Medicare-Medicaid
Dual Eligibles: Translating Lessons Learned Into Strategies for Future Programs

Tuesday, June 21, 2016

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Moderator: Jim Gutman, managing editor at AIS

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(1) Email your question(s) to moderator Jim Gutman at jgutman@aishealth.com or

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WE BINAR M ATERIALS

Future of Duals Programs .................................................................page 1
Presentation by Lisa Rubino

California’s Coordinated Care Initiative ..........................................page 18
Presentation by Sarah Brooks

Translating Lessons Learned Into Strategies for Future Programs ..........page 31
Presentation by Melanie Bella

Selected Articles from Medicare Advantage News ...............................page 38

WE BINAR O UTLINE

Part 1: Lisa Rubino
• Molina’s Footprint Today
• Integration Landscape: Many Paths to Duals Integration
• Lessons Learned
• How LTSS Expenditures Are Changing
• MLTSS Opportunities
• MLTSS Intervention Point
• Nursing Home to Community Transition
• Closing Thoughts: Paths to Better Integration for Duals

Part 2: Sarah Brooks
• CCI Evaluation Efforts
• CCI Evaluation Data
• Lessons Learned: Providers Matter
• Lessons Learned: Provider Engagement Strategies
• Lessons Learned: In-Network Communication
• Lessons Learned: Community Living
• The CCI in 2016
• CCI Announcements
• Resources and Contact Information

Part 3: Melanie Bella
• Medicare-Medicaid Coordination Office
• Financial Alignment Demonstrations
• Challenges
• Successes
• Looking Toward the Future

Part 4: Questions and Answers
Future of Duals Programs
An AIS Webinar

June 21, 2016 | Presented by: Lisa Rubino, Senior Vice President, Medicare & MLTSS
Molina Healthcare, Inc.
Overview

- Molina Footprint
- Big Picture
- Dual Eligible Integration Landscape
- Lessons Learned
- Improving Care and Quality of Life
- Closing Thoughts
- Questions
Molina’s Footprint Today

Health plan footprint includes 4 of 5 largest Medicaid markets

4.2M¹ Members

1% Medicare
15% Marketplace
1% Duals
9% ABD
15% Expansion
59% TANF & CHIP

Member Mix

1. Total enrollment relates to estimated membership as of March 31, 2016.
2. Pathways was previously known as Providence Human Services and was acquired from The Providence Services Corporation in a transaction that closed on November 1, 2015.

ABD = Aged, Blind and Disabled; TANF = Temporary Assistance for Needy Families; CHIP = Children’s Health Insurance Program.
Big Picture

Medicaid
58.2 million eligibles
$447 billion/year

Duals
10.7 million eligibles
$285 billion/year

Medicare
51.3 million eligibles
$586 billion/year

Reference: National Health Expenditure Accounts, Table 21 Expenditures, Enrollment, and Per Enrollee Estimates of Health Insurance.
Reference: Medicare-Medicaid Coordination Office, Fiscal Year 2015 Report to Congress. Published 2016.03.02.
Integration Landscape: Many Paths to Duals Integration

D-SNP = Dual-eligibles Medicare Advantage Special Needs Plan
Lessons Learned

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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<tr>
<td>Most duals who disenroll are scared of what they might lose</td>
<td>▪ States and plans need to start early to publicize value of the program</td>
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<td>▪ Personal relationship with a designated care coordinator is the most</td>
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<td>appealing aspect of the model</td>
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<td></td>
<td>▪ Develop personal stories of how the demo works for individuals</td>
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<td>▪ Allow plans a greater role in facilitating enrollment</td>
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<td>▪ Promote continuity of care</td>
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<td>Slow growth in voluntary enrollment</td>
<td>▪ Allow plans to call their dual-eligible Medicaid members and offer in-</td>
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<td>home appointments</td>
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<td>▪ Allow plans to be present or stay on the line while the prospect is</td>
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<td>talking with Maximus</td>
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<td>▪ Implement “streamlined” enrollment process</td>
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<td>Lack of provider buy-in</td>
<td>▪ Build relationships early and maintain ongoing forums</td>
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<td>▪ States and plans need to communicate the benefits of participating</td>
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<td>▪ In most cases, participating providers get paid the same as they do in</td>
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<td>fee-for-service, yet that is not the perception</td>
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<td></td>
<td>▪ Value Based Reimbursement (VBR) is having positive impact</td>
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Lessons Learned

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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<tr>
<td>“Nothing worthwhile is easy”</td>
<td>▪ Finding members &amp; build trust so they’ll engage. Use Community Connectors and Locator Units</td>
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<td>▪ Addressing their needs often isn’t about their health care but about housing, medication, transportation and Activities of Daily Living.</td>
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<td>▪ Coordinating care and services – “It takes the village.” Get physical, behavioral, social service providers, CBOs involved.</td>
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<td>▪ Members located and assessment more frequently</td>
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<td>▪ Goals achieved: quality of life, independent living, community integration</td>
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<td></td>
<td>▪ Costs reduced: less-restrictive setting usually less costly; reduction in avoidable ED, hospitalization, institutionalization</td>
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<td></td>
<td>▪ Overall Health Care &amp; Health Plan Satisfaction levels high. 8 out of 10 members satisfied in baseline survey</td>
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CBOs = Community-Based Organizations; ED = Emergency Department
How LTSS Expenditures Are Changing

MLTSS
Enables an individual to remain in their home or a community-based setting, provides services and addresses barriers to social determinants of health. Provides long-term care (residential when needed).

Home & Community Based Services (HCBS)
Promotes Independent Living

Long-Term Care Institutional Facility

MLTSS = Managed Long-Term Services and Supports
MLTSS Opportunities

How we impact quality and cost

- Return to the community
- Remain at home
- Shorter stay
- Avoid unnecessary ED visits
- Reduce hospital admissions
- Reduce fraud, waste, and abuse
MLTSS Intervention Point

Nursing home

- Comprehensive health assessment
- Coordinated care
- More frequent provider visits
- Multi-disciplinary team
MLTSS Intervention Point

In-home care

- Provide support for Activities of Daily Living (ADLs)
- Caregiver Training Programs
- Meals
- Transportation
- Multi-disciplinary team
MLTSS Intervention Point

Homeless

- Community connectors outreach
- Transportation
- Substance abuse
- Behavioral health
- Housing pilots
Nursing Home to Community Transition

- Diagnosed with diabetes; cancer in remission
- Nursing home resident
- Transitioned home
- Continues to improve
Nursing Home to Community Transition

Medical Cost Incurred by Month

- LTSS
- Institution
- Rehabilitation
- Home

Note: Based on internal Molina claim data.
Nursing Home to Community Transition

- Diagnosed with diabetes; bipolar depression
- Nursing home resident for long-term care
- Continues coverage with Molina for Medicaid funded services
- Transitioned home
- Continues to improve
Nursing Home to Community Transition

Medical Cost Incurred by Month

Institution

Home

Note: Based on internal Molina claims data.
Closing Thoughts – Paths to Better Integration for Duals

- Make D-SNPs & FIDE-SNPs permanent; stabilize and make MMPs permanent
  - Improve enrollment process for MMPs
- Continue the great work of the Medicare-Medicaid Coordination office (MMCO) at CMS
  - Expand the authority of this office to facilitate integration
  - Align regulatory and operational policies within CMS to improve MIPPA contracting
- Align program oversight & streamline administration
  - Better enrollment and single ID card
  - Simplified member materials
  - Integrated MOC, A&G and Performance Measures (LTSS)
- Electronic Data Integration – Key to seamless transitions and operations
- Encourage further pilots – Housing continues to be a challenge, especially for those with mental issues

A&G = Appeals and Grievances; FIDE-SNPs = Fully Integrated Dual Eligible Special Needs Plans; MMPs = Medicare-Medicaid plans; MIPPA = Medicare Improvements for Patients and Providers Act of 2008; MOC = Models of Care.
Medicare-Medicaid Dual Eligibles: Translating Lessons Learned Into Strategies for Future Programs

California’s Coordinated Care Initiative (CCI)

SARAH BROOKS
DEPUTY DIRECTOR, HEALTH CARE DELIVERY SYSTEMS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
AN AIS WEBINAR
JUNE 21, 2016
Roadmap

- CCI Evaluation Efforts & Data
- SCAN Foundation Case Studies
- Lessons Learned
- The CCI in 2016
- CCI Proposals
CCI Evaluation Efforts

- Several data analysis efforts are helping inform us on how well the program is working for our beneficiaries and areas for improvement:
  - DHCS analysis of non-participating beneficiaries;
  - Field Research Group rapid cycle polling;
  - University of California at San Francisco phone surveys and focus groups;
  - CMS-funded RTI focus groups and evaluation;
  - Plan-funded focus groups; and
  - Anecdotal evidence from CCI outreach coordinators.
CCI Evaluation Data

- Beneficiaries in Cal MediConnect plans are satisfied with:
  - Their choice of doctors (78%) and hospitals (77%).
  - The way different health care providers work together to give them services (78%).
  - The amount of time doctors and staff spend with them (85%).
  - The information provided by their plan to explain benefits (73%).

- 79% of beneficiaries were confident they can get their questions answered about their health needs.
CCI Evaluation Data

- Beneficiaries often lack awareness about Cal MediConnect benefits, including the availability of a care coordinator or continuity of care.

- Transition issues often led to early disenrollment from Cal MediConnect — but those who stayed enrolled were satisfied with how issues were resolved.

- Beneficiaries who opted out were wary of change in their current health care services and losing their doctors.
SCAN Foundation Case Studies

- The SCAN Foundation highlighted some stories of beneficiaries receiving coordinated care through Cal MediConnect.
  - A Place to Call Home
  - Thriving in her Community
  - Aging with Dignity
  - A Confident Caregiver
Lessons Learned:
Providers Matter

- Physicians are essential to successful implementation.
  - Beneficiary trust/relationships.
  - Significant influence on community — especially in diverse communities.
  - Impact enrollment, retention and care coordination efforts.
  - Critical to smooth transition (continuity of care and care transitions).
- Non-medical providers are also key.
  - Trusted community resources.
  - Know beneficiary needs sometimes better than anyone.
    - In-home caregivers
    - Staff at service organizations
  - Often the first point of contact when someone needs help.

- Overall, there is a large need to help support dually eligible beneficiaries’ networks of care and providers.
Lessons Learned: Provider Engagement Strategies

- Providers first and foremost need to feel heard — listen to them and identify their fears or frustration.
- Look for common goals and value propositions and tailor your strategy accordingly.
- Focus on finding and empowering “provider champions” as messengers.
- Tap into existing provider organizations and keep their schedules in mind.
- Connect with key leaders and providers in organizations and communities that serve beneficiaries with diverse backgrounds.
- Create tailored materials for providers, with actionable information (e.g., how to bill Cal MediConnect plans).
Lessons Learned: In-Network Communication

- Combining Medicare and Medi-Cal benefits in the plan is an important first step.
- But in order to truly break down silos — you need to ensure that there is communication throughout the system.
- Communication — and different actors having a clear understanding of roles and responsibilities — is especially important in California’s very heavily delegated system.
  - Plans have a big responsibility — care coordination and oversight activities need to penetrate down to the provider-group level.
  - Providers new to managed care need extra support — particularly nursing facilities in California.
  - DHCS has hosted provider summits to support broader communication.
  - Pilot programs to teach hospital case managers how to leverage Cal MediConnect plans to support member transitions.
  - Dementia Cal MediConnect is leveraging expertise of Alzheimer’s Greater Los Angeles to train plan care managers.
Lessons Learned: Community Living

- One of the key goals of Cal MediConnect was to help more dually eligible beneficiaries live in the community.
  - A Cal MediConnect Hospital Case Manager Toolkit is one tool we have developed to help in care transitions back into the community.

- Plans are using innovative pilot projects.
  - The Community Care Settings Pilot (CCSP) is Health Plan of San Mateo’s (HPSM) highest intensity care management program for beneficiaries in institutions or at risk for institutionalization who can, with appropriate supports, live in the community successfully.
  - HPSM partners with community-based organizations and several state and local resources to deploy services that are necessary to help these beneficiaries migrate out of, or avoid placement in, long-term care facilities.
  - Other plans are also partnering with community-based organizations to support housing case management services to help beneficiaries find and access affordable housing.

- Our CCI quality strategy includes looking at ways to strengthen LTSS referrals.
The CCI in 2016

- RTI’s initial report on all demonstrations touches on California’s robust stakeholder process and strong Ombudsman program, as well as the state’s commitment to continuously studying and improving upon the program.

- Earlier this year, the state budget continued the CCI through at least 2017. This provides DHCS an opportunity to apply the evaluation data and lessons learned to address any issues and strengthen the program.

- In order for Cal MediConnect to be successful over the long term, we know we need to continue strengthening the quality of care beneficiaries receive, and ensure sustainable participation in the program.

