LEAVITT PARTNERS

The Dual Eligible Coalition

The Opportunity to Improve Care

There are more than 12 million dual eligible individuals enrolled in both Medicare and Medicaid. This is a diverse population that includes people with multiple chronic conditions, physical disabilities, mental health conditions, cognitive impairments such as dementia, and intellectual and developmental disabilities.

Both MedPAC and MACPAC have noted that concerns have been raised as to how separate programs and funding streams create barriers to coordination of care and the extent to which lack of coordination leads to poor health outcomes and increases costs. There has been consistent, and growing, bipartisan interest in better aligning incentives and advancing truly integrated care to improve health outcomes and quality of care for dual eligible individuals.

About the Dual Eligible Coalition

The Dual Eligible Coalition is a group of multi-sector stakeholders including beneficiary advocates, managed care plans, provider systems, state advisors, and behavioral health and social support service organizations. The Coalition was founded to develop actionable, long-term policy and programmatic solutions to improve the delivery of care and outcomes for the dual eligible population. State advisors include representatives from Massachusetts, Tennessee, Virginia, and Washington.

The Coalition's Work

The Coalition has been at work since 2017 to assess the challenges and opportunities facing the dual eligible population, their families and the stakeholders who work with and serve them. The Coalition has developed a framework for fully integrating Medicare and Medicaid into a single program addressing medical, long-term care, behavioral, and social needs. In conducting its work, the Coalition seeks to promote a set of principles around integration and whole-person care, including the following:

- Supporting Beneficiaries to Live as Fully as Possible
- Ensuring Comprehensive Integration
- Promoting State-Federal Partnership
- Ensuring Robust Reporting, Accountability, and Continuous Quality Improvement
- Aligning Incentives for Value-Based Care
- Promoting Consumer Engagement

The Coalition's framework was developed through Coalition member input and expertise, as well as a structured stakeholder outreach process in which Leavitt Partners facilitated more than 40 individual conversations with a wide array of diverse stakeholders across the health care community, including with policy experts, providers, advocates, associations, and foundations.

Current Policy Efforts to Integrate Care

In developing its policy framework, the Coalition considered current efforts underway to integrate care for the dual eligible population. Integrated care models are designed to align the delivery, payment, and administration of Medicare and Medicaid services to improve care for dual eligible individuals and reduce spending. There are currently three primary models for integrating Medicare and Medicaid services, with some states using more than one:

- Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), and plans that can also be classified as fully integrated (FIDE-SNPs) or highly integrated (HIDE-DSNPs) depending on the degree of alignment with Medicaid managed long-term services and supports (MLTSS) and behavioral health;
- the Financial Alignment Initiative (FAI)[1]; and,
- the Program of All-Inclusive Care for the Elderly (PACE).

The Coalition's framework builds on the learnings of current efforts and advances the goal of truly integrating care for dual eligible individuals by creating a new program which states could adopt that eliminates the need to navigate both Titles 18 and 19 of the Social Security Act (SSA). The Coalition proposes the new program be created under new title of the SSA, effectuated as the **All Inclusive Medicare-Medicaid (AIM) Program under Title 22** – an approach that highlights the true integration of the best of elements of both Titles 18 and 19.

The Need for Further Integration

The Bipartisan Budget Act of 2018 (BBA18) permanently extended operating authority for MA SNPs and added new integration requirements for Medicaid and SNPs. While many of the BBA18 policies will result in better integrated care for dual eligible individuals, there still remains a level of fragmentation.

Building on the steps of BBA18 to improve integrated care for the dual eligible population, Congress could further work to align incentives, integrate care, and improve efficiencies. For example, even with the requirements in BBA18, areas of fragmentation still exist, such as:

Fragmented Beneficiary Experience

- **Current Fragmentation:** Today, the majority of dual eligible individuals find themselves in fee-for-service or in managed care plans that are not integrated. As a result, they have multiple ID cards; separate provider networks and directories; uncoordinated notices from the state, the Centers for Medicare and Medicaid Services (CMS), and perhaps a health plan; as well as confusing coverage policies in areas of overlap (e.g., home health, durable medical equipment, supplemental benefits, etc.).
- **Further Integration in the AIM Program:** Under Title 22, beneficiaries would be receiving services from a fully integrated program that no longer has to navigate two separate Titles with conflicting or confusing policies and requirements. This new program would give many beneficiaries greater peace of mind and confidence in accessing care.

