November 6, 2012

CMS Approves First Agreement for a Managed-fee-for-service Dual Eligible Demonstration

While each state memorandum of understanding (MOU) will be different, this MOU with the state of Washington provides some insight on what advocates may expect from CMS in future managed-fee-for-service dual eligible demonstration agreements. In particular, this MOU provides new clarity on CMS' expectations for readiness reviews, customer service representatives, evaluation, and the legal authority of the MOU.

On Wednesday, October 24, the state of Washington signed a MOU with the Centers for Medicare and Medicaid Services to establish the first managed fee-for-service (FFS) financial alignment model for Medicare-Medicaid enrollees (dual eligible individuals). This MOU approves only the managed FFS portion of the Washington proposal, which will include dual eligible individuals in much of the state's rural areas. Washington is one of two states that proposed a combined capitated and managed FFS initiative for dual eligible individuals, and a separate MOU for the capitated model is required for that element of the demonstration.

The Washington MOU is centered on the state proposal to better coordinate Medicare and Medicaid benefits through a health home network. As defined by the Washington State Health Care Authority, a health home is the central point for directing patient-centered care, and is responsible for coordinating an individual's primary, acute, behavioral health and long-term services and supports. The state will receive a 90 percent federal match to implement the health home system, and will be eligible to receive a performance payment based on a quality and savings criteria.[1] All dual eligible individuals in participating regions will be enrolled into the demonstration; however, they will not participate in the health home network unless they actively decide to receive health home services.

Below is a summary of the Washington agreement.

The Basics

The demonstration does not change the Medicare and Medicaid services beneficiaries are entitled to receive. Services and care will continue to be provided to beneficiaries on a fee-for-service basis. The demonstration seeks to improve the system by providing beneficiaries with the option to receive health home services.

[1] Affordable Care Act, §1945(c)(1).

The demonstration relies on the State contracting with a Health Home Lead Entity (HHLE) who will subcontract with a Health Home Coordinated Care Organization (HCCO) to coordinate the health home services. Washington has defined seven health home network coverage areas, and it will soon begin to ask for applications for HHLE.[2]

How it works:

- The State enrolls the beneficiary into a qualified Health Home Network (HHN).[3]
- Then, an HHLE [4] assigns the beneficiary to one of the subcontracted HCCOs.[5]
- The HCCO conducts outreach to the beneficiary, and the beneficiary determines if he/she wishes to receive health home services.
- If the beneficiary decides to participate, then he/she must complete a Health Action Plan[6] to begin receiving home health services.
- The Health Home Care Coordinator (coordinator)[7] organizes the beneficiary's services. The services provided by the coordinator will include: comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family supports, referral to community and social support services, and the use of the PRISM tool to improve service coordination and communication.[8]
- Unlike in the managed care plans in the capitated-models pursued by many states, the HHCO is not responsible for providing the actual Medicare and Medicaid services and is not at risk if the cost of services increases. The HHCO is being paid to provide care coordination services that complement the existing fee-for-service system.

[2] Inside Health Policy, "Upcoming Washington State Duals Demo Offers Insight on Managed FFS Model," available at http://www.jdsupra.com/legalnews/upcoming-washington-state-duals-demo-off-64185.
[3] MOU at 6, 30. The HHN is an entity qualified by the state to provide health home services. It includes a broad representation of community-based organizations.
[4] MOU at 6, 30. The HHLE is contracted directly with the State Medicaid agency and is responsible for administrative and oversight functions within a qualified health home.
[5] MOU at 6, 30. The HCCO is subcontracted to the Health Home Lead Entity and provides health home services through a coordinator.
[6] MOU at 15. A Health Action Plan is a: "beneficiary-prioritized plan identifying what the beneficiary plans to do to improve his or her health; at least one beneficiary prioritized goal; the actions the beneficiary is taking to achieve this goal; and the actions of the Health Home Care Coordinators."
[7] MOU at 6, 30. The coordinator is hired by the HCCO and may be a registered nurse, licensed practical nurse, physician's assistant, or a BSW or MSW prepared social worker hired by the coordination organization.
[8] MOU at 5.

Authority

The implementation of the demonstration in each county is contingent upon the State receiving CMS approval for its health home State Plan Amendment in that county.[9]

The MOU does not create any contractual rights between the State and CMS. As stated, "nothing in the MOU may be construed to obligate the parties to any current or future expenditure of resources."[10] The MOU is an agreement between the State and CMS to initiate the demonstration, however, additional details and information will be provided in the Final Demonstration Agreement.[11]

Enrollment

The MOU contains specific information about the enrollment and disenrollment rights of dual eligibles as relates to the demonstration.