- In May, we announced final policy decisions, which all work to:
  - Strengthen the quality of care and care coordination in Cal MediConnect for beneficiaries;
  - Ensure that beneficiary protections remain robust, beneficiary satisfaction remains high and increases, and the beneficiary is always at the center of the program;
  - Generate sustainability for the program; and,
  - Maintain transparency and stakeholder engagement.
CCI Announcements

◦ Strengthening Long-Term Services and Supports (LTSS) Referrals & Care Coordination

◦ Sharing Best Practices & Lessons Learned

◦ Improving Continuity of Care

◦ Exploring Potential Extension of Deeming Period

◦ Voluntary Enrollment Strategy
  ◦ Operationalizing Mandatory MLTSS Enrollment
  ◦ Streamlined Enrollment
  ◦ Targeted Provider Outreach
Resources and Contact Information

- For more information on the CCI — including enrollment, quality data, and toolkits — visit www.calduals.org.

- You can send any questions or comments to info@CalDuals.org.
Medicare-Medicaid Coordination Office

- Section 2602 of the Affordable Care Act
- Purpose: Improve quality, reduce costs, improve the beneficiary experience, reduce/eliminate misalignments between Medicare and Medicaid
- 3 areas of focus: program alignment, data and analytics, models and demonstrations
Financial Alignment Demonstrations

- Two models: capitated and managed fee-for-service
- Demonstrations have been approved in 13 states
  - Capitated (10): CA, IL, MA, MI, NY, OH, RI, SC, TX, VA
  - Managed Fee-For-Service (2): CO, WA
  - Alternative (1): MN
- Enrollment is approaching 400,000
- CMS has offered a 2-year extension of demo
Challenges

- Beneficiary location and engagement
- Enrollment churn
- Provider buy-in
- Integration of long-term services and supports (LTSS), behavioral health (BH) and other non-medical services
- Rates and incentives
- Scaling
Successes

- Positive beneficiary experiences and outcomes
- Critical learning about assessments, care plans and care teams
- Integration of LTSS, BH and other non-medical services
- Unprecedented level of investment in infrastructure, people and community supports
- Meaningful risk adjustment and payment changes
Looking Toward the Future

- Building/strengthening community relationships
- Integrating LTSS into quality ratings
- Creating more demand in the states
- Translating implementation experiences into policy changes — enrollment, marketing, appeals, assessments, etc.
- Medicare-Medicaid Plan (MMP) as a permanent program option
- Understanding relationship between Dual Eligible Special Needs Plans (DSNPs) and MMPs
Alignment Healthcare is a clinically integrated population health platform committed to transforming and improving care for members and providers.

mbella@ahcusa.com
As Mass. Duals Plans Anticipate Two More Years, Engaging Members Is Still Tricky


As plans participating in ongoing state demonstration projects for Medicare- Medicaid dual eligibles contemplate a two-year extension offered by CMS last summer (MAN 7/30/15, p. 1), all eyes are on Massachusetts, which was the first of 14 states selected by CMS to launch a three-year capitated demo program integrating care for eligible beneficiaries. While the financial picture has improved for the two insurers serving the One Care program jointly administered by CMS and MassHealth, executives from both plans tell MAN there are still kinks to be worked out before a permanent version of the program can be established.

The One Care program began in October 2013 and runs through 2016. The Commonwealth is now working with CMS to formalize its request for an extension, and is engaged in three-way discussions with CMS and plans on contract amendments for 2017 and 2018. “We think there’s a likelihood of the demo being extended and that is going to happen imminently,” says Chris Palmieri, president and CEO of Commonwealth Care Alliance (CCA), one of two plans serving the demo. But for CCA, which has an 80% share of enrollment, it’s not a question of whether the not-for-profit plan will participate. Instead, the issue is how it can demonstrate (1) that there are unmet needs of these populations in fee-for-service duals programs as well as Medicaid-only and (2) the value of the program to the roughly 88% of beneficiaries who are eligible but haven’t signed up with One Care. As of April 1, the program served 12,223 total members out of the nearly 101,000 members eligible in the counties offered.

Mass. Hopes to Extend Duals Demo

Like other state demos, One Care has faced its share of challenges, but some are unique to the program because it’s the only one in the country exclusively serving a dual-eligible population that is under 65. “The under-65 duals members are very different from senior dual beneficiaries in ways that affect how to engage with them, how to identify and meet their needs, and the types of services they want and need to improve the quality of their lives and enable independent living,” explains Kit Gorton, M.D., president of the public plans division of Tufts Health Plan, the other participating One Care insurer.

Beneficiaries’ social determinants such as housing stability and transportation have “outsized impacts on their well-being,” and they have high rates of substance use, continues Gorton. “Getting them access to

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<th>Massachusetts Duals-Demo Enrollment As of April 1, 2016</th>
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<tr>
<td><strong>Total Enrollment by Rating Category</strong></td>
</tr>
<tr>
<td>F1</td>
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<td>C3B</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>Total Enrollment by Plan</strong></td>
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<tr>
<td>Commonwealth Care Alliance (CCA)**</td>
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<td>Tufts Health Plan</td>
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<td><strong>Total</strong></td>
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* F1=Long-term care facility-based care; C3B and C3A=High community services needs; C2B and C2A=High behavioral-health community services needs; C1=Individuals in community who don’t meet criteria for other classes.
** As of August 7, 2015, CCA temporarily stopped accepting new One Care enrollments. Members previously enrolled with CCA for One Care may re-enroll. In addition, CCA opened enrollment for a January 1, 2016 effective date for up to 100 new One Care members in Suffolk County.

high-quality care in a respectful and compassionate way requires flexibility and nimbleness and often stretches the boundaries of our standard program designs."

One of the early concerns for CCA and Tufts was that the financial model initially established for the demo was partly based on CMS models that didn’t reflect the actual experience of the under-65 population. “It’s no secret that early on in the demonstration the financing was woefully inadequate to care for these populations, and that’s where we saw that there were unmet needs in fee-for-service. So as people were enrolling, their expenses were going up, because they were now receiving the necessary access to services they weren’t getting in fee-for-service,” explains Palmieri.

As a result, CMS and MassHealth in late 2015 increased the capitation rates to plans that varied by member mix, member risk adjustment and plan performance, with positive results. MassHealth reported at a May 24 open meeting that CCA’s performance improved from a projected net loss of -6.7% in the first demonstration year (Oct. 1, 2013-Dec. 31, 2014) to a projected net loss of -0.1% in full year 2015. And in the same time period, Tufts’ performance improved from a projected net loss of -1.5% to a projected net gain of 5.5%.

**Cost, Quality Data Are Improving**

Palmieri says that in looking at the profile of beneficiaries in the program over the last 14 to 18 months, CCA has observed that costs initially spiked but then stabilized and started to go down, proving that “the reimbursement needs to be risk-adjusted and needs to take into account social determinants and the ability to adjust for the anticipated high-intensity utilization while individuals’ immediate care needs are being met because they weren’t met in fee-for-service….This is what’s demonstrating that these programs have real promise.”

According to preliminary spending data shared by MassHealth, CCA’s per-member per-month (PMPM) spending increased in certain community rating categories but dropped in others. For example, PMPM expenditures on members with very high community services needs rose 2% from $8,220 in the first demonstration year to $8,384 PMPM in the second, while PMPM spending on members with very high behavioral-health community services needs dropped 7% from $3,053 to $2,849 during the same period.

Palmieri says the plan is encouraged by the data it has submitted so far to MassHealth and CMS. Savings from the demonstration are expected to come primarily from reductions in emergency department and inpatient use of both behavioral health and medical services. CMS is using an independent evaluator to assess the effects of all the state demos, including One Care, on cost, quality, utilization and member experiences.

According to MassHealth spokesperson Michelle Hillman, quality data for the first year of the demonstration presented at the May 24 meeting show some “early indicators” that the project is moving in the direction of providing better care through integrated delivery models. For example, results from the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) show that CCA and Tufts consistently performed better than the Medicare Advantage average and better than the Medicare-Medicaid Plan average (capitated model demonstrations). And in 2014, CCA and Tufts earned back 50% and 75% of their quality withhold, respectively, referring to the percentage amount that is kept from the capitation rate and returned to plans subject to their performance on certain quality metrics, according to the presentation.
Duals Have High Behavioral Health Needs

Nearly two-thirds of under-65 dual eligibles are estimated to suffer from diagnosed and undiagnosed mental health issues, and more than 70% of the under-65 population served by CCA has a behavioral health diagnosis (including both mental health and substance use disorders), according to Palmieri. According to Healthcare Effectiveness Data and Information Set (HEDIS) data also presented at the May 24 meeting, all One Care plans show their members accessing behavioral health services at a much greater frequency than those in standard Medicaid-only managed care plans.

Historically, these members were “using different access points in health care as their source of primary care,” including the emergency room, says Palmieri, and that’s why it was critical for CCA to incorporate behavioral health into the primary care model.

“The model is an individualized and stabilizing factor that allows our participants to live full and meaningful lives. It’s not a merry-go-round where they’re constantly having to go back to the emergency room or have constant hospital admissions. We break these cycles,” he asserts. “And what we’re seeing now is those types of investments are starting to pay off and that’s where [the demo] is showing real promise.”

More Outreach Is Needed

But there’s still more work to be done when it comes to informing the dual-eligible population that there are benefits to integrating their care. “We’re finding that through heavy engagement and education, it’s really critical to help support these enrollees and to improve their health outcomes. That level of consumer engagement and participation is extremely valuable in a program like this,” Palmieri says. And having served dual-eligible beneficiaries since 2003 in Massachusetts, CCA’s “brand recognition” helped the plan achieve its high market share, but Palmieri says he thinks more could be done so that more individuals want to participate in One Care.

“Finding and engaging potential members is an unsolved challenge,” concurred Gorton in a recent post to the AHIP blog. High levels of opt-outs in the initial passive enrollment phase of the program “resulted from patients not understanding what One Care is, not wanting to change doctors, or simply not being interested,” he wrote on May 11. “In addition, many have unstable housing, causing them to move frequently and [be] increasingly difficult to keep track of. Even among those enrolled, 30 percent of members simply can’t be found.”

Plans Need Exit Strategy

Another setback for the One Care program was last year’s exit of Fallon Total Care, leaving just CCA and Tufts in the program. Six out of 10 plans were originally identified to participate through a request for responses initiated by MassHealth in June 2012, but by July 2013 three had already opted out based on concerns about the upfront costs. When Fallon left the program in September 2015, approximately 5,310 members were affected, and the other two plans could only accept a small portion of transferred enrollees.

As the initial phase of the program comes to an end, one lingering question is whether health plans can exit the demos without disrupting members and providers, says Gorton. “Six plans have left the demonstrations across the country — we need to know how disruptive their exits were, and whether that process can be improved upon,” he tells MAN. “It is a best practice in business planning to evaluate all options, and the demonstration does not
have a well-defined off-ramp, so the plans need to ask themselves and the regulators these questions.”


For more information, contact Gorton via Sonya Hagopian at sonya_hagopian@tufts-health.com, Hillman at michelle.hillman@state.ma.us, or Palmieri via Jennifer McAlpine at jmcalpine@solomonmccrown.com.

**News Brief: Coordinated Care Initiative, California Dept. of Health Care Services**


In its latest effort to fine-tune and improve the Coordinated Care Initiative, the California Dept. of Health Care Services on May 5 said it will no longer automatically enroll low-income elderly and disabled residents in managed care plans in favor of a streamlined “opt-in” enrollment strategy. Effective July 2016, enrollment in the CMS-backed duals demonstration project will be voluntary, although the state would consider transitioning back to “passive enrollment” should voluntary enrollment not prove sustainable. In the first stage of enrollment, beneficiaries received information packets about the change and were automatically enrolled in managed care plans unless the member or an authorized representative opted out. But many were surprised by the change in coverage, and roughly half of all targeted members have opted out of the pilot, reports Kaiser Health News. In addition, the program will allow members to stay with their Medicare physicians for one year (compared with the current six-month period) before they must switch to doctors in their new plan’s network. Visit www.calduals.org.

**N.Y. Starts Duals Demo for IDD; FIDA Changes May Aid Enrollment**


New York began on April 1 the first CMS-backed demonstration for Medicare-Medicaid dual eligibles with intellectual and developmental disabilities (IDD). And the state’s troubled basic Fully Integrated Duals Advantage (FIDA) demo has made substantial changes this year that plans participating in the CMS-backed initiative tell MAN have improved its outlook. Nevertheless, the enrollment figures for FIDA still are grim, and the start date for adding populous Suffolk and Westchester counties to it has been pushed back indefinitely; that expansion originally had been scheduled for 2015.

The IDD demo, notes Lindsay Barnette, director, models in the demonstration analysis group of CMS’s Medicare and Medicaid Coordination Office (MMCO), is opt-in only, as the basic FIDA demo has become as part of changes unveiled last December. Those changes were designed largely to reduce provider resistance as well as to introduce more flexibility for how eligible duals can be enrolled in FIDA.
While Barnette declines to forecast how many of the 20,000 IDD eligibles in New York will sign up for the new demo, she says MMCO is “very optimistic” based on the “engagement” of the IDD community in the initiative as well as outreach efforts by the state and Partners Health Plan (PHP), the only participating insurer. PHP is a three-year-old not-for-profit plan that grew out of the Association for Retarded Children (ARC), which itself dates back to the late 1940s. New York City-area ARC chapters began evaluating approaches to integrating the continuum of care for the IDD population a few years ago.

