DUAL ELIGIBLE COALITION

Financing in the AIM Program

Overview

The overall goal of the AIM Program is to consolidate care for full benefit dual eligible individuals within a new program expressly designed to address their situation and needs. Such beneficiaries have a much higher average cost for health care, have more chronic conditions and functional limitations, and currently experience considerable fragmentation since they are receiving care from two separate programs.

In the AIM Program, financing care for dual eligible individual requires a combination of federal and state contributions. This new 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 to cover the cost of care for all full benefit dual eligible individuals enrolled in the Program. The funds will no longer be identified as Title 18 (Medicare) or Title 19 (Medicaid); they will be Title 22 (AIM Program) funding.

In evaluating financing options, the Coalition considered six distinct approaches to financing before selecting this model. This paper outlines our financing model. The model envisions ongoing contributions from federal and state governments based on their respective percentage contribution in the base year, adjusted annually as described below. The model also proposes to require the federal and state government to reinvest the decrease in expenditures above 15% back into the program.[1] The Coalition envisions this model will also include robust federal oversight to ensure, at a minimum, that all funds are spent in accordance with AIM Program requirements.

Baseline and Data Sources

The baseline is established on the federal fiscal year two years prior to the implementation of the program. The baseline will be adjusted for any material changes in the Program from one year to the next, as determined by the Secretary, and, if appropriate, an adjustment for year over year growth for the 2 years prior to the implementation of the program.

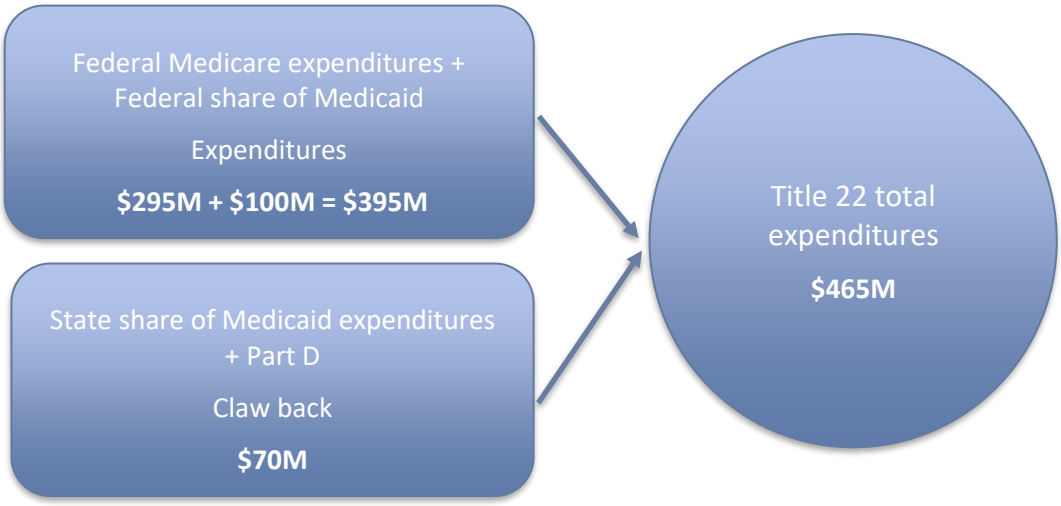
Data will be collected from the Medicare program for original Medicare (Parts A and B), Medicare Advantage Plans (Part C and D-SNP plans) and Prescription Drug Plans (Part D). For Medicaid, expenditures will be collected from fee for service (including case management and waiver services), managed care payments, and the Part D claw back.

[1] The Coalition envisions a financing approach that enables "permanent" financing for the program, akin to how Medicare (vs. Medicaid) is currently financed. While most mandatory spending programs bypass the annual appropriations process and automatically receive funding each year according to either permanent or multi-year appropriations in the substantive law, Medicaid is funded in the annual appropriations acts. For this reason, Medicaid is referred to as an appropriated entitlement. Conversely, Medicare is never appropriated, and is considered an entitlement. (Medicaid is a federal entitlement to states, and in federal-budget parlance entitlement spending is categorized as mandatory spending, which is also referred to as direct spending.)

