



A Federal-State Discourse on Aligning Health Care Payment and Delivery to Improve Care for Dual Eligibles

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Introduction

With the goal of improving care for individuals who are eligible for both Medicare and Medicaid, the federal government and states have been working together to increase financial alignment between the programs and facilitate the integration of primary care, acute care, behavioral health, and long-term services and supports for beneficiaries. What are we accomplishing and learning from their efforts? And what are the challenges and opportunities for improvement going forward?

In September 2016, a group of federal and state policy officials met to consider these questions. At this meeting, convened by National Academy for State Health Policy (NASHP) with support from The Commonwealth Fund, participants discussed several demonstrations and policy options to align health care payment and delivery for dual eligibles. Several broad themes emerged from the conversation:

- Given the complexity of the challenge and uncertainty about what works, policymakers are pursuing a variety of efforts, including duals-specific demonstrations and policies, broader payment and delivery system reform experiments, and both capitated managed care and managed fee-for-service strategies.
- The Medicare-Medicaid Coordination Office (MMCO) in the Center for Medicare and Medicaid Services (CMS) has been a valued resource for states that provides technical support and has increased communication and collaboration between states and the federal government.
- Despite a significant commitment by the federal government to support coordination and the development of new payment and delivery system models, much work remains to be done—by both states and the federal government—to achieve alignment and improve care for dual eligibles.
- Two cross-cutting issues are crucial to help improve care for the population: integrating the full range of Medicare and Medicaid benefits, and continuing to improve the use of data for policy development, implementation, evaluation, and oversight.

Advancing Collaboration and New Payment and Delivery System Models

Given the many differences between Medicare and Medicaid and the general complexity of both programs, pursuing alignment is a complicated endeavor. The Patient Protection and Affordable Care Act of 2010 created two new entities within CMS that play an important role in efforts to facilitate program alignment and improve care for dual eligibles: the Federal Coordinated Health Care Office, more commonly called the Medicare-Medicaid Coordination Office (MMCO), and the Center for Medicare and Medicaid Innovation (CMMI).

MMCO focuses specifically on integrating benefits and improving care for individuals who are eligible for both Medicare and Medicaid.¹ To this end, the office works with both programs, states, and stakeholders to support the development and testing of new payment and delivery system models. MMCO is a key partner in the Financial Alignment Initiative (FAI) for Medicare-Medicaid enrollees, a demonstration to develop integrated care models that provide the full range of Medicare- and Medicaid-covered services. It provides technical resources for states through initiatives such as the Integrated Care Resource Center (ICRC), which assists with program design, stakeholder engagement, and data analysis; and the State Data Resource Center (SDRC), which provides Medicare data and technical support to help states coordinate care, improve quality, and control costs. It also makes legislative recommendations and looks for opportunities to eliminate regulatory conflicts and improve beneficiary experience, among other goals.

State discourse participants praised MMCO as a valued resource that has increased communication and collaboration between states and the federal government. Notably, states identified the process the office uses—engaging states as partners in deliberations—as a key strength. They also described the availability of Medicare data and support to use it as important and welcome. Given the complexity of aligning Medicare and Medicaid, there is an ongoing need for the services provided by this office.

NASHP RECOMMENDATION

The Medicare-Medicaid Coordination Office should continue its work to advance alignment between the programs and improve care for dual eligibles.

CMMI has a broader mission to develop and test innovative payment and service delivery approaches.² Some CMMI demonstrations—including the Financial Alignment Initiative and a demonstration to reduce avoidable hospitalizations among nursing home residents—focus specifically on dual eligibles. Under the FAI, CMMI works closely with MMCO and states to develop and test integrated care models for the population. Other demonstrations—including the Multi-Payer Advanced Primary Care Practice (MAPCP) model, the Comprehensive Primary Care Plus (CPC+) model, and the State Innovation Model (SIM) Initiative—target a broader population, but also help improve care for dual eligibles. For example, Maryland is using a SIM award to develop an accountable care model that builds on the state’s all-payer hospital payment system and integrates Medicare and Medicaid coverage.

Discourse participants described testing a wide variety of alternative payment and delivery system models as part of an overall strategy to improve care for dual eligibles. In addition to the demonstrations noted above, they identified the Comprehensive ESRD Care Model (CEC) as a possible model for some Medicare-Medicaid enrollees, and noted that collaboration with states could be valuable. Under the CEC demonstration, dialysis facilities, nephrologists, and other providers join together to create accountable care organizations (ACOs) that coordinate care for individuals with end-stage renal disease (ESRD). The ACOs are financially accountable for quality outcomes and most Medicare spending.³

Demonstrations and Programs to Support Alignment and Improve Care for Dual Eligibles

Three important demonstrations and programs seek to advance alignment and improve care for dual eligibles: the Medicare-Medicaid FAI, which has been introduced already, Medicare Advantage Special Needs Plans for dual eligibles (D-SNP), and the Program of All-Inclusive Care for the Elderly (PACE).