[1] The Financial Alignment Initiative is designed to provide individuals dually enrolled for Medicare and Medicaid with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. Through the Initiative, CMS partners with states to test two new models for their effectiveness in accomplishing these goals. This initiative is possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office. https://innovation.cms.gov/initiatives/Financial-Alignment/.

Limited State Incentives

- Current Fragmentation: States have limited incentives to develop more integrated D–SNPs (e.g., HIDE or FIDE-SNPs) because they do not benefit financially from any Medicare savings that those plans might generate.
- Further Integration in the AIM Program: Under Title 22, states would have an opportunity to share in savings generated through the operation of a fully integrated program by virtue of the blended state and federal financing.

Two Contracts

- Current Fragmentation: A D-SNP has one contract with CMS and one with the state, and the state contract with the state may or may not include long term services and supports (LTSS) or behavioral health.
- Further Integration in the AIM Program: Under Title 22, there would be one contract between the new program administering entities and the state to cover both Medicaid and Medicare. The state and CMS would have a separate agreement outlining the federal requirements that dictate state participation and federal oversight.

Siloed Funding

- Current Fragmentation: The Medicare D-SNP bid and the Medicaid managed care rate are still developed in isolation of each other, which can result in cost-shifting between the two, duplication of services and benefits, and few or no value-based incentives around quality, total cost of care, and beneficiary experience.
- Further Integration in the AIM Program: Under Title 22, there would be one rate taking into account all services, eliminating duplication of services, aligning incentives for rebalancing, and recognizing efficiencies from integrated care delivery.

Separate Marketing Materials

- Current Fragmentation: Dual eligible individuals get all of the Medicare D-SNP notices along with whatever notices the state uses for Medicaid. While there is an effort for more coordination on Plan Annual Notice of Change and Explanation of Coverage documents, they are still "Medicare" and "Medicaid" notices and these practices create confusion for beneficiaries, providers, and plans.
- Further Integration in the AIM Program: Under Title 22, there would be one set of notices for all practices related to the program (e.g., enrollment, marketing, grievances and appeals, etc.).

Separate Enrollment

- Current Fragmentation: BBA18 did not tackle aligning the actual enrollment processes and making it easier for beneficiaries to get the services which they are entitled to receive. While CMS can do some of this administratively, it is only happening in certain limited instances.
- Further Integration in the AIM Program: Under Title 22, beneficiaries would be enrolled into one program, eliminating the need to coordinate and align enrollment processes that prove challenging today.

The Coalition's Vision for Integrated Care

The Coalition's goal is federal legislation that would create a new integrated program for full benefit dual eligible individuals – overseen by CMS and administered by states – that folds together current Medicare and Medicaid authorities and funding into the AIM Program under Title 22 of the Social Security Act.

PROGRAM ADMINISTRATION

- The Secretary, acting through the Federal Coordinated Health Care Office established under Section 2602 of Public Law 111-148, shall oversee the AIM Program.
- States will be given the option to select to participate in an AIM Program, and states that choose to do so shall undergo and pass a rigorous federal readiness review as a condition of launch. (This program is not federally mandated, so some states may choose not to participate.)
- The AIM Program will be operated under a minimum set of federal standards, including access to care, quality of care, beneficiary protections, marketing and enrollment, grievances and appeals, and procurement, among others. There will be strong federal oversight of the AIM Program in partnership with the state. The oversight structure will build on the institutional learnings from the FAI contract management teams.
- Enhanced funding will be available to states for a period of time to assist with the staff, IT, planning and evaluation, and launch of this option.
- The AIM Program will be delivered at the state level through capitated managed care plans or at-risk/value-based alternative fully-integrated delivery systems, as requested by a state and approved by the Secretary. PACE will continue to be an option within the state, at the discretion of the state.

ELIGIBILITY

- The eligible population is full benefit dual eligible individuals (i.e., anyone with a full Medicaid benefit) aged 21 and over.
- States will not be permitted to carve eligible populations out of the AIM Program. The Secretary will have discretion to allow states to phase in new populations over a defined time frame.
- There will be a standard floor for income and asset levels. A state would have the option to go above the floor in income, assets or disregards.
- There will be a maintenance of effort for existing eligibility levels (e.g., income and asset) for dual eligible individuals.