Some of the CMS-backed duals demos specifically exclude IDD beneficiaries from the program, points out Barnette, but the demo beginning this month directly targets this challenging group with the aid of a “tailored benefit package” and providers that have at least a year of specific experience with this population. MMCO also was interested in a program for IDD, and New York brought it a separate proposal, “based on stakeholder input,” that CMS approved, she says. Barnette adds that the IDD demo is slated to run through Dec. 31, 2020.

The basic FIDA demo, which is focused on managed long-term care (MLTC), is slated to end Dec. 31, 2017, unless the state decides to extend it. FIDA began with opt-in enrollment in January 2015 and has had enrollment problems from the start (MAN 10/29/15, p. 5). As of last month, FIDA had only 6,005 members, down from a high of 8,028 in September, and the number of opt-outs is now more than 60,000. There are more than 100,000 New York duals eligible for this demo. To be eligible, FIDA duals must either require community-based LTC services for more than 120 days or be eligible for but not already receiving facility- or community-based long-term services and supports.

MMCO Director Tim Engelhardt acknowledged last year that FIDA needed “more provider engagement and buy-in,” and CMS has worked with the state on changes to furnish this.

In a joint presentation to providers Jan. 27, Joseph Shunk, FIDA project director in the New York State Department of Health (DOH), and Melissa Seeley, technical director at MMCO, outlined what they thought the major “challenges” were and how the two organizations would be addressing them. Aside from “lower-than-expected enrollment numbers,” their presentation said, major issues have been “Interdisciplinary Team logistics,” provider participation in these IDTs and training requirements.

To deal with IDT issues, they clarified that the team can be as small as just a care manager and participant and that “provider participation in an IDT is adjustable” depending on such factors as member availability, items being discussed and the wishes of the participant. Moreover, primary care providers may review and sign off on the required Person-Centered Service Plan (PCSP) without attending IDT meetings. Also, care managers may meet separately with the various IDT members in developing the PCSP.

### New York FIDA Demonstration at a Glance, April 2015-March 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Program Enrollment</th>
<th>Opt-Outs</th>
<th>Number of Plans Reporting Enrollment*</th>
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<tr>
<td>April 15</td>
<td>6,660</td>
<td>41,906</td>
<td>21</td>
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<tr>
<td>June 15</td>
<td>4,749</td>
<td>47,202</td>
<td>18</td>
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<td>Sept. 15</td>
<td>8,028</td>
<td>57,537</td>
<td>19</td>
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<tr>
<td>Dec. 15</td>
<td>6,528</td>
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<td>15</td>
</tr>
<tr>
<td>March 16</td>
<td>6,005</td>
<td>NA</td>
<td>15</td>
</tr>
</tbody>
</table>

FIDA=Fully Integrated Duals Advantage; NA=Opt-out data are unavailable.
*Refers to plans reporting more than 11 enrollees, in compliance with HIPAA regulations. Of the 21 FIDA plans reporting enrollment in April 2015, four dropped out of the demo before the start of 2016: EmpireBlue HealthPlus, ArchCare Community Advantage, EmblemHealth Dual Assurance FIDA Plan and Integra FIDA Plan. Two other selected plans dropped out before FIDA fully began.

SOURCE: CMS, DUAL Medicare-Medicaid Dual Eligibles Database, an online subscription database and newsfeed from AIS. Visit http://aishealthdata.com/dual for more information and free interactive demo.
To boost IDT flexibility, Shunk and Seeley explained, plans may authorize any medically necessary services included in the PCSP that are outside the scope of practice of IDT members, and while “IDT training will be encouraged,” it is not mandatory. Furthermore, plans have more flexibility than they did at the FIDA outset in “how and when the IDT members communicate with one another.”

The two agencies also trimmed the required number of assessments beneficiaries need when they move from an existing MLTC plan to a FIDA plan. And FIDA plans gained authorization to “market multiple lines of business more easily,” furnish a written or verbal comparison among their MLTC and FIDA products, and send (with DOH/CMS prior approval) FIDA educational material to beneficiaries who have opted out. They also may conduct outbound FIDA marketing calls to eligibles enrolled in any other of their Medicare or Medicaid products.

And FIDA plans now, since all enrollment is opt in, may submit enrollment requests directly to the state’s administrator, Maximus. They thereby would avoid the situation of New York Medicaid Choice, the state’s enrollment broker, sending passively enrolled members a letter saying that if they didn’t opt out of FIDA, they would automatically be enrolled in a FIDA plan.

There “have been improvements” in FIDA, Pat Wang, CEO of Healthfirst, one of the 17 plans remaining in the program, told MAN at the America’s Health Insurance Plans annual health policy conference March 9. She said the state and CMS have been doing some beneficial “streamlining,” including regarding “onerous requirements” surrounding the IDTs. And making FIDA a totally voluntary program also should help in the enrollment process, according to Wang.

However, she added that there still are “issues on the payment side,” although the situation has gotten “better,” including via CMS basing 2016 pay for all duals demo plans more on fee-for-service costs for full duals, thus in effect boosting payment rates (MAN 12/3/15, p. 1).

Payment issues have been one reason four FIDA plans have dropped out of the demo since it began and another two selected plans — units of UnitedHealth Group and Montefiore Health System — never began it. Both the participating plans and the dropouts cite the financial effects of the low enrollment levels in FIDA — only Healthfirst and VNSNY have more than 1,000 members — as causing severe financial strain.

MMCO’s Barnette says CMS understands such concerns and that plans “had to make financial judgments” regarding FIDA. But she asserts MMCO now is “cautiously optimistic” that the new changes will result in “more participation.” Enrollment in FIDA recently has been “relatively stable,” according to Barnette, and the reforms, including outreach efforts with the state to ensure both providers and eligible duals are familiar with the demo, should lead to growth through 2017.

The IDT requirements before were “pretty rigid” regarding who had to be involved, training requirements and attendance mandates, she observes. The recent changes, Barnette says, mean there can be more flexibility, including on provider participation in the IDTs and on how enrollments can be submitted. But it probably will be later in spring before it’s feasible to gauge the impact of the continuing changes and efforts to market the value of FIDA to providers, she adds.
Two Reports Cite Difficulties Assessing Duals Demos, but One Notes Good Signs


To the surprise of virtually no organizations that have worked with Medicare-Medicaid dual eligibles for a while, two recent reports found it extremely difficult to evaluate initial results of the CMS-backed duals demonstration. And since observers stress that the principal objective of the demo — improving care coordination for duals — usually entails different actions for different populations even in the same state, and always in different states, it may be quite a while before good data are available on whether that goal is being achieved.

The additional problem, observers queried by MAN agree, is there are no good measures available to assess care coordination for duals. Given this, nobody seemed particularly alarmed that the Government Accountability Office (GAO) in a December 2015 report not published till Jan. 19 found lots of questions among stakeholders about the degree to which care coordination actually was occurring already in the demo. Nor were they taken aback that GAO recommended CMS develop new measures so demos in the 12 states starting them under provisions of the Affordable Care Act could be compared more easily.

Similarly, they were only slightly heartened by the first report from RTI, the contractor the CMS Medicare-Medicaid Coordination Office (MMCO) retained to evaluate the three-year demos, which found that Washington state’s managed fee-for-service (MFFS) duals demo shows signs of saving money. The RTI preliminary report, completed last fall but not published on CMS’s website until shortly after GAO’s report was out, cautioned that its findings were based on Medicare data only and that “whether these savings have been achieved while improving or maintaining quality of care is not yet known.”

Speaking about the overall duals demo, Richard Bringewatt, chair of the SNP Alliance trade group, which includes numerous sponsors of duals plans, tells MAN, “It’s all heading in a good direction, and we need to be a little careful about being too critical too quickly.” Bringewatt adds that he doesn’t regard the GAO report as overly critical of the demos since it basically just “documented” the kinds of situations these ambitious programs go through.

The RTI report was somewhat similar, says Pamela Parker, a former state health official who is the integration consultant for the SNP Alliance, in pointing to all the “little things coming up that take so much time” on a day-to-day basis as a demo state moves toward integration for duals. RTI noted there is “misalignment” of Medicare and Medicaid rules even in the demo itself, she says, adding that the signs of a utilization decline in Washington state cited by RTI in its preliminary report are “very positive” news considering the obstacles faced.

But Parker also cautions about the estimate of more than 6% Medicare cost savings versus a comparison group during the initial July 2013-December 2014 period mentioned in the
RTI report and cited by Patrick Conway, M.D., CMS chief medical officer, in the agency’s Jan. 22 news release. It wasn’t clear in the report whether there were enough data to do this kind of savings analysis, Parker tells MAN, so there may be an element of “speculation” in it.

Indeed, the report itself explains that the Medicare savings figures represent an estimate and that a separate Medicaid savings calculation won’t be done until a later evaluation. And “this report does not include comparison data to determine whether the changes in utilization and quality measures observed in Washington are due to the demonstration or other factors,” RTI adds. The contractor is slated to do annual reports on this and the other duals demos and then a more detailed final report.

How to Measure Results Is Big Issue

The big issue in the GAO report, Parker says, is less about what is being done in the demos and more about how to measure results. She expresses surprise the report didn’t mention that because Medicare requirements already are on the books, it is hard for states in the demos to change many aspects of duals care.

The GAO publication did recognize that care management must be done differently than it has been, adds Bringewatt, but it’s hard to analyze the demos since there is no standardized approach and the structure of duals programs must vary for different duals populations being managed in the 12 states. The GAO reference to a troublesome lack of uniform state-specific measures with which to compare the duals demos is “simply stating the nature of the beast,” he asserts.

GAO focused some of its attention in the report on the interdisciplinary care teams (ICTs) that are a central part of the demos, and suggested that CMS should require comparable core data measures on them. Some core elements perhaps could lend themselves to that, comments Bringewatt, but there’s a potential problem in “overstructuring standardization” regarding the care teams.

Parker says that based on her own state experience, the concept of ICTs “has to be somewhat virtual” since it’s not feasible to put physicians in the same room as other members of the care team once a week. So it’s important to look at resources “as they actually are,” particularly in rural areas.

Don’t expect good data on cost savings for the duals demos soon, says Bringewatt. He points out that for UnitedHealth Group unit Evercare’s care integration product, it took four or five years for the program to be “stabilized” sufficiently to get meaningful data, “and this [demo] in some ways is more complicated.” There can be gains in avoiding hospitalizations and nursing-home admissions, he adds, but expectations on those must be adjusted for the different kinds of duals populations in the demos.

Moreover, cost savings aren’t the only major objective here, and clinical-quality outcomes could take even longer to achieve, stresses Parker. In addition, the measures for that, she says, will vary with the kind of duals population, citing as an example the frail elderly for whom the improvement will not be in actual clinical outcomes but instead in better management of end-of-life care.

CMS itself had comments incorporated in the GAO report that indicated what it regarded as key outcomes measures for the demos. One such measure in the capitated demos, the agency told GAO in the report, is “nursing-facility diversion,” the percentage of beneficiaries living in the community who “require an institutional level of care but who did not reside...
in a nursing home for more than 100 days. CMS officials told us they believe these types of outcome-oriented measures furnish more valuable information than process-oriented measures because they assess whether care coordination is effectively improving the health of beneficiaries.”

GAO pushed back on those contentions, stating in the report that while outcomes measures are important, “process measures are also needed to determine whether the demonstration is being implemented as intended.” If process measures aren’t in place across the demo states “to identify and correct potential problems, we believe that outcome measures cannot be reliably assessed,” GAO contended.

However, CMS parent HHS and GAO did find common ground on another GAO recommendation: that CMS align state-specific measures regarding the extent to which Individualized Care Plans (ICPs) are being developed across the capitated and MFFS demos “to make them comparable and designate them as a core reporting requirement.” HHS in its unsigned department comments said it “concurs with this recommendation,” and while it now uses “state-specific” measures for the ICPs to reflect differences in the demo parameters across the states, it will “explore ways to improve comparability of measures across demonstrations.”

This doesn’t mean CMS agrees with GAO about the need for uniformity. An MMCO spokesperson notes to MAN “our belief that [the existence of] modest differences in certain measures across demonstrations does not impede the agency’s ability to assess progress toward our overall goals.”

View the RTI and GAO reports by visiting the Feb. 11 From the Editor entries at MAN’s subscriber-only Web page, www.aishealth.com/newsletters/medicareadvantagenuews. Contact Bringewatt at rich@nhpg.org.

Calif. Delays by One Year Needed Decision On Whether to End Biggest Duals Demo


In a victory for the CMS-backed demonstration for Medicare-Medicaid dual eligibles, California Gov. Jerry Brown (D) said in his Jan. 7 budget message that the state will delay by one year a decision required by state law on whether to close its duals demo because of a lack of cost savings. Instead, California will focus this year on increasing participation in the care integration demo, the budget message said, as well as extending a controversial managed care organization (MCO) tax that helps fund it, and then decide by January 2017 whether to halt the demo effective January 2018.