The baseline will also be adjusted if significant populations of dual eligible individuals do not participate. For example, if all, or a significant portion of the dual eligible individuals in nursing homes opt out, the baseline would not accurately reflect the state expenditures for the dual eligible individuals participating since the State provides the majority of nursing home services. If the baseline is not adjusted, the federal and state weighted percentage contribution (WPC) would be incorrectly inflated by the State percentage.

Federal and State Contribution

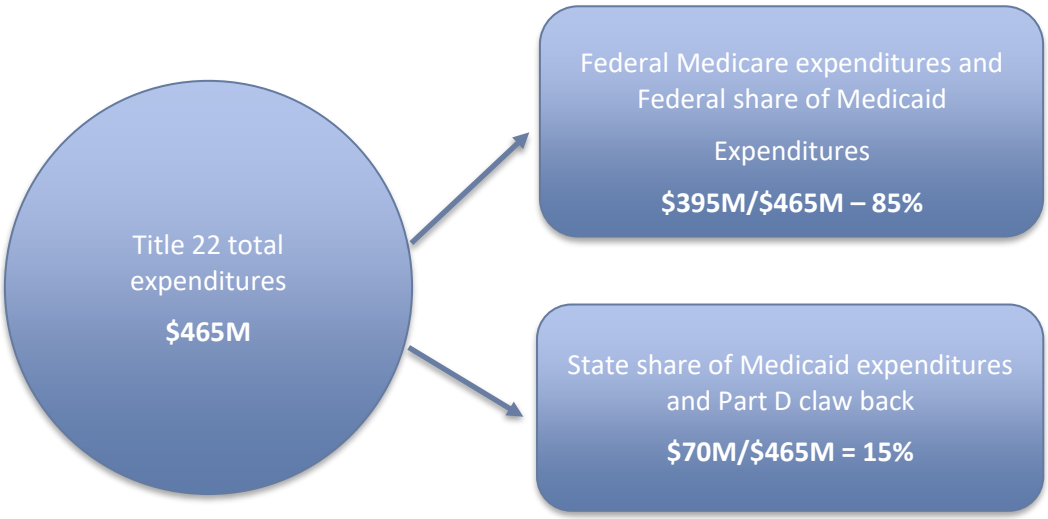
Financing is a blend of a baseline of Medicare and Medicaid expenditures for dual eligible individuals (as described above) derived from a prior federal fiscal year period, weighted by each program's percentage of the baseline's total expenditures. The federal and state contributions to dual eligible beneficiaries' expenditures are combined into one AIM Program total allocation, which would be directed to a participating state that assumes full risk for managing the program. The following example assumes a 60% FMAP for Medicaid expenditures of $175 million and Medicare expenditures of $295 million.



The federal and state share of the expenditures would be determined as follows: in Year 1 and later, all costs for the AIM Program are paid and these costs would be allocated to the federal and state government based on their weighted contribution percentage.

The percentages for Year 1 would be set equal to base year percentages:

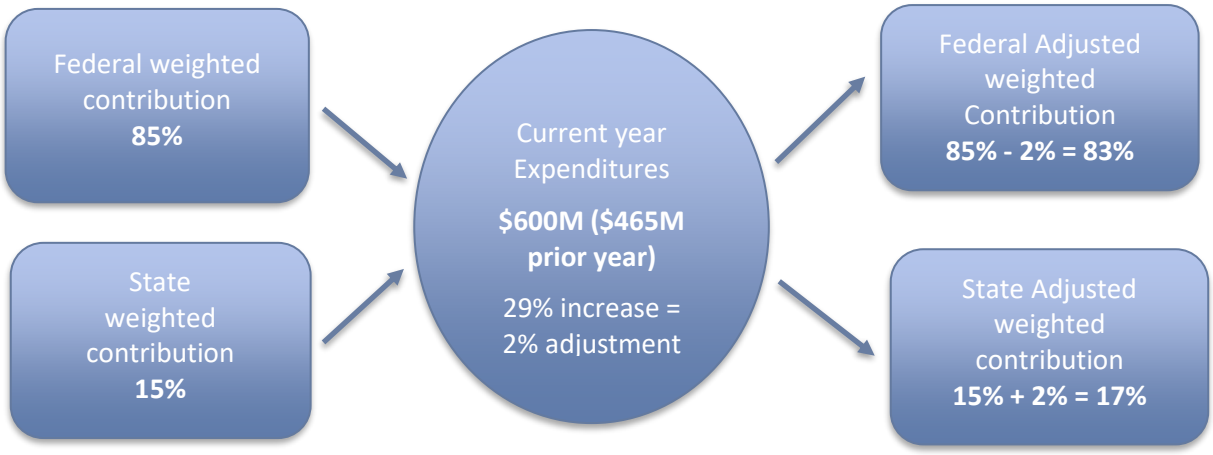
- The federal dollar amount includes all Medicare costs for full benefit dual eligible individuals, plus the federal Medicaid matching payments for full benefit dual eligible individuals;
- The state dollar amount includes all state Medicaid costs for dual eligible beneficiaries (including long term care) and including the claw back payments to Part D; and
- The federal percentage would simply equal the federal dollar in the base year divided by the total federal and state dollar amounts in the base year (with the state percentage share determined similarly.



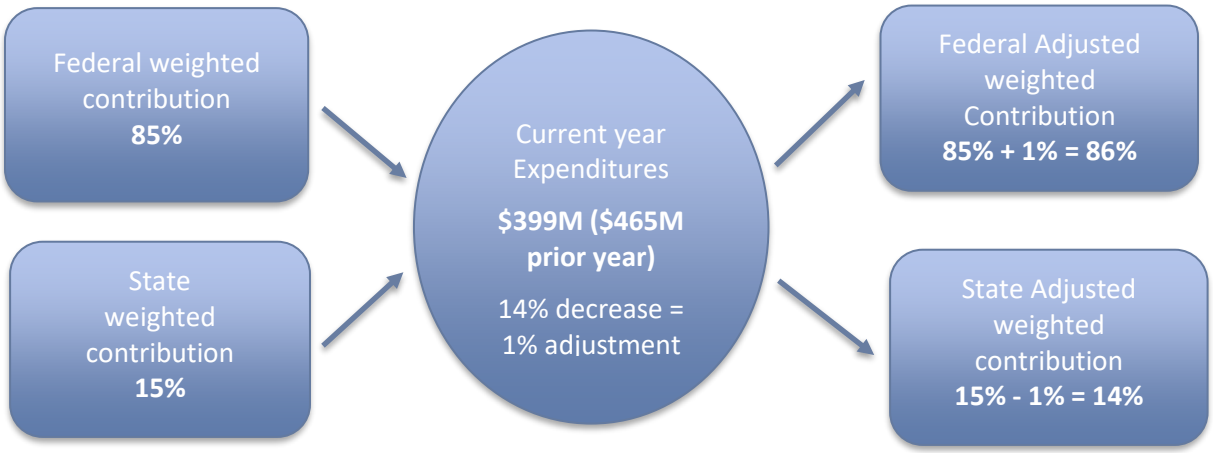
The weighted contribution percentage for each subsequent year would be calculated based on the prior year expenditures. At the end of each year, the weighted contribution percentages are calculated and prospectively applied to the following year expenditures to calculate the federal and state government obligation.

An important part of designing a financing model is to ensure there are appropriate financing incentives to meet the goals of the program. With no further financing adjustments, other than those described above, there is no incentive for states to appropriately limit increases or appropriately decrease expenditures. To provide the right incentives, increases or decreases in expenditures will be controlled by adjusting the federal/state weighted contribution percentages. If total expenditures increase above 10%, the federal contribution decreases 1 percentage point for every 10% increase, and the state contribution increases 1 percentage point for every 10% increase. If the total expenditures decrease below 10%, the federal contribution increases, and the state contribution decreases, in the same way.

Expenditure Increase above 10%



Expenditure Decrease above 10%



Updates and Adjustments

We propose three updates and adjustments to the financial calculation.

First, as described above, the AIM Program WPC is updated annually based on a comparison of current year versus prior year expenditures. As described above, adjustments will be made within spending thresholds to ensure increases and decreases in expenditures are appropriate.