Under Medicare-Medicaid Financial Alignment Initiative, states may choose between two options to integrate care for dual eligibles: a capitated model or a managed fee-for-service (MFFS) model.^{4,5} In the capitated model, CMS, states, and health plans enter into a three-way contract and health plans receive a prospective, capitated payment to provide comprehensive, coordinated care. As of August 2016, more than 368,000 individuals in 10 states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia) received benefits from a Medicare-Medicaid Plan under this model.⁶

Discourse participants emphasized the potential of the capitated model's three-way contracting requirement to facilitate integrated care and program alignment, but also noted that setting up Medicare-Medicaid Plans (MMP) is complicated. Some state participants said that working with health plans was more difficult than necessary because of the annual bidding process for Medicare health plans, which often does not align with state contracting timelines. Some reported that the ramp-up period for MMP plans has been slower than expected because of the time and resources required to develop and implement care coordination strategies. And many noted the difficulty of integrating Medicare and Medicaid policies, procedures, and data systems. Given these challenges, some discourse participants recommended a longer time horizon to evaluate the impact of the MMPs.

In addition to the issues described above, discourse participants noted the relatively low enrollment in MMPs compared to Medicaid managed care, which is mandatory for dual eligibles in some states. Two of the reasons cited for low enrollment were difficulty getting the word out about the benefits of integrated products and the lack of Medicare lock-in periods longer than one month for individuals who enroll in the plans.

Under the FAI's managed fee-for-service model, CMS and states enter into an agreement that allows states to share in savings when state-led initiatives improve quality and reduce costs for both Medicare and Medicaid. States are responsible for integrating all Medicare- and Medicaid-covered services and may use tools like primary care case management, Medicaid health homes, and ACOs to coordinate services. As of October 1, 2015, approximately 52,000 individuals in Colorado and Washington received combined Medicare and Medicaid benefits under this model.⁷

Discourse participants shared different perspectives about the potential impact of shared savings under the MFFS model. Several expressed skepticism because of the time lag between when a state realizes savings and CMS makes an incentive payment to the state, but others described shared savings payments as an important tool that states can use to drive provider-level change. In addition, when discussing the use of specific fee-for-service strategies, some participants expressed a belief that health homes, ACOs, and other managed fee-for-service strategies are likely to be more effective and sustainable when aligned or integrated within system-wide reforms that serve a broader population. The FAI demonstrations in Colorado and Washington are both tied to broader efforts. Colorado's effort allows the population to receive care through the state's accountable care collaborative, and Washington's demonstration builds on the state's Medicaid health home model to improve care for chronically ill dual eligible.

Medicare Advantage Special Needs Plans for dual eligibles. D-SNP plans are Medicare Advantage plans that are designed to serve dual-eligibles. Like other Medicare Advantage plans, D-SNP plans submit bids to provide services for a defined population and are paid a risk-adjusted payment based on the plan's enrollment. To operate in a state, plans must have a contract with the state to facilitate the coordination of Medicare and Medicaid services. The level of integration in D-SNP plans varies significantly and can range from minimally to fully integrated. Fully integrated plans are required to have risk-based contracts to provide all Medicare-covered services as well as most or all Medicaid-covered services for beneficiaries.⁸ As of January 2016, approximately 1.7 million individuals were enrolled in D-SNP plans in 27 states and Puerto Rico.⁹

A federal discourse participant highlighted the existing D-SNP requirement for health plans to contract with states as an underutilized tool that states could use to advance payment and delivery system reforms. For example, a state might require D-SNP plans to implement value-based payment methods that support the meaningful integration of primary care and long-term services and supports. Participants also noted a lack of federal-state collaboration in the D-SNP contracting process as a missed opportunity to help states use the leverage they have to shape D-SNP plans.

NASHP RECOMMENDATIONS

CMS and states should develop a strategy to increase federal-state collaboration in the D-SNP contracting process.

States could use the requirement that D-SNPs contract with Medicaid to assure that D-SNP health plans support state priorities and are integrated with broader payment and delivery system reforms.

In discussing D-SNP plans, discourse participants also repeated two issues that affect MMPs under the FAI. First, participants described the annual bidding process for Medicare Advantage health plans as a barrier to the broader use of D-SNPs because of legislatively mandated annual timelines. Second, they noted that enrollment in D-SNP plans is difficult to maintain without a more substantial Medicare lock-in requirement than is permitted under current statutory authority for Medicare Advantage health plans.

PACE is the oldest of the initiatives for dual eligibles, tracing its roots to the On Lok Senior Health Services program, which began in the 1970's in San Francisco. PACE provides comprehensive, coordinated care, including medical and social services, to older individuals who need a nursing home level of care.¹⁰ Most participants are eligible for both Medicare and Medicaid. For dual eligibles, both programs make a capitated payment to a PACE organization to pay for comprehensive medical and social services, usually in an adult day health center. As of August 2016, just over 36,000 individuals were enrolled in PACE programs in 32 states.¹¹

Federal discourse participants described generally positive outcomes from coordinated care under this model, but acknowledged the need for better data to understand both outcomes and costs. State participants agreed about the need for more information to assess the program's value, and also cited high administrative costs for the small program and the lack of potential for shared savings as undesirable features. One state participant expressed concern about the emergence of for-profit PACE plans. CMS is currently reviewing comments on a proposed rule that would revise and update requirements for the PACE program. Among other changes, the rule offers more flexible options for the composition

of interdisciplinary care teams; it makes existing regulations and program guidance more transparent and consistent; and it streamlines the PACE Program Agreement between CMS, states, and PACE organizations.¹²

Crosscutting Impressions

In the course of discussing specific demonstrations and programs, discourse participants noted a sense of shared commitment to improving alignment between Medicare and Medicaid and advancing new payment and delivery system models. Two crosscutting issues also emerged as priorities: integrating the full range of Medicare and Medicaid benefits, and continuing to improve the use of data for policy development, implementation, evaluation, and oversight.

