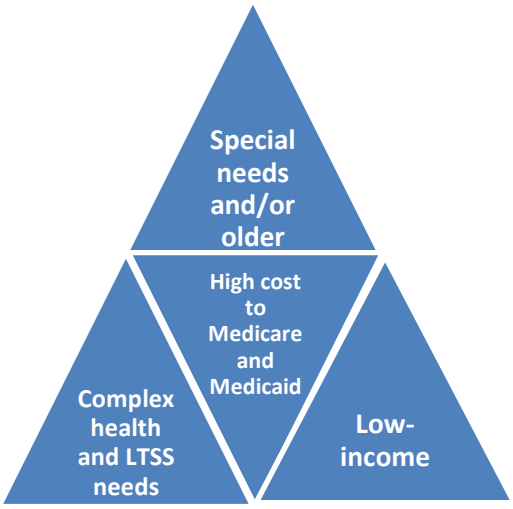
Leadership Council of Aging Organizations

FACT SHEET

OCTOBER 2012

DUAL ELIGIBLE INTEGRATED CARE DEMONSTRATIONS

What are some of the characteristics of the 9 million individuals who receive Medicare and Medicaid (dual eligible individuals)?



Dual eligible individuals are more likely than other Medicare beneficiaries to:

- Be over 85: 14% are at least 85.[1]
- Be disabled: 41% are nonelderly disabled.[2]
- Be a woman of color: racial and ethnic minorities make up 45% of dual-eligible individuals, and women constitute 63% of dual eligible individuals.[3]
- Have a mental or cognitive impairment: 64%.[4]
- Be low-income: 86% have an income level of below 150% of the federal poverty line.[5]
- Have a variety of care needs: 11% of dual eligible individuals have *five or more* chronic conditions, while 38% have one or none.[6]

For these reasons, dual eligible individuals' care is expensive and accounts for 20% of Medicare spending and 30% of Medicaid spending.

The need: Because most dual eligible individuals receive health and long-term services and supports (LTSS) through two payment systems (Medicare and Medicaid) for many, their care is uncoordinated and the system is difficult to navigate.

The Affordable Care Act (ACA): The ACA created the Medicare Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS) to integrate care for dual eligible individuals. It provided broad authority to the Center for Medicare and Medicaid Innovation to pilot new models for financing and delivering care to dual eligible individuals.

The demonstration: In July 2011, MMCO announced a demonstration to eliminate duplication of services, expand access to needed care, and improve the lives of dual eligible individuals, while lowering cost.[7]

What has happened so far?

Spring 2011: CMS released a "State Medicaid Director Letter" offering all states the opportunity to participate in a financial integration demonstration, and awarded 15 states with a $1 million contract to design grant.

2011-2012: 25 states designed a demonstration and submited a plan to CMS for approval.

Summer and Fall 2012: CMS began approving state demonstration plans, starting with Massachusetts in August 2012.

What are the next steps?

- MMCO will review state proposals and comments, and negotiate Memoranda of Understanding (MOU) with participating states.[8]
- Next, in the capitated (managed care) states, MMCO and the state will work together to develop a three-way contract between CMS, the state and the insurance plans who will manage the care.
- CMS and states will conduct a readiness review to test the plans and networks prior to enrollment.
- In some states, enrollment will begin in April 2013.

What states applied to be a part of the demonstration and what do they plan to do?

- 25 states sent CMS a demonstration proposal: AZ, CA, CO, CT, HI, ID, IL IA, MA, MI, MN, MO, NC, NM, NY, OK, OH, OR, RI, SC, TN, TX, VT, VA, WA, and WI.
- 17 states proposed a capitated managed care model, six will use a managed-fee-for-service model, and two will combine managed-fee-for-service and capitation.
- Proposed implementation in 2013: 14 states.
- Proposed implementation in 2014: 11 states.

What did aging advocates, including many LCAO members, advocate for in the state proposals?[9]

- **Choice**: Dual eligible individuals should be able to choose how, where and from whom to receive care.
- **Access**: Dual eligible individuals should have access to all services covered by Medicare and Medicaid, and supplemental benefits to assist individuals living at home and in the community, including culturally and linguistically appropriate access such as American Sign Language.
- **Coordinated Care**: Care should be person-centered, coordinated and continuous, with access to current providers and services and an option to self-direct personal care services.
- **Quality:** Beneficiaries should have access to providers, programs, and plans that have a history of success in serving this population, especially individuals who require LTSS.
- **Consumer protections:** Beneficiaries must be able to change plans, appeal decisions, and file grievances through an accessible and efficient process that maintains due process rights.
- **Cost:** Payment structures should promote delivery of high-quality care and avoid incentives for denial of needed services.
  Oversight and evaluation: Beneficiaries should receive care from plans that are accountable, transparent, and evaluated. Demonstration and control groups should be rigorously evaluated for meaningful comparisons.

What did the states propose that raises concerns for aging advocates?[10]

Each state proposal varied greatly, but some overall concerns include:

- **Size**: MMCO's target enrollment of two million individuals is much larger than a typical demonstration, raising concerns about transitions and ability to evaluate the demonstration.
- **Speed**: The first states could begin enrolling individuals this spring. Significant work still must be done to build provider networks and educate beneficiaries and providers about enrollment.
- **Enrollment**: All states propose passive enrollment which strips the beneficiary of their statutory Medicare right to free choice of providers. Many lack an independent conflict-free enrollment broker.
- **LTSS integration:** Most Medicaid managed care organizations and Medicare Advantage have little experience with managed LTSS.
- **State readiness**: The aggressive timeline raises concerns about state expertise, staff and financial resources necessary to properly implement and oversee the demonstrations.
- **Quality measurement:** The state proposals provide little information on quality, and existing measures do not account for LTSS.
- **Consumer protections:** The proposals miss critical details on key protections, like care continuity and appeals.
- **Oversight and evaluation:** States must involve stakeholders and fund an independent ombudsman.

What should advocates do to ensure low-income older adults and individuals with disabilities continue to receive quality health care and LTSS in the demo?

Stay informed: Read the state proposals[11] and advocate comments[12] to find out what changes may be coming down the road. Contact the LCAO at lcao@ncoa.org with questions about additional resources.

Be involved: At the state level, work with allies to contact the state health agency with concerns and suggestions for the state demonstration. At the federal level, monitor deficit reduction debates for discussion of care for dual eligibles.

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[1] MedPAC: Dual Eligible Beneficiaries, http://1.usa.gov/SFQXNm.
[2] Kaiser Commission on Medicaid and the Uninsured, Medicaid's Role for Low-Income Medicare Beneficiaries, http://bit.ly/QxCVRn.
[3] CMS 2003 Survey, Section 8, Medicare Dually Eligible Population, http://go.cms.gov/OqeUNu.
[4] *Id.*
[5] *Id.*
[6] MedPAC, Coordinating Care for Dual Eligible Beneficiaries, http://1.usa.gov/RE7wwG.
[7] MMCO, State Demonstrations to Integrate Care for Dual Eligibles, http://1.usa.gov/RE7zIO.
[8] After finalized, the MOUs are published on the MMCO website, here: http://go.cms.gov/QU1CDf.
[9] For the complete LCAO Dual Eligible Principles document, please see: http://bit.ly/SKFMn3.
[10] Several national aging and disability advocates detailed their concerns with the demonstration proposals in a letter to MMCO. The letter is available here: http://bit.ly/NBHKEE.
[11] All state proposals are available here: http://bit.ly/QeDIXn .
[12] Advocate comments are available here: http://bit.ly/Px8zyq and here: http://bit.ly/Px8DhC.

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