Second, this model deems expenditures that decrease by more than 15% to be considered "savings." To ensure some of the savings are used to improve the program, there will be a requirement to reinvest those savings back into the program.

Third, there will be an exception process to account for expenditure increases and decreases above or below the 10% threshold that would not be subject to the adjustment in the weighted contribution percentages. Some examples of an exception would be:

- A significant increase in enrollment
- The declaration of a national emergency that impacts Title 22
- Cost increases determined to be beyond the control of the State, at the discretion of the Secretary

Savings Calculation and Distribution

A decrease in expenditures above 15% represents savings to the federal and state government and the benefit is realized by the federal and state government. To ensure these savings are not returned to the federal and state government for other uses, and that there is continued improvement and growth of the program, these savings must be reinvested in the AIM Program. The Federal Coordinated Health Care Office will establish criteria to ensure that the decreased expenditures have not decreased FBDE beneficiaries' access to services.

We are also proposing guidelines for reinvesting savings. For example, the state will have the authority to use savings to promote the core principles, such as:

- **Prevention and Wellness** - striving to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention, wellness, recovery and maintaining independence
- **Pay for Performance** – to employ purchasing and payment methods that encourage and reward service quality and cost-effectiveness by linking reimbursements to common, evidence-based quality performance measures, including patient satisfaction
- **Innovative and Technological Advancements** – making improvements that facilitate remaining in the community
- **Accounting for Social Needs** – increase integration with social needs that impact health outcomes.
- **Hiring for State Personnel**
- **Capacity Building** -- such as community-based care; and caregiver assistance.
- **Improved Enrollment Policies and Processes**
- **Increased Education for Provider and Beneficiaries**
- **Improved Data Collection Regarding Racial Disparities and Health Inequities**

Multi-Year Costs

There will be initial investments and cost incurred to improve the delivery of medical assistance services. While there will be states that will be able to achieve savings early in the program, other states may need some time to allow the early investments to "pay off." At the discretion of the Secretary, the model allows states the flexibility to make these changes, by proposing a 5-year budget neutrality requirement. After five years, the state will be required to pay in full to the Federal government the excess expenditures. It should be noted that these are costs of delivering services and not administrative costs, which are matched separately. A condition for receiving a budget neutrality calculation, is that the state must show significant increase in appropriate home and community-based services and less use of inappropriate institutional care services.

State Reporting and Payment

In lieu of creating a new reporting system, we propose to build on the current process used in the Medicaid Budget and Expenditures System (MBES). The state projects its quarterly expenditures, which determines the amount of federal money available for use by the state in that quarter. The state then draws down the money as it incurs expenditures during the quarter. The estimated expenditures and the incurred expenditures are reconciled at the end of each quarter. There is no annual reconciliation.

The state's estimated matchable expenditures (total computable and federal share) are reported by quarter for each federal fiscal year on the CMS-XX (AIM Program replacement for CMS-37). CMS must make federal funds available based upon the state's estimate, as approved by CMS.

Within thirty (30) days after the end of each quarter, the state would submit the Form CMS-XX (AIM Program replacement for the CMS-64) quarterly expenditure report, showing expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the Form CMS-XX (64 replacement)

with federal funding previously made available to the state, (AIM Program replacement for CMS-37) and include the reconciling adjustment in the finalization of the grant award to the state.[2]

Federal Oversight

First, the current Medicaid statutory and regulatory authorities that govern appropriate sources of non-federal share ("state share") funding will apply to this program (i.e., pertaining to health care-related taxes, provider-related donations, intergovernmental transfers, and certified public expenditures).

Second, the quarterly budget and expenditure process described in the immediately preceding section includes a detailed federal review of the state's quarterly expenditures.

Third, the current Medicaid deferral and disallowance processes will also apply to this program and can be utilized during the federal review of the quarterly expenditures and beyond.

Fourth, there will be federal oversight regarding the use of funds, which may include federal audits by CMS or other federal agencies such as the Office of Inspector General and the Government Accountability Office.

[2] https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-medicaid-chip/index.html.