Another key part of what will happen this year, Mari Cantwell, chief deputy director of the California Department of Health Care Services (DHCS), which oversees the state’s demo, tells MAN, is getting data on cost-savings results so far. She says this includes duals who are able to move out of institutions because of the initiative — “we know that is happening” — or who are avoiding or delaying institutionalization. Some plans participating in Cal MediConnect, as the state’s three-year Coordinated Care Initiative duals demo is called,
already have such data, according to Cantwell, who cites early CCI entrant Health Plan of San Mateo as an example.

**Calif. Won’t End Duals Demo in ’17**

But as the three-page section on CCI in Brown’s budget makes clear, the financial results of the California initiative to date are not encouraging, albeit partly because of factors related to federal regulation rather than to matters under Cal MediConnect’s control. To help pay for CalMediConnect’s implementation, for instance, the budget noted, the feds allowed a 4% tax on MCOs through June 30, 2016. The budget notes, though, that the feds found the way California structured this tax on insurers in the Medi-Cal managed care program “is inconsistent with federal Medicaid regulations and will not be allowed to continue without major modifications.”

While California lawmakers as of late last year had been unable to come up with a replacement for the tax, there may have been a breakthrough on that this month. *Kaiser Health News* reported Jan. 8 that Brown’s administration appears to have reached a tentative agreement with some of the state’s largest insurers on a new broad-based health plan tax that would be offset with reductions in other taxes and could yield a resolution.

The tax is far from the only problem facing the CCI now, Brown’s budget description emphasizes. Other problems, it points out, include that as of Nov. 1, 2015, about 69% of eligible duals had opted out or disenrolled from the demo, and the rate is about 83% among In-Home Supportive Services (IHSS) beneficiaries. And because of revised federal labor rules, IHSS providers have become entitled to overtime compensation, thereby “significantly” increasing the state’s IHSS costs.

Those financial issues are of particular concern because of a bill requested by Brown and passed by the state legislature in 2013 *(MAN 6/27/13, p. 1)*. Under that law, Brown’s new budget points out, the state’s director of finance must send to the legislature annually a determination of whether the CCI is cost-effective. “If the CCI is not cost-effective,” the budget section notes, “the program would automatically cease operation in the following fiscal year,” which would have been January 2017 had Brown invoked the provision in the current budget.

**New Decision Time Will Be Next January**

He apparently could have done this, especially since the section says that “if the managed care tax is not extended, the Budget projects net General Fund costs for the CCI of approximately $130 million in 2016-17 and beyond.” Instead, however, the budget says, “the Administration proposes to continue to implement the CCI in 2016” while retaining the option of deciding next January to drop it effective in January 2018.

“The governor’s decision is an indication of continued support to have this program,” maintains Cantwell.

The state stance drew cheers from demo participants. Martha Smith, chief duals program officer at Health Net, Inc., which serves Los Angeles and San Diego counties in Cal MediConnect, says the insurer is “encouraged by Gov. Brown’s proposed budget and the continuation of the Coordinated Care Initiative through 2016.” Smith tells *MAN* “we continue discussions with the administration in the expectation of finding a solution to continue the MCO tax.”
She adds, “We believe the initiative deserves a long-term commitment from the state so it can continue delivering on its promise to improve care and lower costs.”

Before there is any such long-term commitment, however, the state and its partners will need to find solutions to some continuing problems, including negative provider attitudes and actions regarding the duals demo and their influence in discouraging beneficiary enrollment (MAN 7/30/15, p. 1). Toward that end, Cantwell notes, Sarah Brooks, deputy director - health care delivery systems at DHCS, is working with participating demo plans in California on “education at the provider level,” including sharing “more broadly” evidence turned up in surveys and focus groups that Cal MediConnect is improving care.

Brooks says the steps being taken on this goal also involve development of “toolkits,” including one for providers, to answer questions about the demo. And DHCS and plans are working with foundations for providers, including ones focusing on ethnic groups, “drilling down in the data” to see where particular pockets of problems with providers are.

On the beneficiary side, part of the focus now is on streamlining processes by which duals who previously had opted out of Cal MediConnect can decide to opt in. Such decision reversals by enrollees already are happening “in small numbers,” Brooks tells MAN. Cantwell points out that passive enrollment in Cal MediConnect now is “mostly over,” with late-starting Orange County the main exception, so DHCS is working with participating plans to make sure duals get information about easy enrollment processes available for them to get back in.

The CCI insurers themselves are unlikely to pull out, both California officials suggest, since there were about 116,000 duals already in the state’s demo when this month began, a figure high enough for the plans to want to continue. The California demo is by far the biggest in the 13-state CMS-backed initiative.

The IHSS situation is more complicated. The principal problem, as Cantwell explains it, is the state stands to bear the full costs of a 3.5% increase in annual overtime expenses for those services, with the entire amount being attributed to the CCI even though 51 of the 58 counties in California are not participating in it. She says state officials now are looking into options for changing that.

California is further along on the replacement for the Medi-Cal MCO tax, and Cantwell says the impact of the new tax being discussed would be to improve the cost-effectiveness of the CCI.

With all these factors in mind, DHCS is not focusing now on replacements for Cal MediConnect if the cost-effectiveness is not apparent by next January. Cantwell, however, points out that even if the initiative runs only through 2017, it would mark for California completion of the full three-year duration of the demo, leaving as unused only the two-year extension CMS offered last summer (MAN 7/30/15, p. 1). Other options for duals care integration after that, she tells MAN, could include having duals enroll under Medi-Cal in insurers that also would operate MA Special Needs Plans for duals.

Plans participating in the CCI clearly would rather see the current initiative continue — if it can be improved. “We appreciate the inclusion of the CCI in Governor Brown’s budget proposal,” says, for instance, Lisa Rubino, senior vice president at demo participant Molina Healthcare, Inc. “Recent polls have shown that an overwhelming majority of enrollees are satisfied with the service provided by health plans serving them through the CCI.”
But Rubino also tells MAN that “the success of the program will depend on the number of enrollments — without enough members participating, the savings envisioned in the demonstration project are simply not achievable.”

Contact Cantwell and Brooks via spokesperson Anthony Cava at anthony.cava@dhcs.ca.gov, Smith at martha.smith@healthnet.com and Rubino at lisa.rubino@molinahealthcare.com.

**MMCO, CMS Changes Could Aid Slow-Starting Duals Demo’s Growth**


The focus in the ongoing CMS-backed demonstration for Medicare-Medicaid dual eligibles will begin shifting in 2016 from enrollment to actual results. And with that shift plus ongoing actions being taken by CMS’s Medicare-Medicaid Coordination Office (MMCO) to change processes that have proved troublesome in the demo’s initial years, along with recent steps by CMS to improve pay for duals plans (MAN 12/3/15, p. 1), both the demo’s directors and some industry executives see reasons for optimism.

None of this means, of course, that the demo — created under provisions of the Affordable Care Act — won’t have some further defections in 2016 in terms of both participating insurers and states, or that more states won’t start their own duals initiatives then.

Virginia, for instance, already has told MMCO it will halt the demo there on its originally scheduled end date in December 2017 rather than extend because the state intends then to implement a new statewide Medicaid managed care program — including coverage of long-term care (LTC) — that includes duals, MMCO Director Tim Engelhardt confirms for MAN. Moreover, California’s budget release this month will unveil whether that state will be able to continue its big duals demo after 2016. And Wisconsin, which isn’t in the demo, is required under a new law to propose by April 1 an LTC integration program covering about 50,000 state residents, 70% of whom are duals.

But for the vast majority of the 13 states in the demo, the indicators are that they will continue to participate. And Engelhardt says he is “very optimistic” about what CMS will find in the first batch of clinical-quality, cost and member-experience outcomes data submitted by three participating states during 2016 for 2013 and 2014. Limiting the implications of those results is the fact that each of those states is somewhat unusual: Massachusetts is the only state restricting its demo to the under-65 population, Minnesota’s demo is basically a better-coordinated version of its longstanding Senior Health Options program for duals and Washington state’s demo is fee-for-service (FFS) rather than capitated.

Nevertheless, each of the three will help build the “evidence base” that Engelhardt sees as vital for the long-term success of the demo. Another ingredient in that success, he suggests, is “continuous performance improvement,” and he cites several ways participating states, insurers and CMS itself already are accomplishing this in the demo. The improvements, he says, have included changes in enrollment processes, collection of provider encounter data and integration of appeals processes.
N.Y. Gets More Integrated Appeals Process

Kerry Branick, acting group director in the demo models for MMCO, elaborated on the latter changes during a presentation at the Medicaid Health Plans of America (MHPA) annual meeting in Washington, D.C., Nov. 13. In New York state, she said then, the appeals-handling procedure under the demo now is “much more integrated” than it is in earlier demo states, where industry executives have complained that there still are numerous separate Medicare and Medicaid requirements. Integrating processes for handling appeals and grievances, she told the MHPA audience, has been “tougher than anticipated.” But Engelhardt says that across the group of demo states there will be more integration of this in 2016 than there had been in 2015.

Another area of improvement, according to Engelhardt, relates to regulations imposed on providers, especially regarding training. New York seems to be a major focus for this as well. Faced with clear evidence there of provider resistance to the demo’s concept of having to train for and work with interdisciplinary care teams — and with perhaps the highest opt-out ratio in the demo resulting in only about 8,000 enrollees among 170,000 eligible beneficiaries in New York — MMCO “will make some adjustments,” he says.

Engelhardt explains that MMCO is simply “trying to be sensitive to having a high bar” for demo standards and the “reality of provider decision-making.” Toward those ends and recognizing that the demos now are moving out of the “ramp-up stages” and into key operational phases, “we’re revisiting the regulations on provider training, which are extremely ambitious,” Engelhardt tells MAN. He stresses that MMCO will maintain the actual requirements for the demo, but perhaps with more “flexibility” about the training aspects.

Such actions undoubtedly will be welcome to at least one New York demo insurer, WellCare Health Plans, Inc. Its senior vice president and chief legal and administrative officer, Blair Todt, said at the MHPA conference that the demo’s training requirements are “significant” and leave providers “not incentivized” to encourage duals to remain in the demo.

The forthcoming modifications also should be encouraging to insurers participating in the Fully-Integrated Duals Advantage (FIDA) program, as New York’s demo is known. Five of the original 22 carriers have dropped out of FIDA, although Engelhardt notes that one of those withdrew before the demo started.

The changes in New York, where FIDA enrollment has been “extremely disappointing,” Branick acknowledged at the MHPA meeting, also include getting patient-advocacy groups more actively involved and conducting focus groups and site visits to better gauge attitudes toward the demo. Engelhardt says he is “optimistic” that FIDA will be moving in the right direction, and he points out it has been running for only a year. Nevertheless, he concedes that it’s yet to be determined whether the enrollment level in this demo “proves to be sustainable.”

Calif. Demo Decision May Come This Month

There also are questions about California’s continued participation in the demo. That state’s governor, Jerry Brown (D), is expected to say in his budget release this month whether the demo has met a California law requirement on cost savings sufficient to continue in the demo beyond the end of this year.

No states other than Virginia have told MMCO they won’t extend the demo, according to Engelhardt. Some such as Texas have asked for significant changes in order to be able to
extend (MAN 10/29/15, p. 5), and MMCO has begun a “dialogue” with state officials about that, he says. Illinois, which changed to a Republican governor in 2015 and reportedly has been undecided about extending (MAN 7/30/15, p. 1), has had a “constructive and positive” exchange of ideas with the duals office about the extension, he adds.

Engelhardt also notes that MMCO is continuing to focus on duals initiatives outside the demo as well as within it, citing as an example ongoing discussions with Pennsylvania about converting its Medicaid managed care demo into one that integrates Medicare as well. And a new federal law, he points out, will give MMCO new options for duals initiatives that would use care models based on the Program of All-inclusive Care for the Elderly (PACE).

One state model completely separate from the major duals demo is taking form in Wisconsin. Tom Lutzow, Ph.D., president and CEO of duals insurer Independent Care Health Plan (iCare) there, tells MAN that Wisconsin’s so-called Act 55 enacted in 2015 would require LTC programs now run by county districts in the state to get insurance licenses and include long-term services and supports in their offerings. Most of the beneficiaries who would be affected are duals, he says.

The law requires an integration proposal to be completed by April 1, although it wouldn’t start till 2017, and it has the potential to disrupt care systems in the state, asserts Lutzow. That’s especially since beneficiaries would have to be enrolled into the new structure, he explains, and some current organizations offering LTC services could have difficulties converting into insurers.

“The hill here is so steep” that some local communities are “averse” to the changes under Act 55, Lutzow says. In light of this, he sees the possibility of changes that would allow local districts to contract with large national insurers, which then would recontract at the district level, thus allowing for some “co-management” of cases.

But regardless of what happens on state programs such as this, Lutzow sees the duals demo — the structure of which he has questioned in areas such as enrollment and payment rules — as now moving in the right direction. He praises CMS’s recent stance recognizing the negative impact of low socioeconomic status on outcomes, and deciding to adjust Medicare Parts A and B payments to plans participating in the demo to better align them with FFS costs of full-benefit duals (MAN 12/3/15, p. 1).

