Integrated benefit programs: The future for dual eligibles

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INTRODUCTION

State and federal spending on dual-eligible beneficiaries, individuals who are eligible for both Medicare and Medicaid, is perhaps higher than any other broad subset of the population. With approximately 9.6 million dual eligibles nationwide[1] and average spending of about $2,500 per month,[2] it is easy to see why there is interest in trying to provide these benefits more efficiently.

Traditionally, the healthcare services that this population needs have been funded in silos. For example, Medicare provides primary acute care benefits and Medicaid covers long-term care benefits. Even within Medicaid, beneficiaries who require long-term care services are typically segmented between the "state plan" that pays for nursing home benefits and waiver plans that pay for home- and community-based support services.

There are a myriad of programs and demonstrations under way across the country to test the theory that coordinating all benefits under a single umbrella will lead to better quality care and lower spending. We believe there will be continued interest among state Medicaid agencies and the federal government in expanding current dual-eligible programs and testing new ideas. This paper focuses on the key features of the existing dual-eligible demonstration programs and provides a glimpse of what the next wave of innovation may look like.

Why the interest in dual eligibles?

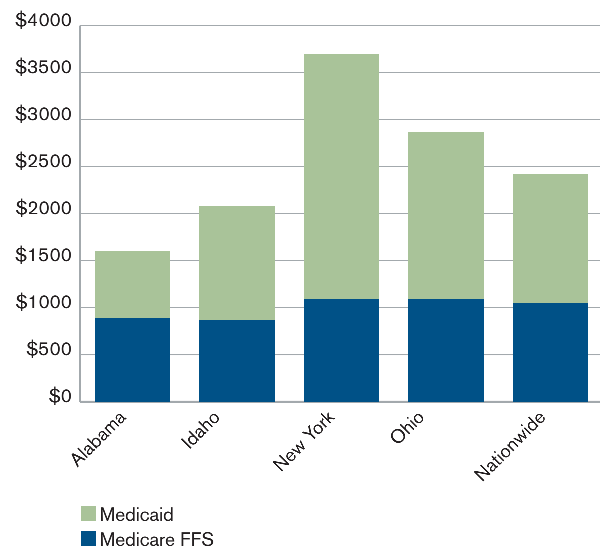
Dual eligibles fall into several general categories of individuals, all of whom meet financial requirements to be eligible for Medicaid and also meet age or disability requirements to be eligible for Medicare. Most dual eligibles fall into one of the following categories:

- Elderly and disabled, with or without long-term care support needs
- People with severe behavioral health needs
- People with intellectual or developmental disabilities
- People who have certain diseases, such as hepatitis C virus (HCV), human immunodeficiency virus (HIV), or hemophilia

While some dual eligibles may suffer from multiple chronic conditions and severe illnesses, many are relatively healthy but, because of advanced age or disability, require assistance in performing activities of daily living (ADLs). These people often need nursing home care or additional skilled and non-skilled support services to continue to live in their homes. Other dual eligibles are both healthy and free from ADL limitations.

The chart in Figure 1 shows average Medicare (Parts A and B) and Medicaid spending on a per member per month (PMPM) basis for a sample of states across the country.

FIGURE 1: SPENDING PER DUAL-ELIGIBLE BENEFICIARY ($ PMPM)



Sources:

(1) Medicaid: Kaiser Family Foundation FY 2010. Medicaid Spending per Dual Eligible per Year. State Health Facts. Retrieved May 20, 2015, from http://kff.org/medicaid/state-indicator/spending-per-dual-eligible/.

(2) Medicare: Authors' analysis of Medicare 5% Sample Dataset CY 2012.

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1 Kaiser Family Foundation. Number of Dual Eligible Beneficiaries (as of FY 2010). State Health Facts. Retrieved May 20, 2015, from http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries/.

2 Authors' analysis of Medicaid data summaries as reported by Kaiser Family Foundation for FY 2010 and Medicare 5% Sample Dataset for CY 2012.

Current landscape of dual eligible programs

Although the concept of integrating Medicare and Medicaid benefits dates back to the early 1970s, the first generation of programs, called Programs for All-Inclusive Care for the Elderly (PACE), did not come about until the 1990s. Current enrollment has reached only about 34,000.[3] Many of the newer programs seek to provide integration for many more people.

The next generation of managed care programs for dual eligibles was created by pasting together a Medicaid managed care program, with or without long-term care benefits, and a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP). Approximately 1.7 million dual eligibles are enrolled in D-SNPs nationwide.[4] This combination of benefit plans has the result of covering all or most of the benefits that beneficiaries require, but they are not always integrated. In some cases, beneficiaries sign up with one carrier for their managed Medicaid program and another for their Medicare D-SNP.

