



SMDL #19-002

Re: Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare

April 24, 2019

Dear State Medicaid Director:

As we build a more competitive American healthcare system that delivers affordable, high-quality care at a sustainable cost, we are focusing on ways to improve the quality and cost of care for the over 11 million individuals who are concurrently enrolled in Medicaid and Medicare. Less than 10% of dually eligible individuals are enrolled in any form of care that integrates Medicare and Medicaid services, and instead have to navigate disconnected delivery and payment systems.ⁱ Such dually eligible individuals may either be enrolled first in Medicare by virtue of age or disability and then qualify for Medicaid on the basis of income and other eligibility factors, or vice versa. Dually eligible individuals experience high rates of chronic illness, with many having multiple chronic conditions and/or social risk factors.ⁱⁱ Forty-one percent of dually eligible individuals have at least one mental health diagnosis, and about half use long-term services and supports (LTSS).ⁱⁱⁱ

As a result of these complexities, dually eligible individuals account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs. Historically, dually eligible individuals have accounted for 20 percent of Medicare enrollees, yet 34 percent of Medicare spending. The same individuals have accounted for 15 percent of Medicaid enrollees and 33 percent of Medicaid spending.^{iv} Across both programs, that equates to over \$300 billion in state and federal spending each year.^v Improving care for this population provides opportunities for state and federal governments to achieve greater value from our Medicare and Medicaid investment. This is especially critical as Medicaid spending is already among the two largest items in most state budgets and as more of the baby boom generation ages into Medicare eligibility each day.

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment, and the programs have operated as separate and distinct systems despite a growing number of people who depend on both programs for their health care. This lack of alignment between the programs can lead to administrative inefficiency, fragmented or episodic care for

dually eligible individuals, and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs. For example, state investments in Medicaid services to improve care for dually eligible individuals (e.g., enhanced behavioral health or LTSS) may result in savings that accrue to Medicare from lower acute care utilization. Historically, states have needed to shoulder the burden of such investments without sharing in the acute care savings.

Developing new and innovative ways to serve dually eligible individuals that address these concerns is an important challenge for CMS and state Medicaid agencies.

We have heard from many states that want opportunities to develop, revise, or continue the approaches to serving dually eligible individuals that work best for the unique needs of your state. This letter describes three new opportunities to test state-driven approaches to integrating care for dually eligible individuals. This letter complements the State Medicaid Director letter released on December 19, 2018 highlighting 10 existing opportunities to improve care for dually eligible individuals.^{vi}

1. The Medicare-Medicaid Financial Alignment Initiative

a. OPPORTUNITY #1 – Integrating care through the capitated financial alignment model

We are currently partnering with nine states^{vii} on capitated model demonstrations under the Financial Alignment Initiative, tested under the authority of the CMS Innovation Center, through which CMS, the state, and health plans (called Medicare-Medicaid Plans or MMPs) enter into three-way contracts to provide the full array of Medicare and Medicaid services for enrollees.^{viii} We have recently reduced many of the administrative burdens associated with the model while maintaining our focus on reducing expenditures while preserving or enhancing quality of care for beneficiaries. The independent evaluation of the Financial Alignment Initiative is still underway, but early feedback is encouraging, especially from beneficiary surveys and focus groups.^{ix} For example:

Enrollee Satisfaction: Medicare-Medicaid Plan enrollees report high levels of satisfaction with their MMPs through member experience surveys. When asked to rate their health plan on a scale from 0 to 10 (with 0 being the worst possible and 10 being the best possible), 90 percent of respondents rated their health plan and health care a 7 or higher in 2018. Sixty-five percent of all demonstration respondents rated their MMP a 9 or 10 in 2017, up from 59 percent in 2016.^x These ratings have improved continuously since the plans started reporting such data in 2015.