In light of such steps, he predicts, “there will be more and more interest” in the CMS-backed duals demo. “It will become a hot area.”

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Trade Groups Cite Doubts About CMS’s Two Options for Adjusting Stars for SES


Trade associations representing Medicare Advantage plans serving disadvantaged populations expressed numerous reservations about the two options CMS last month requested comments on for offering interim relief on star quality ratings for such plans (MAN 12/3/15, p. 1). In their comment letters filed by the Dec. 10 CMS deadline, the associations all thanked ailing plan sponsors in the short run, but
said they had numerous questions remaining even after a Dec. 3 one-hour CMS conference call on the two options. And they generally voiced doubts about how effective either option would be in granting meaningful relief.

At least one association alluded to another potentially troublesome issue that came up in the agency’s responses on the conference call. Regardless of which option CMS chooses, affected plans may not be able to preview their star ratings for the next year until significantly later in the year than they do now. And if CMS adopts the Indirect Standardization (IS) option, it needs to be based on the current year’s data, adding more uncertainties to the process for insurers.

The reservations expressed in the comment letters could lead CMS not to adopt either option. That would parallel action it took this year when it dropped a proposal to reduce the weighting of certain stars measures that plans serving populations with low socioeconomic status (SES) do poorly on after the vast majority of the comments it received were critical of that approach (MAN 4/9/15, p. 1).

In their comments, stakeholders praised aspects of both the IS option and the Categorical Adjustment Index (CAI) alternative, which was favored by the Medicare Payment Advisory Commission (MedPAC), among others. CAI uses a factor added to or subtracted from a contract’s overall and/or summary star rating to adjust within-contract disparities based on an MA contract’s percentages of low-income subsidy (LIS)/Medicare-Medicaid dual eligible (DE) and/or disabled beneficiaries. IS instead would adjust a subset of individual star ratings scores to account for within-contract LIS/DE and/or disability status differences not related to plan quality and would use an “expected measure score” as its key standard.

MedPAC, in its Dec. 2 letter from Chairman Francis (Jay) Crosson, M.D., said it has “two concerns” regarding the IS approach. One of them, according to the letter, is that several of the measures for which CMS and MedPAC “found population-based differences are measures that are reported based on medical record sampling (generally 411 records)” or on which some contracts report based on sampling while others report based on “the universe of enrollees to whom the measure applies.” The question MedPAC has, explained Crosson, is whether such a sample “yields a sufficient number of records for a subpopulation within a contract to be able to determine a valid measure result for the subpopulation.”

He said the second concern is that “if all enrollees within a subpopulation are used to determine an all-contract expected rate, then undue weight would be given to contracts that report based on the universe of enrollees to whom the measure applied.” An MA contract with far more diabetic enrollees than another plan has would yield a disproportionate impact on the key calculation of the expected rate, Crosson observed.

By contrast, he asserted, the CAI “is administratively less complicated but still addresses the concerns plans have raised.” So “we would thus urge CMS to implement this approach as an interim measure” given CMS’s desire to offer interim relief, he added.

**ACAP Seeks Examples on Duals Plans**

The Association for Community Affiliated Plans, on the other hand, did not take a position on the two options, contending that more information from CMS is needed before ACAP can determine how well the two approaches “adjust for SES.” Specifically, wrote ACAP CEO Meg Murray in the comments letter, it would like more detail and numeric examples to show this, “particularly for contracts with majority or 100% dual [i.e., Medicare-Medicaid dual eligibles] enrollment.”
Murray said ACAP also would like estimates of how star ratings would change for contracts under each approach and the “strengths and weaknesses” of each. And the letter asked for clarification on whether plans would need a minimum number of LIS/dual or disabled enrollees in order to receive an adjustment via either approach. Of ACAP’s 61 “safety net” plan members, 15 are in the ongoing CMS-backed demonstration for duals.

On the CAI, Murray wrote, ACAP asks to clarify whether institutionalized beneficiaries would be included in the adjustment. And on the IS option CMS should “clarify to what extent, if at all, the subset of adjusted measures would change year-to-year” and whether insurers “should expect both upside and downside adjustment” since in a few stars measures plans with high proportions of disabled duals outperform other plans, she said.

Consulting firm Avalere Health LLC prepared an analysis of the two options as part of a stars-changes webinar Dec. 8. In this webinar, Christie Teigland, Ph.D., an Avalere vice president, said that more information is needed even after CMS’s Dec. 3 call on the options, especially on how the average national rates the agency would use in the options are calculated. But she added that for many of the stars measures, any adjustments would be “pretty small” under either option. This is especially true since the 16 star measures that could be adjusted account for only 27% of potential stars scores, according to Teigland.

All of those points figured prominently in the comments about the proposals submitted by two other associations, America’s Health Insurance Plans (AHIP) and the SNP Alliance, which represents MA Special Needs Plans.

The lengthy SNP Alliance comments centered on “four principal concerns” it had about the proposed options. The first one, the alliance wrote, is that “both options may only minimally account for underlying disparities in star performance for plans specializing in care of poor Medicare beneficiaries.” It based that conclusion on research showing that adjusting for just dual and/or LIS status “does not capture the full amount of within-contract differences in stars performance.”

Moreover, according to the alliance, “The number of measures targeted for inclusion in both models represents a subset of measures that research suggests are impacted by SES. We strongly urge CMS to apply the interim adjustment to all measures in the star rating system related to patient care” while excluding measures such as customer service and appeals rates “directly related to plan activity.”

**Alliance Fears Interim Policy Could Stay**

The alliance also asserted that “neither option incorporates many of the factors shown in the research to be of greatest importance in accounting for social determinants of health” such as income, education, occupation and social supports. The third concern was that CMS has not furnished sufficient information for plans to understand and fully evaluate the feasibility and impact of the options despite the details given in the agency’s Request for Comments (RFC) and call. Finally, and perhaps underlying its other three reservations, the alliance said it “is concerned that the interim proposal could easily become long-term policy without a more aggressive approach to address social determinants of health.”

Its recommendations, based on these reservations, included that “CMS should risk adjust quality measures in the star rating system for beneficiaries’ socio-demographic characteristics beginning in 2018.” For interim relief, it suggested that CMS maximize the number of measures selected for adjustment, with “at a minimum” using all 12 measures showing “a

...
negative performance gap for dual eligible members, as well as consideration of neighborhood poverty and physician shortage factors.”

AHIP’s comments, sent by Mark Hamelburg, senior vice president, federal programs, begin by calling the proposals “an important step forward.” But AHIP too says it is being hampered in commenting by the lack of “detailed analyses of the potential impact of each approach.” While CMS has said it would be furnishing more details on both approaches when it releases the draft 2017 MA pay notice and Call Letter in February, Hamelburg noted, “we strongly urge the agency to release this information as far in advance of that time as possible,” along with estimates of the “total impact of each approach on the program as a whole.”

The comments go on to raise concerns about the time factors, pointing out CMS said in the Dec. 3 call that the options would require additional data-processing steps, resulting in a “compressed timeframe” for MA and Part D plans’ preview of their star ratings.

But AHIP’s strongest comments related to the potential impact on “high performing plans.” Citing comments in both the RFC and Dec. 3 call that the proposed adjustments could reduce star ratings for some plans, Hamelburg wrote that “we strongly disagree with this approach. No contract should be penalized if the adjusted Part C or D Summary Rating or Overall Rating calculated under the adopted approach would be lower than the unadjusted rating.” The Social Security Act “does not require changes to the star ratings system to be budget neutral,” he added.

Those comments may have stemmed from responses made in the CMS call by Elizabeth Goldstein, Ph.D., director of consumer assessment and plan performance in the agency’s Medicare Drug Benefit and C&D Data Group. She said that the adjustments could be either positive or negative and that CMS in any interim relief would be able to make adjustments only for those factors it has sufficient data on.

This raises a question articulated by Avalere Vice President and former CMS official Tom Kornfield during that firm’s webinar. “The question is whether it’s better to do nothing than to do this,” he asserted, and to wait for the permanent relief CMS may be able to offer in 2018 after it gets more data. Avalere’s sense of the options outlined in the RFC, he added, is “this doesn’t really solve the problem.”

View the CMS Dec. 3 presentation on the stars adjustment options by visiting the Dec. 17 From the Editor entry at MAN’s subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantage-news. Contact Murray at mmurray@communityplans.net, SNP Alliance Chair Rich Bringewatt at rich@nhpg.org, Hamelburg at mhamelburg@ahip.org, Teigland at cteigland1@inovalon.com and Kornfield at tkornfield@avalere.com.

| CAI and Indirect Standardization Differ In Approach Across Key Parameters |
|---------------------------------|---------------------------------|---------------------------------|
| **Method 1: Categorical Adjustment Index (CAI)** | **Method 2: Indirect Standardization** |
| Star Measures Adjusted | Subset of 16 HEDIS/HOS/PDE measures | Subset of 16 HEDIS/HOS/PDE measures |
| Data Measurement Year | Current year or prior year | Current year |
| Adjustment Level | Adjusts based on mean difference in Star Rating (adjusted rating vs. observed rating) for groups of contracts | Adjusts measure scores at contract level |
| Method | Linear regression to calculate impact of dual eligible/disabled on measure score | Logistic regression to calculate impact of dual eligible/disabled on measure score |
| Adjustment | Groups of contracts with similar levels of duals/disabled | Contract |

Note: HEDIS=Healthcare Effectiveness Data and Information Set; HOS=Health Outcomes Survey; PDE=Prescription Drug Event.

CMS Says It Will Improve MMPs’ Pay by Basing It More on FFS Costs for Full Duals


In an unusual step apparently designed to respond to indications of weak initial financial performance by many plans participating in the CMS-backed demonstration for Medicare-Medicaid dual eligibles, the agency on Nov. 12 said it would change certain aspects of the plans’ payment rates for 2016.

The move drew widespread applause from duals demo plans and their trade groups even though many of the specifics of what CMS is intending to do are not yet available. But one participating insurer asked that the same policies be applied in 2016 to other plans that have substantial duals enrollment, an apparent reference to CMS’s intention to delay until 2017 star-ratings relief for Medicare Advantage plans and stand-alone Prescription Drug Plans with large proportions of low-socioeconomic-status (SES) and disabled enrollees.

The two-page memo precipitating all those comments was sent to duals demo plans by Cheri Rice, director of CMS’s Medicare Plan Payment Group, and Tim Engelhardt, director of the agency’s Medicare-Medicaid Coordination Office. While payments to the Medicare-Medicaid plans (MMPs) in the demo will continue to be based on the same CMS Hierarchical Condition Category (HCC) risk-adjustment model used in MA, they wrote, “Medicare A/B payment rates will be adjusted to better align MMP payments with FFS [i.e., fee-for-service] costs for full benefit dual eligible beneficiaries.” CMS in an Oct. 28 memo had acknowledged that the care of such full duals costs more than that of duals who have only partial Medicaid benefits (MAN 11/12/15, p. 1).

The new rate updates for MMPs, the Nov. 12 memo said, would apply to all 12 months of 2016, but since the current rates already have been loaded into the payment system, there may need to be “some retroactive adjustments for the early months” of next year.

Determining the size of the presumably higher payment rates for MMPs under the new policy, though, will not be easy. The new memo said adjustments for the Medicare Parts A and B FFS component for beneficiaries who don’t have end-stage renal disease (ESRD) “will be determined on a demonstration-specific basis. Specifically, the adjustment will consider the demonstration-specific proportion of revenue associated with each subgroup in the target population.” That would include beneficiaries above and under age 65 and those who reside in the community versus in institutions, the memo added.

CMS also emphasized that this adjustment applies only to 2016. The agency said it would “release separate guidance” on 2017 payments for MMPs following the issuance of the 2017 MA and Part D rate announcement and Call Letter, which is due out in early April 2016.

Qualifiers notwithstanding, the memo drew prompt applause from MMP sponsors and their trade groups.

John Baackes, CEO of L.A. Care Health Plan, which is with 15,000 MMP members the second largest insurer in California’s demo, says the memo is “all good news.” While it’s not yet possible to determine the change’s precise effect, Baackes tells MAN that an “educated estimate” is that it will be “material” and improve revenue in the “mid-single-digit” range. Although many of the industry questions about the current MMP pay structure have
focused on the Medicaid side, and this change is on the Medicare side, “any relief on either side would be welcome,” especially since it takes a year or two before MMPs feasibly can achieve cost savings, he adds.

“We’re delighted that CMS has moved quickly to adjust Medicare payments for plans serving full-benefit dual eligibles in the duals demonstration so that these plans are paid more accurately,” Meg Murray, CEO of the Association for Community Affiliated Plans, whose members include some demo-plan sponsors, tells MAN. “These changes will be a boon to the stability of the duals demonstration programs.”

**Molina Lauds 2016 Start for Pay Change**

“We’re thrilled” with this CMS action on payment for MMPs, Lisa Rubino, senior vice president for Medicare and duals at Molina Healthcare, Inc., tells MAN. She notes that Molina has lobbied “for many months” for CMS to do something that recognizes the cost differentials between full and partial duals, as the new policy does. She terms as “terrific” that CMS is making the pay change for 2016 rather than any later.

