Financial Alignment Demonstration for Medicare/Medicaid Dual Eligibles: The Next Frontier

Sponsored by the Medicare Advantage and Part D Affinity Group of the Payors, Plans, and Managed Care (PPMC) Practice Group

March 8, 2013 · 12:00-1:15pm Eastern

Presenters:

Roy M. Albert, Esquire
Associate
Mintz Levin Cohn Ferris Glovsky and Popeo PC
Washington, DC
rmalbert@mintz.com

Susan W. Berson Esquire
Member
Mintz Levin Cohn Ferris Glovsky and Popeo PC
Washington, DC
sberson@mintz.com

Moderators:

Janice H. Ziegler, Esquire
Partner
SNR Denton US LLP
Washington, DC
janice.ziegler@snrdenton.com

Lyn Amor M. Macaraeg, Esquire
Deputy General Counsel
CareMore
Cerritos, CA
lyn.macaraeg@caremore.com
What Will We Cover?

- Historical lack of coordination of care for individuals eligible for both Medicare and Medicaid ("dual eligibles" or "duals")
- New authority in Patient Protection and Affordable Care Act of 2010 ("ACA")
- Description of Financial Alignment Demonstration to Support State Efforts to Integrate Care (the "Demonstration")
- Status and reactions to the Demonstration, and challenges with implementation
"Dual Eligibles" Generally

- Over 9 million dual eligibles
- They are more likely to have chronic conditions
- Dual eligibles account for a significant percentage of Medicare and Medicaid spending
- Controlling cost of dual eligibles is widely recognized as one important way to "bend the cost curve"
Managing Care of Dual Eligibles, Pre-ACA

- There were few effective programs to coordinate care of dual eligibles.
  - Ex: Medicare Advantage special needs plan for dual eligibles ("D-SNPs").
    - Offerings tailored to duals.
    - Limited to certain geographic areas.
    - Plan sponsors separately contract with CMS and States.

- Lack of coordination leads to worse patient outcomes and inefficient/expensive costs.
The ACA and Dual Eligibles

Creation of the Medicare-Medicaid Coordination Office

- Integrate benefits for dual eligibles.
- Improve coordination between Federal Government and State Medicaid agencies.
- "[S]upport State efforts to coordinate and align acute care and long term services for [dual eligibles] with other items and services furnished under the Medicare program." ACA, § 2602(c).
- Provide “support for coordination of contracting and oversight by States and [CMS] with respect to the integration of the Medicare and Medicaid programs.” ACA, § 2602(d)(2) and (d)(3).
The ACA and Dual Eligibles (continued)

Goals of the Medicare-Medicaid Coordination Office

- Providing full access to entitled benefits
- Simplifying the processes to access items and services
- Improving the quality of health care and long-term services
- Increasing understanding of and satisfaction with coverage
- Eliminating conflicts between rules under Medicare and Medicaid
- Improving care continuity
- Ensuring safe and effective care transitions
- Eliminating cost-shifting between Medicare and Medicaid
- Improving the quality of performance by providers of healthcare services
The ACA and Dual Eligibles (continued)

- Establishment of the Center for Medicare and Medicaid Innovation ("CMMI").
- Purpose is “to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished…” ACA, § 3021(a).
  - States may:
    - Use models to test/evaluate integrating care for dual eligibles
    - Test/evaluate systems of all-payer payment reform
The Demonstration

We will discuss:

- Two Demonstration models
- General timeline
- The application
- Plan selection process
- States that presently have MOUs with CMS
- Challenges of Demonstration implementation
Demonstration Models

- CMS created the Demonstration to “develop, test and validate fully integrated delivery system and care coordination models that can be replicated in other States.”

- CMS is testing two models:
  - (1) a capitated model in which CMS, the State, and health plans would enter into a three-party contract whereby the participating plans would receive a prospective blended payment; and
  - (2) a managed fee-for-service model between CMS and the State built on the existing fee-for-service system in the State.
Capitated Model

- CMS and State enter into a memorandum of understanding (MOU)
- In a "joint process," CMS and States select health plans ("Medicare-Medicaid Plans") that will participate
  - Medicare-Medicaid Plans must demonstrate that they can meet the terms of the MOU
- Three party agreement between CMS, the State, and Medicare-Medicaid Plans
  - Medicare and Medicaid requirements must be incorporated into each contract
Payments Under the Capitated Model

