides.[25] Plans also are struggling with limits to the current infrastructure of behavioral health services. A plan in Massachusetts, having identified a gap in available services in the community, created a residential facility for individuals who otherwise would need in-patient psychiatric hospitalization. [26]

- *Person-centered care:* The process of eliciting goals and preferences from the beneficiary and incorporating them in a meaningful way into a care plan is challenging to implement. Plans have had varying levels of success to date but evaluations have shown that, when successful, the level of consumer satisfaction is high.[27] A related challenge has been fully engaging busy primary care providers in care team planning and in-person discussions. Paying PCPs for participation in care planning is one approach being tried in New York and considered in other states.[28] IT systems that do not allow PCPs to routinely access plans of care for their patients and failure of providers to provide timely data also have been issues not yet fully resolved.[29]

- *Outreach to plan members:* After passive enrollment, plans found that some listed addresses for new members were inaccurate or that the members had unstable housing. Plans are experimenting to find effective ways to reach members including visiting neighborhoods to locate members and, when found,

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22 Massachusetts Implementation Council, available at mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid/implementation-council.html.

23 Early Implementation, at p. 28.

24 MedPAC, *Issues Affecting Dual-Eligible Beneficiaries: CMS's Financial Alignment Demonstration and the Medicare Savings Programs* (June 2016) ("MedPAC Report"), at pp. 286-87, available at medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0 .

25 RTI, *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative (March, 2017) ("Care Coordination")* at pp. 24-25, available at cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf. See also Pi-Ju Liu et al., *The Coordination of Behavioral Health Through Cal MediConnect*, (August 2017), available at thescanfoundation.org/sites/default/files/coordination_of_behavioral_health_care_through_cal_mediconnect_brief_ucb-_august_2017.pdf and Melanie Au, et al., *Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems* (ICRC, Aug. 2017), which discusses these challenges in both the alignment demonstration and in other managed care models, available at integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf.

26 *Respite Care Home Opens in Brighton* (June 3, 2015), Boston Globe, available at bostonglobe.com/business/2015/06/02/brighton-facility-filling-demand-for-mental-health-services/YC5hKxu6Ae5XmF46N6IMXM/story.html.

27 *Care Coordination*, supra note 25 at pp. 14-16.

28 *Id.*, at p. 24.

29 *Id.*

giving them cell phones to stay in touch.[30]

- *Integration of LTSS providers:* Because managed care plans and LTSS providers have often worked in separate spheres, the business practices, culture and approaches to consumer care of the different organizations often are quite distinct.[31] Bridging this divide and coordinating both business systems and care models have been challenging.

Section 4: Where Do We Go From Here

Start-up and initial enrollment are over and eleven states are extending their participation in the demonstration. The next two years will provide an opportunity to focus on implementation with much more to be learned.

More evaluations are planned and more data are being collected and analyzed. Comparative evaluations to date have primarily compared outcomes and costs for demonstration participants compared to beneficiaries in fee-for-service Medicare in the same state. As more information becomes available, it may be possible to make additional comparisons between the capitated and fee-for-service models in the demonstration as well as between this demonstration and other care coordination strategies that currently are being tested and implemented. It may also be possible to better assess which sub-populations among dual eligibles most benefit from particular care coordination strategies.

Conclusion

The Financial Alignment Demonstration is now in its fourth year, though implementation has been staged among the states. Over 400,000 dual eligible are enrolled. The demonstration includes a robust evaluation component and, though early, evaluations are starting to provide a picture of the successes and challenges encountered. Comprehensive information on costs and consumer outcomes is not yet available.

Additional Resources

- Medicare-Medicaid Coordination Office Website, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html
- Kaiser Family Foundation, *Health Plan Enrollment in the Capitated Financial Alignment Demonstrations For Dual Eligible Beneficiaries* (August 2017), kff.org/medicaid/fact-sheet/health-plan-enrollment-in-the-capitated-financial-alignment-demonstrations-for-dual-eligible-beneficiaries/
- Kaiser Family Foundation, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memorandum of Understanding Approved by CMS* (September 2015), kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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30 *MedPAC Report, supra* note 24, at p. 285.

31 *Care Coordination, supra* note 25, at pp. 4-7.