



## Integrated System of Care for Dual Eligibles: Capitated Approach

### New Guidance from CMS on Payment Model to Improve Care for Dual Eligibles

The Medicare-Medicaid Coordination Office (MMCO), created by the Affordable Care Act (ACA) [released guidance](#) for those health plans or other qualified entities interested in pursuing the capitated financial model to improve the quality of care for the dually eligible Medicare and Medicaid beneficiaries (“dual eligibles”).

Advocates may recall, that in [July 2011](#) MMCO announced a demonstration program to test two new payment models designed to help states improve quality and share in the lower costs that result from better coordinating dual eligibles care. The models are:

1. A **capitated approach**, in which CMS, the state, and health plans would enter into a three-way contract. Under this approach, participating plans would receive a prospective blended payment to provide comprehensive, seamless coverage to dually eligible members of their plans.
2. A **managed fee-for-service approach** in which CMS and a state will enter into agreement whereby the state would be eligible for a portion of the savings resulting from initiatives that improve quality and reduce costs for both Medicaid and Medicare.

While the guidance highlights important issues for health plans or other qualified entities, advocates need to keep a close watch on which plans are chosen and ensure that the demonstration takes into account key elements: enrollment, provider networks, appeals process, marketing including how beneficiaries receive information, quality measures, financing, and consumer protections. Advocates should make certain that CMS and the state choose a plan that demonstrates the capacity and commitment to providing seamless, fully integrated care that will strongly influence the goals of the duals demonstrations: improving care and reducing costs. Once a plan is selected, ongoing assessment and monitoring will be necessary to identify and address problems early on in the demonstration.

For each issue the guidance discusses, consumer advocates can play a role to ensure that the proposed demonstrations keep the beneficiary at the center.

#### Key dates

- The guidance outlines an aggressive schedule for the demonstration approval and plan selection processes as well as the beneficiary notification and enrollment:
  - **Spring-Summer 2012:** States submit demonstration proposals
  - **Summer – Fall 2012:** States and CMS negotiate Memorandums of Understanding (MOU)

- **Mid-September 2012:** Selection of plans and execution of three-way contract
- **October 1, 2012:** Notice to beneficiaries being passively enrolled into plans
- **January 1, 2013:** Enrollment becomes effective

#### **What can consumer advocates do?**

- Get involved now! Find out as much as possible about your state's plans for its demonstration proposal. Make sure the state holds public stakeholder meetings and use these opportunities to shape the demonstration design. It is imperative that advocates be a part of every stage, from planning to implementation to oversight of the program.
- Once a demonstration proposal is released, voice your opinions during public comment periods. The state is required to release the proposal for a 30-day comment period prior to sending to CMS. Once CMS receives the proposal, it will post it for an additional 30-day comment period.
- Insist on a phased approach to enrollment with plans accepting new enrollees only as they are deemed to have the necessary providers and systems in place.

#### **Payment principles**

- CMS and the state will jointly develop rates based on a baseline spending in both programs and projected savings that will result from integration and improved care management.
- Rates will provide upfront savings.

#### **What can consumer advocates do?**

- Ensure that the proposed rate is risk adjusted to take into account the individual needs of dually eligible beneficiaries, including any functional limitations.
- Any savings accrued by the entity should be reinvested into beneficiary services and supports.

#### **Standards in programmatic areas**

- The guidance summarizes key programmatic standards for the demonstration based on current Medicare and Medicaid requirements and notes that Medicare prescription drug (Part D) requirements will be applicable under the demonstration.
- Appendix I of the guidance provides a detailed chart that summarizes Medicare and Medicaid requirements and CMS' intended standards.

#### **What can consumer advocates do?**

- Advocates should keep a close eye on programmatic areas such as, enrollment, provider networks, appeals process, marketing, quality measures, financing and consumer protections.

#### **Network adequacy**

- The guidance states that the standard for demonstrating network adequacy will be based on Medicare standards for medical services and prescription drugs. For long-term services and supports (LTSS), plans will use state Medicaid standards.
- For areas of overlap in Medicare and Medicaid services, the standard will be determined by the CMS-state MOU negotiations and honored in the three-way contract with the health plan.
  - The requirements must ensure a sufficient network of providers to meet the needs of the enrollees.

- MMCO will provide more information associated with submission and evaluation of network adequacy in a final call letter due out on April 2, 2012.

**What can consumer advocates do?**

- Create safeguards that prevent the demonstration from interrupting established beneficiary-provider relationships or an existing course of treatment.
- Ensure that CMS, the state and health plans share specific details about the number of providers, competency of providers including for complex population who need LTSS, and a clear definition of what it means to have adequate access.

**Other Resources**[Medicare-Medicaid Coordination Office](#)

- [Annual Report](#)

## Community Catalyst

- [The “Dual Eligible” Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid](#)

## National Senior Citizen’s Law Center

- [Issue Brief: Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles](#)

## Kaiser Family Foundation

- [Summary of Proposals: 15 State Design Contracts Funded by CMS](#)
- [Financial Alignment Models for Dual Eligibles: An Update](#)