With a few exceptions, all dual eligibles who do not reside in the urban counties participating in the capitated model will be passively enrolled into the demonstration on April 1, 2013:

- Dual eligible individuals currently enrolled in PACE, Medicare Advantage, hospice and individuals receiving 1915(b) mental health wavier services will not be enrolled.[12]
- American Indians and Alaska natives will not be passively enrolled; however they may choose to enroll into the health home system at anytime.[13]
- Individuals currently participating in another Medicare shared savings program will not be attributed to the demonstration, unless the shared savings program and the demonstration program launch on the same day, in which case, they will attributed to both.[14]
- While all dual eligible individuals will be passively enrolled, individuals will not begin to receive health home services unless and until they actively elect to receive services by completing a Health Action Plan.[15] If they do not elect to receive services, they will not get the extra benefit of the care coordination provided by the HHCO, but they will otherwise see no change to how they receive their services.

[9] MOU at 40.
[10] MOU at 27.
[11] MOU at 8.
[12] MOU at 10. These individuals may participate in the demonstration if the disenroll from their current program.
[13] MOU at 11.
[14] MOU at 10. Attribution refers to the process CMS will use for attributing the beneficiaries to the demonstration for evaluation and performance payment determinations. It does not impact beneficiary services.
[15] MOU at 6 and 11.

- An individual may change HHCO's within the network, or discontinue the health home services at anytime. If a beneficiary decides to disenroll, the beneficiary has several options for disenrollment, such as the Interactive Voice Recognition System or the Medicaid Assistance Customer Service Center. The HHLE is responsible for providing any assistance the beneficiary may need during the disenrollment process.
- The State originally proposed to begin enrollment on January 1, 2014, however, under the MOU, enrollment will not begin until April 1, 2013.

Outreach and education

The MOU demonstrates careful thought on outreach and education. The State will develop and distribute materials to beneficiaries in advance of their enrollment. The MOU details the state responsibility to create materials that are accessible and understandable to beneficiaries (including provisions for alternative formats and translations into multiple languages), the information that must be contained in notices, and a requirement that CMS approve all materials prior their dissemination.[16]

Customer Service

This MOU clarifies the customer service roles of the State and CMS. In the MOU, CMS expressly commits to equipping its 1-800-MEDICARE call center representatives with information on the demonstration. The State also agrees to train its Medical Assistance Customer Service Centers (MACSC) with information about the demonstration, and designates the MACSC as the entity that will facilitate enrollment and disenrollment from the health home.[17]

Readiness review

In this agreement, CMS requires the State to demonstrate it has capacity and infrastructure necessary to protect beneficiaries before implementing the demonstration. The readiness review will take place *prior to* the signing of the Final Demonstration Agreement, providing the State with the opportunity to identify and fix any gaps in readiness before to enrollment.[18]

Comparison group

For the first time, CMS answered an outstanding question about the demonstration: who will act as the control group when evaluating whether or not the demonstration is working? With this MOU, CMS and the State have agreed that an Evaluation Contractor will use cluster analysis to draw a comparison group of Medicare-Medicaid enrollees from states or regions of states *not participating* in a dual eligible demonstration. The comparison group will be weighted so

[16] MOU at 13-14.
[17] MOU at 20.
[18] MOU at 21.

that the distribution of beneficiary characteristics prior to the start of the demonstration matches Washington's demonstration group.[19]

Financing

The state will have the opportunity to earn a retrospective performance payment for the new care coordination services it will provide to dual eligibles under the demonstration.[20] The amount of that payment will be based on the amount of overall Federal savings the demonstration achieves. Savings will be determined by comparing what was spent on the demonstration population to what would have been spent on the population without the demonstration.[21]

If the savings to the Medicare program exceed an established Medicare Minimum Savings Rate (the rate will vary depending on the size of the enrollment population, but the minimum will be 2%), the state will qualify to earn up to 50% of the net Federal savings.[22] The net Federal savings will be determined by deducting increases in Medicaid costs from decreases in Medicare costs. The amount of savings the state will actually receive will be subject to quality requirements.[23]

With this MOU, CMS has now provided a framework for both the capitated and managed-fee-for-service demonstration models. For more information on other state proposals and updates on forthcoming state agreements, please visit NSCLC's dual eligible website at www.dualsdemoadvocacy.org.

[19] MOU at 42.
[20] MOU at 41.
[21] MOU at 42-44.
[22] MOU at 45-47.
[23] MOU at 47.