Asked what will be the impact of the changes contained in the Nov. 12 memo on Molina, which is the largest duals-demo operator with about 55,000 total enrollees in six states, Rubino responds that it is “hard to say right now.” All the members in Molina’s MMPs are full duals, so the changes are clearly “a step in the right direction,” she says.

Richard Bringewatt, chair of the SNP Alliance trade association that represents Medicare Advantage Special Needs Plans, several of whose operators also have MMPs, cites CMS’s research, as released in the Oct. 28 memo, in explaining why his group “fully supports” the agency’s actions on Medicare Parts A and B payments.

“This correction is urgently needed because Medicare payment under the demonstrations builds in savings relative to FFS costs under each state’s initiative,” Bringewatt tells MAN. “If left uncorrected, the current CMS-HCC model will drastically underpay MMPs below the expected savings as the predictive ratio alone for full-benefit dual eligibles is .914 of FFS costs.” A predictive ratio of less than 1.0, as CMS explained in the Oct. 28 document, means that the payment amount is lower than it should be based on expected costs.

**What Will CMS Do for Non-Demo Duals Plans?**

But while expressing satisfaction with the new MMP pay proposal, Bringewatt said CMS also needs to focus on other duals plans. “We see a similar urgency for the proposed model correction for plans serving dual eligibles outside of demonstration authority,” he asserts. He points to SNPs for duals (D-SNPs), including fully integrated dual eligible (FIDE) SNPs, saying that they “in many areas of the country struggle under MA benchmark rates to afford to offer their plans.” Several D-SNPs, according to Bringewatt, “have reluctantly scaled back or have closed their offerings for disabled” duals because the current MA financial model “has not worked for plans to specialize in their care — similar to the MMPs.”

Bringewatt adds, “We understand that under CMMI [i.e., CMS's Center for Medicare and Medicaid Innovation] demonstration authority CMS has more latitude to incorporate changes into MMP payment compared to MA payment. However, it’s important to recognize many FIDE-SNPs and D-SNPs will also be seriously underpaid in 2016.”

WellCare Health Plans, Inc., a prominent SNP operator continuing to be hampered by relatively low CMS star quality ratings, made a similar pitch in a post-memo interview with Modern Healthcare. “We would support applying that [new MMP payment] methodology
to all plans serving large proportions of Duals in the 2016 plan year,” Elizabeth Goodman, WellCare’s vice president of public policy and government affairs, told the magazine. Otherwise, she said, the new MMP policy would result in “a substantial payment inequity” versus MA plans.

View the new memo by visiting the Nov. 13 From the Editor entry at MAN’s subscriber-only Web page: www.aishealth.com/newsletters/medicareadvantagediagnosis. Contact Baackes at jbaackes@lacare.org, Bringewatt at rich@nhpg.org, Murray at mmurray@communityplans.net and Rubino at lisa.rubino@molinahealthcare.com.

Idaho Overcomes Many Hurdles in Starting State-Run Duals Program


Idaho’s journey in launching a Medicare-Medicaid Dual Eligibles integration initiative may rival any other state’s in the degree of difficulty it has encountered — and the degree of state-insurer cooperation it has achieved.

The hurdles began when a Regence unit that was one of the two insurers applying to participate in the CMS-backed duals demonstration in the state pulled out in 2013, leaving Blue Cross of Idaho as the sole plan and thus meaning that Idaho would need to proceed on its own outside the CMS demo. This also meant enrollment would have to be voluntary, making economies of scale difficult in a predominantly rural and lightly populated state.

The same population characteristics have led to an environment in which providers tend to be small and therefore more difficult to migrate to a Web-based claims administration system needed for the demo. And they have resulted in community-based services taking on a different meaning than in most other duals-program states, using, for instance, “certified family home” caretakers rather than bigger and more formal services. Moreover, Blue Cross of Idaho may have made things tougher on itself initially, admits Beth Nelson, the insurer’s Medicaid programs director, by opting to contract and build its own provider network rather than using the state’s vendor-based network.

But hurdles notwithstanding, Idaho does now have a fully functioning duals program, serving about 1,700 beneficiaries after starting with just over 600 a year ago, according to Nelson. And while she tells MAN that meaningful patient-outcome and savings results data won’t be available for about another year, the program has “very low disenrollment” and already has achieved some key goals such as a big increase in use of preventive services.

Blue Cross of Idaho was not a newcomer to duals before the program that began last year, Nelson points out. It had a Medicare Advantage duals Special Needs Plan (D-SNP), including for mental health services, in the state since 2007, she notes. And after the CMS-backed demo ceased to be a feasible option for Idaho, Nelson says, the Blues plan was able to add the long-term care and other services needed for the D-SNP to become a fully integrated dual eligibles SNP (FIDE-SNP) and launched the new program on July 1, 2014, after completing a state readiness review in May.

In a joint presentation with Chris Barrott, contract manager at the Idaho Department of Health & Welfare, at World Congress’ Dual Eligibles Summit in Arlington, Va., July 15,
Nelson discussed how the state and insurer have worked together closely to get the program off to a good start. One key aspect, they said, was “flexibility,” since goals and expectations are “a moving target” in the first year of implementation.

Voluntary enrollments, they added, proved to be a much bigger challenge than anticipated, and it was important for the program to have the “stamp of approval” from the state to instill trust among enrollees. The plan and state conducted an aggressive communications effort for the program, including written communications and public events, stressing not only the financial advantages for members but also that enrolled beneficiaries get “your own care coordinator.”

**HCBS Inclusion Had Big Training Impact**

The inclusion of home and community based waiver services (HCBS) has involved a whole set of other challenges, Nelson noted in a separate presentation at the conference. For instance, there was a “heavy lift” in training staff, including customer-service representatives, in such aspects as the different kinds of waivers being used. And there needed to be “a policy and procedure for everything” to make clear even what constitutes a “home delivered meal,” she said.

Nelson conceded that one of the biggest decisions Idaho Blue Cross had to make is one that, “in hindsight,” it might have done differently, and this was opting at the start to build and contract with its own provider network. The plan decided this, she explains to MAN, in an effort to have “ongoing control of the quality of the network.” Many times states don't have the resources or background for such aspects as “the kind of credentialing needed” for providers going into beneficiaries’ homes, according to Nelson.

By doing this function itself, “we took the most complicated contract Blue Cross has and put it in the hands of providers” who often in Idaho are “mom-and-pop shops,” acknowledges Nelson. The alternative would have been to use contracts of the state’s vendor, which would have been much easier initially, she says. But she adds that now with the transition over and its own contracts in place, “I’m glad we did it.”

And Nelson says Idaho Blue Cross did make several good decisions on the duals program, such as starting with its currently contracted providers. “Since everything takes longer than expected” on launching HCBS, that helped, she maintains, as did opting to pay HCBS providers within two weeks after the date of service and having a gift-card drawing for providers who get their paperwork for the program completed in time. This is particularly true since HCBS providers can “drive enrollment” in a voluntary program such as Idaho’s.

Although these features have worked out, there have been difficulties because of the nature of Idaho. Most of the potential members for the duals program, for example, had been in fee-for-service, so managed care is new for them, and many don’t have regular computer access, Nelson observes. Similarly, some HCBS providers in the state, she says, don’t have and can’t afford high amounts of liability insurance coverage. And the patient volume the duals program drives for providers is pretty low, she notes.

Despite the obstacles, both Nelson and Barrott say, the efforts already have proved worthwhile. As evidence of that, they cite data showing that use of preventive services by the enrolled duals is up 17% compared with before the program started, which Nelson contends will have long-term benefits in the form of cost savings as well as patient outcomes.

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CMS Offers Two-Year Extension on Duals Demo, But Not All States May Accept It


Responding to both insurers and states that have said they need more than the authorized three years for their CMS-backed Medicare-Medicaid dual-eligibles demonstration programs to be successful, the agency on July 16 offered to extend interested states’ scheduled completion dates by two years. The memo, which also suggested CMS will be open to further changes in demo contract terms and would make available more funding, drew widespread applause from plans and states. But at least two of the 12 demo states have indicated they’re not sure yet whether they’ll ask for an extension.

The situation in one of those states was generally known, since California has a state law (MAN 6/27/13, p. 1) that requires ending the demo in 2016 if it is not producing cost savings, which it apparently hasn’t yet. Anthony Cava, a spokesperson for the California Department of Health Care Services (DHCS), told MAN July 22 that it still was in discussions about what to do about the extension, for which requests must be into CMS by Sept. 1, and does not anticipate decisions until August. The California demo is by far the largest, with 120,470 enrollees as of July 1 out of about 400,000 in the CMS program nationwide.

Illinois represents an emerging situation complicated by the state’s budget problems, which include not only red ink but also no budget yet beyond the current fiscal year. The administration of Republican Gov. Bruce Rauner, who succeeded Democratic Gov. Pat Quinn this year, has suspended payments to plans for 60 days while awaiting a new budget but asked demo plans to keep paying the providers in the interim.

Moreover, MAN was told by a health plan industry source that Robert Mendonsa, the new deputy administrator of the Illinois Department of Healthcare and Family Services, privately expressed doubts after the CMS extension memo came out about whether Illinois wants to extend the demo. Among the state’s concerns, Mendonsa reportedly said, was that the demo involves too many plans, too much oversight and uncertain results.

However, Mendonsa on July 24 told MAN this takes out of context what he said, and there has been no discussion within the Illinois executive branch yet about whether to apply for the two-year extension. “We do have a budget situation,” he acknowledged, and “there is a doubt that we need any more plans” in the demo, but nobody in Illinois government has complained about the demo’s extent of oversight or quality of results. “We need a meeting of the minds” in the executive branch to discuss the potential extension, he said, and to weigh any potential minuses versus the continuing plus of better coordinating care for the duals.

CMS Memo Cites ‘Signs of Progress’

The three-page CMS memo itself, from Tim Engelhardt, acting director of the agency’s Medicare-Medicaid Coordination Office (MMCO), points to numerous “early signs of progress” in the demo, including 150,000 health risk assessments completed and more than 2,500 care coordinators hired by health plans. Engelhardt then noted in the memo CMS is aware that states soon will have to develop budgets for fiscal years extending beyond the scheduled end dates of the demo, and that the initial major evaluation reports “will be based on only
the first full demonstration year...[and] may conclude that more experience is needed before assessing overall success or failure.”

With this in mind, and wanting to avoid a situation in which infrastructure investments cease “in advance of a scheduled end date” while awaiting more detailed evaluation results of the demo, he said, “we intend to work with interested states to extend the scheduled end dates for each demonstration by two years.” Engelhardt warned, however, that “we will modify or terminate any demonstrations that are failing to improve outcomes” in keeping with the waiver provisions of the Social Security Act (SSA).

Responding in the memo to any concerns about funding in a CMS demo extension not approved by Congress, Engelhardt wrote that “we will make additional funding available” for both ombudsman and State Health Insurance Assistance Program (SHIP)/Aging and Disability Resource Center (ADRC) activities, which provide counseling for beneficiaries. The memo added that “aggregate annualized funding levels will be similar to the amounts currently available.”

While the memo didn’t detail how much that is, ombudsman funding was about $12 million over three years and SHIP/ADRC funding was approximately $8 million.

The memo also indicated that the agency expects to make further “updates and improvements” in the three-way (i.e., CMS-state-plan) contracts for the demo, and they’re not necessarily limited to altering the end dates. Although it cautioned that “material changes to the three-way contracts will require separate federal review processes,” the memo said “all parties will preserve their current opportunities to terminate the contract or demonstration prior to the scheduled end date.”

**Letters of Intent Are Due Sept. 1**

Engelhardt in the memo asked the 12 states for a non-binding letter of intent by Sept. 1 stating whether they are interested in extending the demo’s end date.

Asked why the agency is choosing two years as the extension time frame, a CMS spokesperson tells MAN, “We believe two years is sufficient time to provide us with better information to enable the agency to consider whether a demonstration meets the prerequisites for expansion” under terms of the SSA.

Queried about the criteria CMS would use to modify or terminate a state’s duals demo, the spokesperson points to language in both the SSA and the Affordable Care Act. This language would consider a demo successful if it improves quality without increasing spending or reduces spending without reducing quality, as well as, of course, improving on both points.

While the spokesperson would not elaborate on the kinds of additional changes in contract language CMS would be open to in the demo, the agency views the extension as an “independent action. It neither creates nor precludes opportunities for other changes necessary to help the demonstrations meet our objectives.” And the agency says it expects the extension opportunity “will be generally well-received by state officials.”

It certainly was by the heads of some trade associations whose members are active in the demo.

“This will give plans the opportunity to recoup some of the investments they made with a more realistic time period,” says Richard Bringewatt, chair of the SNP Alliance, which has numerous member insurers participating. “This is the kind of thing you don’t start and...
then close the door,” he tells MAN, noting there have needed to be changes to Medicare and Medicaid programs and new systems put in place. He adds that “this is tough stuff” and that with some of the demos just getting started in 2015, “it’s dangerous” to make judgments about whether there are cost savings yet, for instance.

