



VALUE-BASED PURCHASING SNAPSHOT || NOVEMBER 2016

Integrated Accountable Care Organizations for Dually Eligible Individuals

Federal and state policymakers share a common goal of reducing fragmentation and improving health outcomes for individuals covered by both Medicare and Medicaid. These individuals are some of the highest need and most complex populations served by both programs. Efforts to date to improve care coordination across payers include the CMS Financial Alignment Demonstrations and the Program for All-Inclusive Care for the Elderly (PACE). In addition to existing models, there is a growing state interest in the potential for an integrated Medicare/Medicaid accountable care organization (ACO) model to drive coordinated care for dually eligible individuals. ACOs are a delivery construct where a group of providers voluntarily come together to care for a defined group of beneficiaries, and share in the savings achieved by coordinating care and improving health outcomes for the population (or share in risk for not effectively doing so).

This resource explores the concept of an integrated ACO model for dually eligible individuals and outlines issues federal policymakers would need to keep in mind in the design of such an approach. The National Association of Medicaid Directors (NAMD) partnered with states to examine this issue and identified five specific considerations for federal policymakers in the design of an ACO model for dually eligible beneficiaries:

1. The importance of state partnership in the design and implementation of an integrated ACO for dually eligible beneficiaries;
2. The availability of close-to-real-time, person-level integrated Medicare and Medicaid data;
3. The alignment of quality measures and measure reporting strategies between Medicare and Medicaid;
4. The clinical and demographic heterogeneity of the dually eligible population and model targeting;
5. The need for state staffing capacity and infrastructure to implement and oversee a duals ACO program.

This resource was developed through NAMD’s Sentinel States Project, which is being supported by The Commonwealth Fund. The Sentinel States Project seeks to enhance federal and state engagement around value-based purchasing and provide timely information to policymakers on state-led payment reforms.

Background

Individuals who are dually eligible for Medicare and Medicaid represent some of the most complex and costly beneficiaries covered by either payer. The dually eligible population consists of those who are Medicare eligible based on either age or disability and Medicaid eligible because of income. As a result, the population is very diverse in terms of demographics, functional status, and health care needs.¹ In 2013, more than 10.7 million individuals were dually eligible for both programs.² In addition, 2011 data showed that these individuals represented 14 percent of all Medicaid participants but accounted for 33 percent of program spending.³

Historically, there has been little or no coordination of benefits and services provided by the respective programs for these beneficiaries, and limited ability for Medicaid or Medicare to share in cost savings delivered to the other program through increased efficiencies. This has led to duplication of services (i.e., assessments and coordination activities) and a lack of holistic care coordination that looks across all services and supports for dual eligible beneficiaries. The consequence of this fragmentation and duplication is poor health outcomes and quality of life for this unique population.

Recognizing the opportunity to improve the integration of care and increase efficiencies, state Medicaid programs and federal policymakers have implemented a variety of strategies in the last few years to address this fragmentation (Table 1).⁴

¹ MEDPAC. <http://www.medpac.gov/documents/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf>.

² Centers for Medicare and Medicaid Services. “Medicare-Medicaid Coordination Office Fiscal Year 2015 Report to Congress.” March 2016. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2015_RTC.pdf

³ MEDPAC and MACPAC. “Beneficiaries Dually Eligible for Medicare and Medicaid.” January 2016. <https://www.macpac.gov/wp-content/uploads/2015/01/Dually-Eligible-Beneficiaries-DataBook.pdf>.

⁴ MaryBeth Musumeci. Kaiser Family Foundation. “Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS.” Dec. 7, 2015. <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.