Another limitation of this approach is that the Centers for Medicare and Medicaid Services (CMS) does not mandate enrollment in D-SNPs. Beneficiaries have the choice of staying in the unmanaged Medicare fee-for-service (FFS) program. The voluntary nature of D-SNPs and the unavailability of these plans in many parts of the country have prevented widespread enrollment. The Medicare-Medicaid dual demonstrations have attempted to solve these limitations.

Key features of Medicare-Medicaid dual demonstrations

There have been multiple opportunities in recent years for states wishing to implement payment and service delivery reforms that affect their Medicare-Medicaid dual eligible populations. This wave of demonstration programs attempts to better integrate the benefits provided by Medicare and Medicaid by eliminating the possibility that beneficiaries can sign up for two different carriers. Organizations participating in the demonstrations still receive separate funding from Medicare and Medicaid but all benefits are managed under one roof. The success of these programs in reducing costs and enrolling large numbers of beneficiaries is still unknown.

The most prominent of these programs are described below.

- The primary aim of the **Financial Alignment Initiative** is to align financial incentives across Medicare and Medicaid for dual-eligible beneficiaries. Through this initiative, CMS is testing two models (a capitated model and a managed fee-for-service model).[5] The initiative is run through the Medicare-Medicaid Coordination Office (MMCO). There are currently 12 states participating in the initiative;[6] CMS is not currently accepting new applicants to the Financial Alignment Initiative.[7]

- The two rounds of the **State Innovation Models (SIM) initiatives** have resulted in an investment of nearly $1 billion by the Center for Medicare and Medicaid Innovation (CMMI).[8] These SIM awards are focused on comprehensive state-based innovation in healthcare payment or delivery system transformation, which could affect Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries as well as other residents of participating states. There are 38 total awardees (including 34 states, three territories, and Washington, D.C.), with the most recent set of awards made on December 16, 2014.[9]

Neither of these programs was required by federal legislation; rather, both were developed under the discretionary authority of their respective offices, both newly created by the Patient Protection and Affordable Care Act. Neither is currently accepting applications.

CMS guidance on current dual demonstrations

We can look to prior guidance from CMS concerning demonstration programs for dual eligibles to anticipate some of the likely features of future programs.

Through its 2011 solicitation for entrants to the Financial Alignment Initiative, CMS provided both implicit and explicit guidance on several factors that it values in a Medicare-Medicaid integration demonstration.[10] In January 2012 and April 2013, CMS issued public guidance to states working on developing managed FFS models under the Financial Alignment Initiative.

3 National PACE Association (January 2015). PACE in the States. Retrieved May 20, 2015, from http://www.npaonline.org/website/download.asp?id=1741&title=PACE_in_the_States.

4 Centers for Medicare and Medicaid Services (April 2015). SNP Comprehensive Report. Retrieved May 20, 2015, from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2015-04.html?DLPage=1&DLSort=1&DLSortDir=descending.

5 Centers for Medicare and Medicaid Services (May 14, 2015). Financial Alignment Initiative. Medicare-Medicaid Coordination. Retrieved May 20, 2015, from http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

6 Nine capitated models (Calif., Ill., Mass., Mich., N.Y., Ohio, S.C., Texas, and Va.), two FFS models (Colo. and Wash.), and one administrative alignment model (Minn). See http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html.

7 Conversation with CMS representative of MMCO, December 30, 2014.

8 Centers for Medicare and Medicaid Services. State Innovation Models Initiative: General Information. Innovation Center. Retrieved May 20, 2015, from http://innovation.cms.gov/initiatives/State-Innovations/.

9 Centers for Medicare and Medicaid Services. State Innovation Models Initiative: Round Two. Innovation Center. Retrieved May 20, 2015, from http://innovation.cms.gov/initiatives/State-Innovations-Round-Two/index.html.

10 Centers for Medicare and Medicaid Services (September 19, 2014). State Proposals. Medicare-Medicaid Innovation. Retrieved May 20, 2015, from http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/StateProposals.html.