Bringewatt considers the memo’s reference to willingness to consider additional changes to contract terms an important “opportunity.” There is a lot of interest among the demo states, he says, in making changes in such areas as the definition of provider-network adequacy and aligning both reporting and appeals- and grievance-handling requirements between Medicare and Medicaid, as well as exploring modifications in provisions governing payment rates and withhold.

“We are very pleased” with the decision to extend the demo, says Meg Murray, CEO of the Association for Community Affiliated Plans (ACAP), whose members cover about one-third of the current enrollees in it. In some states, she tells MAN, more than 50% of eligible beneficiaries now are enrolled in the demo, calling that “a good sign for a new program.”

Murray also praises the memo’s language about receptivity to future contract modifications. She expresses hope that there will be changes in the current “not adequate” risk-adjustment system for full duals, including further adjustments for behavioral-health conditions, which are abundant in that population.

The demo extension is “a good step” for CMS to take, given the challenges in gathering and analyzing data so far, Jeff Myers, CEO of the Medicaid Health Plans of America (MHPA) trade group, tells MAN. The CMS Financial Alignment Initiative, as the duals demo is called, always was intended to find out whether certain reforms were feasible and, at this point, he says, it is “no secret that the FAI has not worked to expectations.”

There are particular factors hindering the demo in California and Illinois, he notes, when asked why there may be uncertainties about accepting the demo extension in those states. In California, for example, Myers tells MAN, one reason the demo has not yet saved money is “adverse selection” of duals beneficiaries. He points to efforts some providers have made to encourage healthier duals to opt out, thereby leaving a smaller and sicker population in the demo.

In Illinois, he adds, budget problems have resulted in delays in getting information to duals eligible for the demo, and that has hampered plans participating in it, including MHPA members.

He would like CMS in the extension to rethink its passive-enrollment processes that now may be slowing down the growth of the demo.

“My general impression is that both quality and savings data are incomplete and the demonstrations cannot be evaluated with any confidence,” says Thomas Lutzow, Ph.D., president and CEO of Independent Care Health Plan (iCare), a longstanding duals plan that is not in the demo.

Lutzow, who has been with iCare since its inception and is well versed on duals programs nationwide, is quick to add that member satisfaction among demo enrollees who have not opted out of the program “is running favorable” and that “it would be very difficult to unwind the demos” at this point. The programs have “unearthed pent-up and unmet needs” that have resulted in driving up initial costs, he tells MAN, and therefore “the real value of the model might not be felt for several years down the road as health conditions and utilization patterns are adjusted.”
Why isn’t enrollment in programs for Medicare-Medicaid dual eligibles growing as quickly as expected? A big reason, said some health plan executives in the initial batch of second-quarter earnings calls with investors this month, is many physicians don’t want and are seeking to discourage the programs. The plans’ comments made more public sentiments that had been expressed in a subdued fashion by several state and insurer officials in prior quarters.

“The challenge in all of these [i.e., duals] markets is that there is a very low rate of physician acceptance,” said, for instance, Barry Smith, chairman and CEO of Magellan Health, Inc., during that company’s July 27 earnings call. Smith added that he doesn’t expect to see “a great change” in physician acceptance, despite the efforts of Magellan and other duals-plan sponsors to show those providers the benefits for them, so it is developing “strategic risk contracting relationships with large provider organizations” in an attempt to deal with this. But for now, he indicated, the lack of provider support has translated into many duals not seeing “a clear benefit” for staying in a duals plan in which they’re passively enrolled.

Similarly, when asked about the lack of major duals-plan enrollment progress in Centene Corp.’s July 28 earnings call, Chief Financial Officer William Scheffel said, “One of the biggest drivers of it is the attitude of the provider community about moving people into managed care programs versus fee-for-service Medicare.”

Centene Chairman and CEO Michael Neidorff elaborated on this in response to a question about which types of providers are encouraging their duals patients to opt out of the CMS-backed demo in the four states (Michigan, Ohio, South Carolina and Texas) it serves in that program. He indicated all of the kinds of providers the questioner asked about — nursing homes, home health and post-acute care — were “at different times providing that pressure.”

But Centene is trying hard to make the duals demo “easier and less complicated” for them, he stressed, with the aid of medical management systems and is making a little headway. Ohio, for instance, has an opt-out rate for the company’s duals plan of “30% to 32%,” he said, which would make it well below opt-out rates being reported in some other states, and “it is coming down a bit.” Centene now has a total of about 19,700 duals enrollees in the four states after opt-outs are subtracted, he added.

Magellan has only “relatively modest” membership in the duals product sponsored by its AlphaCare managed long-term care (MLTC) plan in New York’s delayed Fully Integrated Duals Advantage (FIDA) demo that began in January, reported Smith. He explained that
AlphaCare has about 3,200 members in all its product lines, with 1,900 of them in the Medicaid MLTC product that FIDA attempts to build on.

Even with the “initial lack of acceptance of FIDA,” he asserted, AlphaCare’s other products (i.e., MLTC, Medicare Advantage and MA dual-eligible Special Needs Plans) “can still be very successful.” The keys, he said, are for AlphaCare to develop “incremental contracts” with licensed home care and other agencies and to increase the number of “distribution channels” for the MLTC product.

He explained that most MLTC providers in New York “have not been excited about moving to FIDA because they don’t want the incremental expenses of the Medicare overhead and compliance structure required for the FIDA program.” These providers are “politically very strong,” said Smith, and “my sense is that’s true across the country,” so there’s no likelihood of a program like FIDA being made mandatory.

Contact Magellan financial spokesperson Renie Shapiro Silver at (877) 645-6464 and Centene Senior Vice President Edmund Kroll, Jr. at (212) 759-0382.

**Fallon Will Exit Mass. Duals Demo, Citing Financial Results; Others Seek More Help**


In an unsurprising decision but one that raised new doubts about the viability of the huge CMS-backed demonstration program for Medicare-Medicaid dual eligibles, Fallon Total Care said in mid-June that it would exit the Massachusetts duals demo for financial reasons on Sept. 30. This would leave only two plans in a state that initially selected six insurers to participate in the nation’s first CMS-funded duals demo but in which three of those chosen dropped out before the program began in late 2013 (*MAN* 7/25/13, p. 1).

Both of the plans — Commonwealth Care Alliance (CCA) and Tufts Health Public Plan — remaining in the Massachusetts demo tell *MAN* they intend to stay in despite their initial losses, although neither seems to want to add on major portions of Fallon’s membership in the near future. And both plans praise the CMS Medicare-Medicaid Coordination Office (MMCO) for having taken and continuing to develop steps to assist the demo plans in dealing with certain problems unique to the Massachusetts demo.

However, they also say the Fallon pullout underscores the need to resolve remaining issues promptly, including showing a clear path for continuation of the demo beyond the three years authorized in the Affordable Care Act (ACA).

**Fallon Decides to Exit Mass. Demo**

There now are about 340,000 duals enrolled in the demo nationwide, with more to come as states starting up this year complete their rollouts. There are 65 health plans participating in the demo, including multiple units of the same parent organizations.

CMS would not comment on the Fallon departure. But MMCO and CMS as a whole are known to be actively seeking additional ways to help demo plans succeed. The actions being considered include streamlining reporting requirements and administratively implementing steps to ensure the demo continues beyond the initial period. Other possible steps
include perhaps even changing the current risk-adjustment system that lumps for payment purposes the full duals served by the demo in the same category as less-expensive partial duals served by other plans.

Any of those actions, of course, would come too late for Fallon, which with about 5,500 members in One Care, as the Massachusetts demo is known, has been the second largest plan there. The entire state demo had 17,637 members as of the May enrollment report from One Care, well below the 27,396 eligibles who have opted out of the initiative in a state that has large and powerful provider systems not fully enamored of the demo. There are 97,987 Massachusetts beneficiaries eligible for the demo, according to One Care.

‘Participation Was Not Economically Sustainable’

Parent organization Fallon Community Health Plan said in a prepared statement that it had “decided reluctantly” to withdraw from the demo after exploring alternatives with both the state and CMS. Fallon “ultimately determined that our continued participation was not economically sustainable,” the statement added. The company declines to elaborate on its financial results in the demo or on why it needed to leave when the other two participants, also not-for-profits, are staying.

The Massachusetts Executive Office of Health and Human Services, known as MassHealth, was similarly limited in its comments. “MassHealth is committed to the One Care Program, which provides coordinated care for a population with complex needs,” spokesperson Michelle Hillman tells MAN. “We will work with Fallon Total Care members to ensure a smooth transition and continuation of coverage under another One Care plan or through MassHealth and Medicare directly.”

It is not clear yet whether the state will seek to assign Fallon Total Care’s members to the two remaining One Care plans, notes Kit Gorton, M.D., president of the public plans division of Tufts Health Plan. Regardless of what is done, Gorton tells MAN, Tufts Health Public Plan (the new moniker for the duals plan formerly called Network Health) does not expect any “deleterious impact” of the Fallon withdrawal on its own duals operation.

Gorton says Tufts’ decision to start slowly and have “measured, methodical growth” in the demo has proved helpful to its plan. The unit is breaking even on a “run-rate basis,” he says, although he acknowledges that if One Care ends after the now-authorized three-year term, “we will not have recovered our original investment.”

Tufts Seeks Modest Expansion in Demo

Tufts had a total of just 1,832 duals-demo members in two counties as of One Care’s May enrollment report. Its current game plan, notes Gorton, is to expand next into Suffolk County to get at least 1,000 additional enrollees and then into Norfolk.

### Massachusetts Duals-Demo Enrollment As of May 1, 2015

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<td>C3A</td>
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<tr>
<th>Total Enrollment by Plan</th>
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</thead>
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<tr>
<td>Commonwealth Care Alliance</td>
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<td>Fallon Total Care</td>
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<td>Network Health (Tufts)</td>
<td>1,832</td>
</tr>
<tr>
<td>Total</td>
<td>17,637</td>
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</tbody>
</table>

* F1 = Long-term care facility-based care; C3B and C3A = High community services needs; C2B and C2A = High behavioral-health community services needs; C1 = Individuals in community who don’t meet criteria for other classes.

County, which would complete a “southern ring” around Boston and bring its One Care total membership to more than 3,000. To make this feasible, he stresses, the demo would need to be extended beyond the current three-year scope.

The Fallon withdrawal decision is “not surprising” but nonetheless disappointing since its duals plan has done “good and important work,” he asserts. As for Tufts itself, Gorton adds, “we have no plans to withdraw from the demo at this time,” although he wouldn’t rule out such an action in the future “if anything changes” since Tufts is a not-for-profit with limited financial resources.

There are some unique aspects of the Massachusetts demo, Gorton explains, that have complicated the situation for the duals plans there. “Going first comes with risk,” he says, partly because there weren’t other demo plans from whose experience the Massachusetts participants could learn. Perhaps a bigger issue, though, is the fact that the state’s CMS-backed demo is the only one exclusively for an under-65 population, he points out.

This has meant that about 60% of its target population has mental health issues, compared with the “single digits” that would be the norm in a Medicare Advantage population, according to Gorton. He says Tufts in its demo thus has had to deal with major substance-abuse and homelessness problems among its population and the need for expensive acute care to stabilize those duals before programs to improve their care can take effect. Add to this the lack of a “delivery system” in Massachusetts for the kind of “step-down” services needed, and the task becomes even more difficult, he maintains.

But he also is quick to cite successes Tufts already has had in the demo, including sharp reductions in the number of its duals in “yo-yo” situations of going back and forth with hospitalizations. Some of the duals it has helped avoid this, via such means as finding housing for them, won’t be fully stable by the scheduled end of the duals demo, says Gorton, partly because true managed care services for them can’t start until perhaps more than half of the demo period is over. And this brings him to where he thinks more government help is needed.

Gorton lauds the actions MMCO has taken in the Massachusetts demo, such as extending risk corridors to the second and third years and lowering savings expectations, which has the effect of boosting pay for the demo plans (MAN 3/26/15, p. 1). “Those things were enormously important,” he asserts, but Gorton says there are additional steps the government could take that would help the plans accomplish the important goals set out for them in the demo.

He cites as a specific problem now having to submit encounter data in two different formats, one for CMS and one for Massachusetts. Similarly, he points out, there are two sets of regulations for handling appeals and grievances, two sets of timelines to meet and the continuation of a system by which the Medicare claim must be paid before Medicaid will act on “what’s left” in the claim.

MMCO Acting Director Tim Engelhardt is aware of these continuing problems and doing what he can to remedy them, Gorton emphasizes, but in some cases MMCO doesn’t have the resources or authority to do everything that’s needed. While Tufts’ medical experience in the demo so far has been worse than expected, its administrative expenses, including compliance costs, have been “much worse,” he observes.