Financing: The capitated financial alignment model was designed to allow states and CMS to prospectively share in savings that result from integration. We do this by reducing the Medicare and Medicaid components of the capitated rates paid to the MMPs up front by an agreed upon “savings factor” that scales up as each demonstration matures. These savings factors vary by state and currently average 4.4%. That means we expect states, on average, are currently achieving 4.4% savings through their participation in these demonstrations.^{xi}

Sustainable and cost-effective financing requires accurate payment and that is why, in the last two years, CMS has made several improvements in Medicare's Hierarchical Condition Category (HCC) risk adjustment model, including through the addition of new mental health, substance use disorder, and chronic kidney disease variables. The predictive accuracy in the HCC model has improved for full-benefit dually eligible individuals, and further improvements will be phased in over the next few years. However, we also know that market dynamics play an important role. As we consider new demonstration opportunities, we are committed to exploring ways to ensure cost-effectiveness while maintaining market viability.

Implementation: In addition, through our joint CMS-state oversight and monitoring of the capitated model demonstrations, we have learned that we have been able to:

- Create a competitive market, with multiple choices for beneficiaries, while maintaining high expectations for plans around care coordination and cost effectiveness;
- Enroll enough people into these integrated plans to support long-term viability;
- Create a successful framework for joint state and CMS oversight and contract management;
- Incentivize health plans to innovate and invest to better serve the dual eligible population; and
- Create an integrated plan in which enrollees are satisfied, as supported by the member experience survey results above.

For interested states with capitated financial alignment model demonstrations already underway, we are open to partnering on revisions, such as:

- Multi-year extension of scheduled demonstration end dates based on promising evidence, or the need for more time to collect and analyze data, when coupled with adjustments designed to improve outcomes for individuals, increase person-centered practices, reduce administrative burdens, and improve the financial sustainability for Medicare and Medicaid;
- Changes to the geographic scope of demonstrations, where such geographic changes are consistent with state priorities and allow for more efficient administration.

At a minimum, any such actions will need to meet four basic criteria for CMS approval: (a) CMS projects that the action would result in savings for Medicare and Medicaid, (b) CMS projects that the action would preserve or enhance quality of care, (c) the action is developed with robust stakeholder engagement and collaboration, and (d) state commitment to the timely submission of data needed to evaluate its model(s).

Since the outset of these demonstrations, our shared goal with state partners has been development of models that improve quality, enhance beneficiary engagement, and lower costs, which if successful, could be implemented on a broader scale. Our goal in approving these multi-year extensions would be to allow for continued data collection that ultimately informs decisions about potential certification such that further time-limited extensions beyond 2023 would no longer be necessary.

State staff interested in exploring opportunities around existing capitated model demonstrations should contact their current CMS Medicare-Medicaid Coordination Office (MMCO) points of contact or Lindsay Barnette in MMCO at Lindsay.Barnette@cms.hhs.gov.

For interested states without capitated financial alignment model demonstrations underway, we welcome interest in testing the model through new demonstrations in additional states. Using the existing capitated financial alignment model framework, we are willing to partner with states on the timing, geographic scope, and target population that best fit state policy priorities. We encourage interested states to 1) contact MMCO for a more detailed overview of the capitated model, opportunities for state customization, and timing; and 2) begin to engage local stakeholders on their proposed demonstration approach (e.g., target population, geographic scope, care model specifics). We would approach such new opportunities with the intent to build on the lessons learned from the demonstrations to date, including:

- Meaningful stakeholder engagement and collaboration;
- Robust beneficiary support mechanisms;
- Significant outreach and education for beneficiaries and providers;
- Person-centered planning and systems changes necessary for full implementation;
- Careful preparation and system testing prior to implementation;
- Phased implementation and/or enrollment of beneficiaries;
- Focus on minimizing administrative burden for providers (e.g., ensuring MMPs can pay claims accurately and timely prior to implementation);
- State-specific savings factors that reflect local market dynamics and are designed to increase over time;
- Quality withholds that put health plans at financial risk based on performance on relevant quality metrics; and
- Risk arrangements that allow CMS and the state to share in plan savings/losses (e.g., risk corridors, experience rebates, etc.).