Regarding benefits, participants emphasized the importance of comprehensive services for the population—including medical, behavioral health, dental, and long-term services and supports (LTSS). They cited the need for increased investment to integrate medical care and behavioral health services, and singled out LTSS as being poorly integrated and behind-the-curve in developing value-based payment and delivery models.

NASHP RECOMMENDATION

To facilitate the integration of LTSS with primary and acute medical care, states and the federal government should devote more resources to helping LTSS providers develop the capacity to participate in new health care payment and delivery models.

In addition to emphasizing LTSS integration, discourse participants described dental services as a highly valued benefit that might be used to help increase beneficiary enrollment and retention in demonstration programs. They also noted an ongoing need to address more granular issues regarding benefits, such as overlapping coverage rules for durable medical equipment, which can make it difficult for Medicare-Medicaid enrollees to obtain the equipment they need.

Regarding data, state discourse participants praised MMCO's significant efforts to provide Medicare data to states, but also described uncertainty about how to use the information. They stressed the importance of linking different types of data to help ensure its accuracy and utility for payment and other purposes, and then noted a disconnect between the data that states submit for Medicaid payment (on the CMS 64 Quarterly Expense Report for states) and the data they report to the Transformed Medicaid Statistical Information System (T-MSIS). More broadly, participants described a lack of consensus about how to use data for different purposes, from influencing point-of-care decision making to evaluating payment and delivery system models and the care that dual eligibles receive.

Despite many challenges, states and the federal government are beginning to make progress in a joint effort to better align Medicare and Medicaid. It is a gigantic effort that will take time, but the federal government has provided important resources through the MMCO and CMMI to help facilitate change and states have responded by undertaking complex payment and delivery system reform experiments. More needs to be done, but there is promise that current efforts will ultimately lead to better care for dual eligibles and the more efficient use of resources in both programs.

Endnotes

1. For background and information on MMCO activities, see Centers for Medicare & Medicaid Services, Department of Health and Human Services, Medicare-Medicaid Coordination Office, Fiscal 2015 Report to Congress. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2015_RTC.pdf.
2. Centers for Medicare & Medicaid Services, Department of Health and Human Services, "About the CMS Innovation Center," <https://innovation.cms.gov/about/index.html>.
3. Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Comprehensive ESRD Care Model," <https://innovation.cms.gov/initiatives/comprehensive-ESRD-care/>.
4. Centers for Medicare & Medicaid Services, Department of Health and Human Services, "Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," State Medicaid Director Letter #11-008. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/financial_models_supporting_integrated_care_smd.pdf.
5. Minnesota is implementing an alternative model under the FAI to improve administrative alignment and beneficiary experience in the Minnesota Senior Health Options (MSHO) program. The MSHO program serves dual eligibles through health plans that contract with the state and with CMS as Medicaid managed care organizations and Medicare Advantage D-SNP plans, respectively.
6. Integrated Care Resource Center, Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, August 2016 to August 2016 (Technical Assistance Tool), August 2016.
7. CMS, Medicare-Medicaid Coordination Office, Fiscal Year 2015 Report to Congress.
8. For background and technical resources on D-SNP Medicare Advantage plans, see the Integrated Care Resource Center, "Dual Eligible Special Needs Plans" resource page, <http://www.integratedcareresourcecenter.com/optionsForMMIntegration/specialNeeds.aspx>.
9. Integrated Care Resource Center, New and Departing Dual Eligible Special Needs Plans (D-SNPs) in Calendar Year 2016, by State (Technical Assistance Tool), February 2016.
10. Medicaid.gov, "Program of All-Inclusive Care for the Elderly," <https://www.medicaid.gov/medicaid/ltss/pace/index.html>.
11. Integrated Care Resource Center, Program of All-Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization (Technical Assistance Tool), August 2016.
12. For a fact sheet on the proposed rule, see: Centers for Medicare & Medicaid Services, "Programs of All-Inclusive Care for the Elderly (PACE) (CMS-4168-P)," <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-11.html>. For the rule itself, see: Centers for Medicare & Medicaid Services, HHS, Proposed rule, "Medicare and Medicaid Programs; Program of All-Inclusive Care for the Elderly (PACE)" Federal Register 81, no. 158 (August 16, 2016): 54665, <https://www.gpo.gov/fdsys/pkg/FR-2016-08-16/pdf/2016-19153.pdf>

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