BENEFITS

- AIM Program funding shall be available to cover a core benefit package that addresses medical, behavioral, long-term care, and social needs. The core package will include:
    - all Medicare A, B and D services;
    - all Medicaid mandatory services; and
    - additional behavioral health, social and supportive services provided “in lieu of” that enable flexibility to achieve person-centered outcomes in the most cost-effective settings.
- There will be a maintenance of effort for participating states to maintain existing benefit levels for dual eligible individuals.
- There shall be no benefit or services carve-outs in Title 22, unless determined essential by the Secretary for a state to take such option. In such a case, the Secretary may make an exception for limited period of time.

ENROLLMENT AND BENEFICIARY PROTECTIONS

- Each AIM Program participating state will be required to contract with an independent enrollment broker to assist beneficiaries in understanding the AIM Program and making enrollment choices.
- States will be permitted to utilize existing enrollment flexibilities that exist today (e.g., default enrollment).
- Each participating state will establish a dedicated Ombudsman Program that will coordinate with current state and federal beneficiary protection services and provide three core services:
    - individual assistance;
    - systemic monitoring and reporting; and
    - consumer education and empowerment.
- Each AIM administering entity will be required to have a Beneficiary Advisory Council.
- Each administering state and each administering entity in each administering state will establish a Consumer Advisory Board that will provide regular feedback to the administering state and the administering entity's governing board, respectively, on issues of beneficiary care.
- Continuity of care provisions shall apply for the first 6 months of an individual's enrollment in the AIM Program.

PROGRAM FINANCING

- This new AIM Program will combine the Medicare expenditures (Parts A, B, and D), the federal share of Medicaid expenditures, and state share of Medicaid expenditures (including for Part D) into a single, integrated funding stream that would be sufficient to cover the cost of care for all individuals enrolled in the program. The funds will no longer be identified as Medicare or Medicaid; they will be Title 22 federal/state contributions.
- The Coalition evaluated several different financing models and has selected an expenditures-based model. This model acknowledges the need for up front investments in financing the program, as well as ongoing contributions from federal and state governments.
- The current statutory and regulatory authorities that govern appropriate source and use of federal and state dollars will generally continue to be applied to the AIM Program and there will be federal CMS oversight regarding the use of funds, which may include federal audits.

PROCUREMENT STANDARDS

- The Federal Coordinated Health Care Office will consult with states to develop a set of minimum procurement standards for administering states' selection of an entity within such state to administer the program within one year of the date of passage.
- Consistent with other requirements, the state must implement the program with a capitated managed care plan or other entities with two-sided risk.
- Selection criteria for the administering entity must take into account prior experience in serving the dual eligible population, and can include other criteria such as:
    - Quality measure performance and performance on key health outcomes;
    - Member satisfaction scores;
    - Models of care (including models for social supports);
    - Experience with supplemental benefits;
    - Provider network adequacy and access to essential providers; and
    - Experience with LTSS and behavioral health, including experience integrating medical, LTSS, and behavioral health.

OVERSIGHT RESPONSIBILITIES

- Administering states will be responsible for day-to-day oversight of the administering entity.
    - Oversight will include comprehensive readiness reviews, compliance monitoring, and review and approval of areas such as network adequacy, outreach materials, complaints and appeals procedures, utilization management functions, eligibility processes, and assessment tools.
    - Administering states will also be responsible for performance reviews, periodic audits, receiving and responding to complaints, enrollee surveys, and sanctions if appropriate.
- CMS will be responsible for oversight of the administering state.
    - Oversight includes monitoring selection of organizations to participate in the AIM Program, conducting a readiness review of the state, ensuring the state maintains a dedicated Ombudsman program, and ensuring state oversight of administering entity compliance.
    - CMS will also coordinate review of eligibility and enrollment processes and procedures, monitor state data systems, ensure actuarial soundness of rates, conduct state audits, and apply any warranted disciplinary action.
- The administering state and CMS will also share a joint partnership role in oversight through Joint Contract Management Teams (CMTs) utilized in the FAI.
    - The CMT will be composed of one contract officer from CMS and at least one contract officer from the state.
    - CMT will serve as a liaison among the administering entity and CMS to facilitate communications and smooth operations.

Moving Forward

With more than 12 million dual eligible beneficiaries enrolled in both Medicare and Medicaid, the Coalition is committed to working collaboratively to legislatively advance its framework for fully integrating Medicare and Medicaid into a single program addressing medical, long-term care, behavioral, and social needs.