State staff interested in exploring new opportunities to test the capitated financial alignment model should contact Lindsay Barnette in MMCO at Lindsay.Barnette@cms.hhs.gov.

b. OPPORTUNITY #2 – Integrating care through the managed fee-for-service model

While states have increasingly turned to capitated managed care for dually eligible individuals, others administer fee-for-service (FFS) programs or combinations of capitated managed care and FFS. Under the Financial Alignment Initiative, we have partnered with two states (Washington and Colorado) to test a managed FFS model through which states have an opportunity to share in Medicare savings resulting from Medicaid FFS interventions (e.g., health homes that integrate and coordinate all primary, acute, behavioral health, and LTSS for individuals with two or more chronic conditions^{xii}). While the independent evaluation is still underway, we have seen promising results under the Washington demonstration, which leverages its Medicaid health homes to provide a high-intensity care coordination intervention to high-risk beneficiaries. Washington’s approach emphasizes individual activation, engagement, and self-management.

For most participants, the cornerstone is development of individualized “health action plans” and ongoing support for individuals to improve their own health.^{xiii}

Preliminary results from the first three demonstration years in Washington show gross Medicare Parts A & B savings of 11% (over \$200 pmpm), with evidence of positive beneficiary experience and quality trends. Based on these results, we have already made interim performance payments of over \$36 million to the state of Washington. The Colorado demonstration, which applied a broader intervention to all dually eligible individuals enrolled in the state’s Accountable Care Collaborative, has not seen these types of results.^{xiv}

CMS is open to working with additional states to test this model through new demonstrations using an approach similar to Washington’s (i.e., high-intensity intervention for high-risk beneficiaries). We recognize that a retrospective shared-savings approach may present challenges for states in a balanced budget environment. Following the promising results in Washington, we welcome the opportunity to engage with additional states.

Interested state staff should contact Lindsay Barnette in MMCO at Lindsay.Barnette@cms.hhs.gov.

2. New models for integration

a. OPPORTUNITY #3 – State-specific models

States have expressed interest in developing new, state-specific models to integrate care for dually eligible individuals.^{xv} **We are also open to partnering with states on testing new state-developed models for better serving dually eligible individuals and invite states to come to us with your ideas, concept papers, and/or proposals.**

States could consider approaches broadly applicable to all dually eligible individuals or focus on certain segments of the population, such as people using LTSS, younger people with disabilities, and/or people living in rural areas. These approaches could build off elements from the FAI demonstrations or other types of delivery system reforms including alternative payment methodologies, value-based purchasing, or episode-based bundled payments. An important priority for the Innovation Center and across CMS is addressing social determinants of health.^{xvi} We have begun to create new opportunities – through new Medicare Advantage flexibilities, Innovation Center models, and innovative Medicaid 1115(a) demonstrations^{xvii} – to address social determinants in systems that are flexible, accountable, and person-centered.

While we look to states for innovation, we are especially interested in concepts that:

- Promote empowerment and independence for dually eligible individuals;
- Increase access to coordinated care, encompassing both Medicare and Medicaid services;
- Enhance the quality of care furnished to individuals, with an emphasis on health outcomes;
- Reduce expenditures for the Medicare and Medicaid programs;
- Preserve:
 - Access to all covered Medicare benefits;
 - Cost-sharing protections for full-benefit dually eligible individuals;

- Beneficiary choice of providers.

We expect robust stakeholder engagement throughout the design and (if applicable) implementation process from states pursuing new models or demonstrations, including demonstrations under the Financial Alignment Initiative. We will also post any new state-specific demonstration proposals for a 30-day CMS comment period.

State staff interested in partnering with CMS on developing and testing new innovations should contact Lindsay Barnette in MMCO at Lindsay.Barnette@cms.hhs.gov.