The other remaining plan, CCA with 10,305 enrolled duals as of May, also praises MMCO and Massachusetts officials and would like the government to do more on
Executives of Duals-Demo Plans Warn That Short-Term Objectives Won’t Be Achieved


Now that almost all of the CMS-backed initiatives for Medicare-Medicaid dual eligibles are up and running, it has become clear that reaching many of the ambitious goals in these programs will be nearly impossible over the short term. There have been and will continue to be improvements in integrated care for duals as a result of the demo, plan executives tell
MAN, but such aspects as cost savings, good outcomes data, full integration of behavioral and medical care, and combining Medicare and Medicaid regulation will be longer in coming than many have expected.

This at least seemed to be the consensus among the 11 speakers at AIS’s April 16 virtual conference on the initial results of duals initiatives. Virtually all of the speakers praised the concept of the demos and the work of CMS’s Medicare and Medicaid Coordination Office (MMCO) in working to solve the problems, but they cited a host of complications as well.

The delays in starting the CMS-backed state demo, for instance, have been very costly for participating plans, said L.A. Care Health Plan CEO John Baackes, a speaker at the conference’s opening session. Baackes joined that plan, which participates in the Los Angeles County duals demo, March 23 after heading Medicare Advantage and duals programs at the AmeriHealth Caritas Family of Companies, which participates in duals demos that started this year in Michigan and South Carolina.

The delays are a problem, he explained at the conference, because duals plans have such “significant upfront costs” and had to amend provider contracts after they were negotiated since government payment-rate determinations were slow in coming. Moreover, states’ Medicaid staffs didn’t have enough knowledge of Medicare processes, causing delays in getting needed information to the plans.

Baackes praised the MMCO leaders for their accessibility and responsiveness to participating plans, including willingness to amend the Massachusetts contract to reduce expected savings (more such modifications are likely, observers say) and to stretch out the completion of some demos till 2018. But he said there are “fundamental flaws” in the demo, including having to meet quality targets “just to get the basic pay” for plans under the demo’s withhold provisions and the continued separate reporting for Medicare and Medicaid on both provider encounters and claims. This has caused additional burdens for the participating plans, he asserted.

Other problems in the demos so far, according to Baackes, lie in how government agencies have communicated — or not communicated — with beneficiaries and providers. He said the materials for beneficiaries, for example, have lacked “marketing pizazz,” and that has hurt enrollment results. The first time a beneficiary hears of the demo, Baackes added, often is via a mailed notice with a deadline for action, and this is one reason the demos “will wind up smaller than anybody has anticipated.”

He also said, however, that once enrollment stabilizes after the opt-out period, “retention will be high.” One way to help bring this about, he suggested, is to make sure plans know by next year whether there will be an extension of the three-year demos beyond 2018, an event he called “critical…and likely.” Baackes cautioned that it will take at least two years before there are good data by which people can judge the success of the demos.

**Demo Extension Might Be Done Without Law**

While MMCO declined to discuss specific timetables, Obama administration health policy makers are known to believe they have the authority to extend the demo without needing new legislation. They have pointed out that although administrative infrastructure funding had to come from CMS’s Center for Medicare and Medicaid Innovation under the Affordable Care Act, most of those big expenditures are completed, and the large costs remaining are just the capitation payments from normal Medicare and Medicaid channels.
Several of the speakers pointed to the difficulties of incorporating long-term care (LTC) into the duals demos. Martha Smith, chief duals program officer for Health Net, Inc., for instance, while noting her plan’s improvements since the beginning of the demo in its ability to “find” and contact passively enrolled duals in the California demo and get them to complete health risk assessments (HRAs), also said that it is hard to get provider encounter data for the demo.

The whole new responsibility for LTC has been “challenging” for L.A. Care, added that plan’s chief operating officer, John Wallace, and L.A. Care basically has had to develop a separate network specifically for duals residing in LTC facilities.

Behavioral health (BH) care has generated a separate set of problems in the demo so far. Molina Healthcare, Inc., which operates plans in six of the demo states, for example, has found up to half of the duals have serious BH issues, according to Tom Standring, vice president, Medicare. He said Molina’s efforts to contract with third parties to help manage these beneficiaries’ behavioral care are complicated by regulations restricting access to protected health information (PHI).

Brian Wheelan, executive vice president and chief strategy officer at behavioral health managed care specialist Beacon Health Options, which operates in eight of the duals demo states, cited the PHI issue as one reason that every plan in each of Beacon’s states is “struggling with outreach and engagement with the mentally ill.”

Although administration health policy makers have conceded that data-privacy issues are a legitimate issue they are working on, they also have pointed out that the demo member can authorize any sharing of information. They acknowledge duals may not always agree to this.

It is “unrealistic,” continued Wheelan, to expect primary care physicians to integrate care for those duals with BH conditions. It also is hard to achieve “reverse integration” and focus behavioral care in the demos around community mental health centers, which will take time “to scale” up to establish “meaningful primary care capability,” Wheelan said. Similarly, he observed, Federally Qualified Health Centers have “notable financial advantages and commitment, but complex patients are not their strength (yet). This is even more true for the” seriously mentally ill (SMI) population.

**Demo Still Struggles With Engaging Duals**

“The whole demo is struggling with engagement,” maintained Wheelan, who does not expect it to be extended. “Unable-to-reach” rates are running 30% to 40% overall, and are even higher with the SMI, he said, adding, “Outreach is expensive; penalties make it worse.”

Moreover, according to Wheelan, “there still is an immediate shortage of subacute services and crisis-stabilization beds” for duals with BH issues. While “we should be able to build those, that will take time,” he said. At least one duals demo plan, Commonwealth Care Alliance (CCA) in Massachusetts, already has done this itself (MAN 1/8/15, p. 3), and others have used church basements among various existing non-health care facilities for duals-beneficiary meetings with care coordinators.

The financial implications in BH are even more severe than on the medical side, said Wheelan, because opt-out rates in the SMI population tend to be “much lower” than in the overall duals population.
Lois Simon, president of CCA, pointed to another aspect of the same problem in saying that of the more than 10,000 enrollees CCA has attracted in the Massachusetts duals demo, 70% have a BH diagnosis. And many of them who are classified, and thus paid for, in plan compensation in the demo as needing a relatively low degree of care turn out to be more seriously ill, said Simon.

This contributes to another issue, she suggested. About 25% of CCA medical spending in the Massachusetts OneCare duals demo is for pharmacy, which is “off the charts” in comparison with the senior population CCA serves outside the demo, she asserted. The Massachusetts demo is only for those aged below 65.

However, there also are several areas in which the demo is working well, several of the speakers emphasized. Health Net’s Smith, for instance, noted that the satisfaction rate once beneficiaries actually begin the California program has been “very high” so far. Mari Cantwell, chief deputy director, health care programs in the California Department of Health Care Services, agreed, saying there isn't a high level of disenrollment among demo participants who didn’t opt out initially. Even the above 50% opt-out rate in Los Angeles County now is starting to decline, added Wallace.

Both Wallace and Smith cited good progress in getting duals in the California demo to complete HRAs. Wallace said L.A. Care is “pleased” with the 70% HRA completion rate it has, although he acknowledged that “sometimes” the plan has to approach duals beneficiaries “more than once” to achieve this. Smith said Health Net “struggled” at the outset of the demo in getting HRAs completed because of incorrect contact information for many of the beneficiaries, but it now is using such resources as pharmacy data and information related to duals’ use of long-term services and supports (LTSS) to find the members. Once Health Net finds them, she added, their completion rates for the HRA are good.

More than 150,000 HRAs already have been completed for the duals demo nationwide.

Contact Baackes at jbaackes@lacare.org, Smith at martha.smith@healthnet.com, Wallace at jwallace@lacare.org, Standring at tom.standring@molinahealthcare.com, Wheelan at brian.wheelan@beaconhealthoptions.com and Simon at lsimon@commonwealthcare.org.

Voluntary Duals Program in N.J. Survives Plan Exits, Gets Support From Stakeholders


While some health plans and states participating in the huge CMS-backed demonstration for Medicare-Medicaid dual eligibles have struggled with its passive-enrollment emphasis, New Jersey’s own voluntary duals initiative begun in 2012 has avoided many of those difficulties. And a key reason for this, state officials say, is that New Jersey’s program is built around Medicare Advantage Special Needs Plans (SNPs) for duals.

But New Jersey has faced its own challenges with this approach, including two managed care organizations (MCOs) exiting the initiative at the end of last year for financial-related reasons, although one other big insurer re-entered it for 2015. The result of this has been duals’ membership figures going dramatically up and down twice with the MCOs’ departures and arrivals.
Difficulties notwithstanding, state officials defend the approach New Jersey took, saying it has paid off in such areas as the support of beneficiaries, providers and patient-advocacy groups, including in behavioral health. The voluntary enrollment, says, for instance, Elizabeth Wood, director, duals integration in the state Department of Human Services’ (DHS) Office of Managed Healthcare, enabled the duals program to start small. And using a D-SNP as the main vehicle, Wood tells MAN, has led to beneficiary satisfaction with the program, the health plans in it and the patient-provider relationship.

Wood recalls that New Jersey started working on duals integration before CMS’s Financial Alignment Initiative (FAI) began taking form in 2011. The state, she noted in a duals session at the World Health Care Congress in Washington, D.C., March 24, had 170,000 duals when it began incorporating them into the state’s Medicaid managed care program that year. New Jersey chose to keep pursuing just an independent approach toward full integration of duals care, including managed long term services and supports (LTSS) for them, rather than also pursuing an FAI application, according to Wood, because “it would be too much to do both.” Moreover, the state liked the D-SNP-focused approach’s potential incorporating LTSS for looking at a duals member “holistically.”

So it rolled out the D-SNP approach starting in January 2012, with a design requiring that plans selected already be contracting with the state for Medicaid managed care via the NJ FamilyCare program. Wood explains that this facilitated use of “fully integrated member materials,” including a single ID card. While the state did consider seeking passive enrollment via the FAI, it instead chose a voluntary approach because that was what “our stakeholders wanted,” and “it has worked out,” she asserts.

But there clearly have been bumps along the way. Wood recalls that the voluntary program started with 7,000 duals in 2012 and rapidly grew to 30,000 in 2013 before UnitedHealth Group’s AmeriChoice unit, one of four contractors for the initiative then, exited at the end of the year as part of the company’s star-ratings-related D-SNP pullback. “We were sad to see them go,” she says.

While this withdrawal meant a big membership loss, enrollment grew again to 27,000 before both Healthfirst Health Plan of New Jersey, Inc. and Horizon NJ Health left at the end of 2014, apparently in part because of the financial woes afflicting many SNP operators. So membership

<table>
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<tr>
<th>Duals Programs Operating in New Jersey</th>
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<tbody>
<tr>
<td>Program复印</td>
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<tr>
<td>Enrollment</td>
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<tr>
<td># Plans</td>
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<td>New Jersey FamilyCare (NJ-MLTSS)</td>
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<td>152,165</td>
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<tr>
<td>Dual-Eligible Special Needs Plans (D-SNP)</td>
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<td>Program of All-Inclusive Care for the Elderly (PACE)</td>
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<td>Total as of April 2015</td>
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<th>Duals Plans in New Jersey</th>
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SOURCE: Medicare-Medicaid Dual Eligibles Database (DUAL), an online subscription database and newsfeed from AIS. Visit http://aishealthdata.com/dual for more information.
fell back to 9,000, but it is rising again at 6% per month in light of the re-entry of United, with CMS’s blessing, via its Oxford unit this January, Wood notes. United has been “very committed to integration” for duals throughout the time New Jersey’s program has been running, she says. The insurer now serves four counties in the state.

The one continuing MCO in the program is the Amerigroup New Jersey, Inc. unit of Anthem, Inc., which operates in 10 counties in 2015.

‘Sky Is the Limit’ on Membership

Membership in the program could reach 40,000 to 60,000 if it can keep its contractors, contends Wood, adding that “the sky is the limit” over the longer term as the initiative expands into more counties and demonstrates the value of having all services for duals “in one place.” Unlike numerous other duals programs, the New Jersey one serves some children and duals below age 65.

The state’s program offers several benefits that may account for part of its popularity. They include, according to Wood, unlimited days in a nursing facility when warranted, a “comprehensive” dental benefit and zero-dollar copayments on prescriptions at pharmacies. She also points out that New Jersey last July implemented LTSS for Medicaid managed care and intends to roll more of that into the D-SNP initiative “over time.” In 2016, she adds, the duals program will add home and community based services (HCBS).

It is too early to track some outcomes from the New Jersey D-SNP program, Wood suggests, but there have been improvements in the hospital readmission rate after the initial year. There was “a lot of utilization” then in terms of both hospitalizations and emergency department visits, as would be expected in a new program. The first goal of the state, she stresses, is to change the system and “establish baselines,” because that’s necessary before duals can use services in a more effective manner. There are some “negotiated cost savings” with the MCOs, but this is a secondary objective behind health care “transformation” for duals.

The growth and contraction in the state’s duals program has “created a set of difficulties,” acknowledges Carol Grant, chief of managed care at DHS. But she emphasizes that the decisions New Jersey made on the initiative seem to have been the right ones, including the preference for “careful considered growth” over the more rapid growth a passive-enrollment-based program would have entailed.

“We’re just happy we’re still in the market,” she says.

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