- Medicare-Medicaid Plan receives a single, integrated/capitated payment
- CMS pays Medicare Parts A, B, and D components of rate to Medicare-Medicaid Plan
- State pays Medicaid component of rate to Medicare-Medicaid Plan
- CMS and State proportionately share in savings achieved through Demonstration
Managed Fee-for-Service ("FFS") Model

- Uses States' existing FFS delivery system
- States may receive performance payments based on Medicare savings that are achieved net of increased Federal Medicaid costs
  - Payments made only if quality thresholds met/exceeded
- Health plans are not a contracting party under this model
General Timeline

- States submit a letter of intent to participate in the Demonstration.
- States develop Demonstration proposals based on ongoing, meaningful stakeholder input.
  - Stakeholders include Demonstration participants, health plans, consumer advocacy groups, and providers.
- States post Demonstration proposals for a 30-day public comment period.
- States submit Demonstration proposals to CMS.
- CMS posts proposals to the CMS website for a 30-day public comment period.
General Timeline (continued)

- CMS evaluates Demonstration proposals against standards and conditions and, if met, enters into a Memorandum of Understanding (“MOU”) with the State.

- For States participating in the capitated model, health plans are selected.
  - In order to qualify for participation, health plans must apply for Demonstration eligibility, often before CMS and States enter into MOU.

- After Medicare-Medicaid Plans are selected for Demonstration participation, CMS and the State will assess the plans' ability to offer high quality, coordinated care while meeting Federal/State requirements.
  - CMS and the State will also conduct implementation monitoring and ongoing monitoring.
CMS Application

Application focuses on "key Medicare criteria," including:

- Part D requirements;
- Part D and Medicare medical service network adequacy standards under CMS regulations;
- Documentation to demonstrate State licensure, solvency, and fiscal soundness consistent with CMS regulations;
- Administrative and management requirements consistent with CMS regulations; and
- A model of care for the targeted population consistent with CMS regulations.

For the second year of the Demonstration (2014), CMS application deadlines are consistent with Parts C and D.

CMS notes that many critical aspects of the Demonstration (including self-directed care, community integration, and recovery oriented behavioral health) are included in State requirements and not subject to the minimum Medicare requirements set forth in CMS guidance.
The Application – Model of Care

- Model of care requirements are based on elements CMS has established for SNPs.
- **Elements include:**
  - Description of the plan-specific target population
  - Measurable goals
  - Staff structure and care management goals
  - Interdisciplinary care team
  - Provider network having specialized expertise and use of clinical practice guidelines and protocols
  - Model of care training for personnel and provider network
  - Health risk assessment
  - Individualized care plan
  - Integrated communication network
  - Care management for the most vulnerable subpopulations
  - Performance and health outcomes measurement
- NCQA will review and approve model of care submissions on CMS’s behalf.
Plan Selection Process

- Medicare-Medicaid Plans may apply to participate regardless of existing experience.
- CMS states that selecting Medicare-Medicaid Plans is a "joint process" between CMS and the State.
- Medicare-Medicaid Plans must demonstrate proficiency in Medicare and Medicaid through the application.
- Medicare and Medicaid past performance is taken into account.
- What happens if CMS and States disagree about which Medicare-Medicaid Plan(s) are best qualified to participate?
States that Presently Have MOUs with CMS

- 26 States have submitted proposals to CMS to participate in the Demonstration.
- However, there are only four States that have entered into MOUs at this time:
  - Massachusetts (Capitated Model)
  - Washington (Managed FFS Model)
  - Ohio (Capitated Model)
  - Illinois (Capitated Model)
Reactions to Demonstration Implementation

- Is it too broad?
- Is it consistent with statutory authority?
- Is it too ambitious?
- Does it protect the people whose care it was designed to help – dual eligibles?
Resources

- Websites of individual States that plan to administer the Demonstration.
Questions?
Contact Information

Susan W. Berson
Member
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
701 Pennsylvania Ave., NW
Washington, DC 20004
Direct: (202) 661-8715
E-mail: SBerson@mintz.com

Roy M. Albert
Associate
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
701 Pennsylvania Ave., NW
Washington, DC 20004
Direct: (202) 434-7422
E-mail: RMAAlbert@mintz.com
Financial Alignment Demonstration for Medicare/Medicaid Dual Eligibles: The Next Frontier
© 2013 is published by the American Health Lawyers Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—from a declaration of the American Bar Association