We are here to help!

The challenges of running a Medicaid agency are immense, and developing a new model or refining an existing model involves a number of key decision points. We are happy to talk with you or your staff to help assess the opportunities that work best for your state.

There are also a number of opportunities available to states that do not require demonstration authority or waivers to better serve dually eligible individuals. As noted above, on December 19th, 2018 we released a State Medicaid Director Letter outlining 10 such opportunities, including integrating care through dual eligible special needs plans (D-SNPs), using Medicare data to inform care coordination and program integrity initiatives, and reducing administrative burden for dually eligible individuals and the providers who serve them. We look forward to partnering with states on any or all of those approaches, in addition to the demonstration opportunities discussed above.

We also provide resources for states, including technical support and peer-to-peer learning through the Integrated Care Resource Center (ICRC),^{xviii} as well as MMCO and ICRC listserv updates,^{xix,xx} described in further detail in the State Medicaid Director Letter issued December 19th.

For any other comments or questions, or to explore other potential opportunities, please contact Tim Engelhardt, MMCO Director, at Tim.Engelhardt@cms.hhs.gov.

Sincerely,

/s/

Seema Verma
Administrator

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health

Endnotes

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- ⁱ Source: analysis performed by the Integrated Care Resource Center, under contract with CMS.
- ⁱⁱ For discussion of social risk factors, see <https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs>.
- ⁱⁱⁱ Medicare-Medicaid Coordination Office, National Profile 2012. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf.
- ^{iv} Ibid.
- ^v Ibid.
- ^{vi} <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>.
- ^{vii} States currently participating in the capitated financial alignment model are California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas.
- ^{viii} For more information on the capitated financial alignment model see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/CapitatedModel.html>.
- ^{ix} For more information on Financial Alignment Initiative evaluation see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>.
- ^x Medicare-Medicaid Coordination Office, Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results through the 2017 CAHPS Surveys. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsDec2017.pdf>.
- ^{xi} Early evaluation findings have reinforced our belief that savings are achievable even while improving beneficiary experiences and access to care. For example, evaluations of Medicare Parts A & B spending have found savings for the first demonstration periods in Ohio (4%), and Illinois (2%). While Medicaid cost analyses are still pending, we have heard from a number of states that they are also projecting savings.
- ^{xii} For more information on Medicaid health homes see <https://www.medicaid.gov/medicaid/ttss/health-homes/index.html>.
- ^{xiii} For a full description of the Washington demonstration, see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAFirstAnnualEvalReport.pdf>.
- ^{xiv} The first evaluation and Medicare cost savings reports for Washington, and the final DY 1 Medicare cost savings report for Colorado, can be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>. The first evaluation report for the Colorado demonstration is not yet available. The first Medicare actuarial cost report for the Colorado demonstration indicated a gross increase of approximately \$10 million in Medicare Parts A and B spending (approximately \$36 per member per month). The Colorado demonstration ended as scheduled on December 31, 2017.
- ^{xv} For example, CMS has partnered with the state of Minnesota on a demonstration that build upon a successful integrated dual eligible special needs plan (D-SNP) program by improving Medicare and Medicaid administrative alignment.
- ^{xvi} *The Root of the Problem: America's Social Determinants of Health*, Alex M. Azar II, available at <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html>.
- ^{xvii} *CMS Approves North Carolina's Innovative Medicaid Demonstration to Help Improve Health Outcomes*, Seema Verma, available at: <https://www.healthaffairs.org/doi/10.1377/hblog20181024.406020/full/>.
- ^{xviii} For more information, see the ICRC website at <http://www.integratedcarerresourcecenter.com/>.
- ^{xix} Sign up for the MMCO listserv at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_7840.
- ^{xx} Sign up for the ICRC listserv at: <https://www.integratedcarerresourcecenter.com/about-us/e-alerts>.