FIGURE 2: CMS GUIDANCE ON DUAL DEMONSTRATIONS

Integration of benefits	The proposed model ensures all necessary services covered by Medicare and Medicaid are provided and coordinated.
Care model	Mechanisms for person-centered coordination of care and improvement of care transitions are provided for by the proposed model.
Stakeholder engagement	State can demonstrate that there has been ongoing interaction with key stakeholders throughout model development, and that input has been incorporated into the proposal from this interaction.
Beneficiary protections	Protections have been identified ensuring that beneficiaries would have access to high-quality health and support services, and that their health and safety is of the highest priority.
State capacity	State can demonstrate that it has or can establish the infrastructure necessary to implement the proposed model.
Network adequacy	State can ensure adequate access to medical and supportive service providers.
Measurement/reporting	State has systems in place to oversee program and ensure continuous quality improvement.
Data	State agrees to collect data and provide it to CMS to inform rate development and evaluation.
Enrollment	State has enrollment targets, as well as strategies for conducting beneficiary education and outreach.
Expected savings	State has financial modeling demonstrating that the model will achieve meaningful savings while maintaining or improving quality.
Public notice	State has provided at least a 30-day public notice and comment period, at least two public meetings prior to submission, and (if needed) appropriate tribunal consultation for any new requirements or changes to existing Medicaid waivers, state plan amendments, or demonstration proposals.
Implementation	State has demonstrated that it is able to do the following prior to implementation: ▪ Continue meaningful stakeholder engagement ▪ Submit and approve any necessary Medicaid waiver applications and/or state plan amendments ▪ Receive any necessary state legislative or budget authority ▪ Establish joint procurement process (for capitated models) ▪ Establish beneficiary outreach process

The January 2012 guidance issued by CMS outlined standards and conditions that CMS viewed as prerequisites towards demonstration approval.[11] These are outlined in the table in Figure 2.

The April 2013 guidance was more specific toward managed FFS-style demonstration programs. It established the following key principles that would govern the managed FFS model from the perspective of CMS:[12]

- State opportunity to benefit from Medicare savings
- Achieving performance goals
  - Even in the presence of statistically significant savings, states are only eligible to receive a payment under the managed FFS model if they meet or exceed established quality thresholds for the Medicare-Medicaid enrollees in the program.
- Statistically significant savings
- Use of well-crafted comparison groups
- Limiting risk for participating states
- Consideration of all federal spending

11 Centers for Medicare and Medicaid Services. Medicare-Medicaid Financial Alignment Demonstration – Standards & Conditions. Retrieved May 20, 2015, from http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FADemonstrationsStandardsandConditionswithCoverPage.pdf.

12 U.S. Department of Health and Human Services (April 17, 2013). MFFS guidance letter. Retrieved May 20, 2015, from http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMCO_MFFS_Guidance_4_17_13.pdf.

The final point is particularly relevant given the complex cost-sharing arrangements that are currently funding many state Medicaid programs. Specifically, the document states the following:

> *In order to receive a performance payment, States must demonstrate a reduction in overall Federal spending on Medicare-Medicaid enrollees. Accordingly, increases in Federal Medicaid spending will be deducted before States receive a performance payment based on Medicare savings. Each demonstration will include a Medicaid significance factor against which Medicaid increases will be measured to reduce the likelihood of attributing cost increases to the demonstration that are simply the result of chance or random variation.*[13]

Understanding the interplay between state and federal Medicaid funding in savings calculations for a dual eligible program will be key to developing an acceptable application for one of these alternate payment arrangements.

Future directions

CMS has indicated that it is willing to turn demonstrations and programs into policy. For example, the Bundled Payment for Care Improvement Initiative may be adopted as Medicare's standard fee-for-service methodology for relevant clinical conditions, and was included in the 2015 Hospital Inpatient Prospective Payment System proposed rule.[14] However, the implementation and evidence from the current Medicare-Medicaid dual eligible demonstrations have been slow to emerge, so we believe CMS is likely to explore additional demonstrations before adopting a wholesale shift in direction.

In addition to the features that have been important in the existing dual demonstrations listed above, we believe the following themes are likely to be an integral part of future programs:

- Alternative provider payment methodologies
- Interdisciplinary teams of primary care providers, behavioral health providers, and long-term care providers (both nursing home and community-based)
- Quality and performance standards
- Involvement of accountable care organizations (ACOs)

To date, CMS has established two large ACO programs—the Medicare Shared Savings Program and the Pioneer ACO Model—but these include Medicare benefits only. CMS has also recently implemented patient attribution on a universal scale through its Medicare Spending per Beneficiary program, where hospitals will see their reimbursements reduced if the spending for the lives attributed to the hospital (including nonhospital spending) is above benchmarks.

At a recent presentation to the Emergency Care Research Institute, Dr. Patrick Conway of CMMI presented a draft Integrated ACO Model that would test the concept of an ACO-based approach for dual eligible beneficiaries, similar to the Pioneer or Medicare Shared Savings approaches. This demonstration appears to be in the early stages of development, and we expect there will be significant interest among states and provider groups.

Because of the expense and opportunity for improvement, we expect additional programs and changes in coming years.

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13 *Federal Register* (April 30, 2015). Proposed Rule: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program. Retrieved May 20, 2015, from http://federalregister.gov/a/2015-09245.

14 Centers for Medicare and Medicaid Services (November 6, 2014). CMS Innovation Center – Improving Care for Complex Patients. ECRI Institute. Retrieved May 20, 2015, from https://www.ecri.org/Resources/Conference/3_Conway.pdf.

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