Table 1: Key Integration Models for Dual Eligible Individuals		
	Demonstration (Yes/No)	Description
Financial Alignment Demonstrations	Yes	<p>Thirteen states are testing one of three integration approaches in this demonstration. These approaches include:</p> <ul style="list-style-type: none"> • A capitated financial alignment model, where a single managed care plan enters in to a 3-way contract and receives a capitation payment from CMS for Medicare services and a capitation payment from the state for Medicaid services; • A managed fee-for-service approach where payment is made by CMS and states on a fee-for-service basis and states can share in Medicare savings; and • An administrative alignment approach.⁵
Medicare Advantage Special Needs Plans for Dually Eligible Beneficiaries (D-SNPs)	No	<p>Some states are seeking to achieve alignment through D-SNPs that result in financial, administrative and beneficiary/consumer experience improvements. D-SNPs are managed care plans that specialize in serving individuals who are eligible for both programs. In contrast to the Financial Alignment Demonstrations, the state Medicaid agency and CMS contract separately with D-SNPs, and D-SNPs cannot operate in a state without such an agreement in place with the state (as required under the Medicare Improvements for Patients and Providers Act (MIPPA)). This MIPPA agreement has provided a vehicle for states to drive alignment and desired coordination for individuals served by D-SNPs.⁶</p>
Program for All-Inclusive Care for the Elderly (PACE)	No	<p>PACE serves older individuals who are dually eligible for Medicaid and Medicare and require a nursing home level of care. PACE sites serve a relatively small segment of the population, but provide an array of services for these beneficiaries and receive integrated financing from both Medicare and Medicaid.</p>

⁵ Medicare-Medicaid Coordination Office. “Financial Alignment Initiative.” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>; Medicare-Medicaid Coordination Office. “Approved Demonstrations - Signed MOUs.” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>.

⁶ Booz Allen Hamilton. “State Options for Designing Dual SNP Contracts with Medicare Advantage Organizations that Adhere to MIPPA Requirements.” Dec. 2, 2009. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/MIPPA_State_Contracting_Options_010410.pdf.

While states desire to build these existing models, there is also interest in additional alternative approaches, especially in health care markets that lack robust MCO penetration or where the state Medicaid program is pursuing a different delivery model. In some cases, states are interested in the use of ACOs for this population. A state could contract with such a “duals ACO” either directly, or through a Medicaid Managed Care Organization. The Centers for Medicare and Medicaid Services defines an ACO as:

*Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their [...] patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves.⁷*

Similarly, the entity may share in financial risk if the expected total cost of care for the population is exceeded. Because this model requires the providers to take on responsibility for care they deliver, plus consider the costs of hospitalizations, post-acute care, specialty services and other costs, it often results in a focus on prevention and care coordination.⁸

While more than half a dozen states have created or are designing Medicaid ACO models in their programs, only a few states have included either elderly or disabled dually eligible individuals in their ACOs to date

(See Table 2). States continue to explore if and how they may include dually eligible individuals in existing or new Medicaid ACOs.¹⁰ At the same time, Medicaid Directors recognize the opportunity that may exist to improve care for dually eligible individuals through an integrated Medicare and Medicaid ACO

Table 2: Examples of Medicaid ACO Models that Include Dually Eligible Individuals⁹	
State	Medicare Included in Total Cost of Care Calculation
Colorado	Yes
Maine	No
Oregon	No

model for this population. Such an effort would require significant federal/state collaboration and would need to navigate many complex considerations for this unique population.

⁷ “Accountable Care Organizations (ACO).” Centers for Medicare and Medicaid Services. Jan. 6, 2015.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/Aco>.

⁸ Bailit Health Purchasing, National Association of Medicaid Directors. “The Role of State Medicaid Programs in Improving the Value of the Health Care System.” March 22, 2016. http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf.

⁹ Rob Huston and Michelle Herman Soper. Center for Health Care Strategies. “Exploring the Feasibility of Including Medicare-Medicaid Enrollees in Medicaid Accountable Care Organizations.” April 2015. <http://www.chcs.org/media/Dually-Eligible-Individuals-in-ACOs1.pdf>.

¹⁰ Ibid.

Considerations for an Integrated Duals ACO

The following sections explore five considerations state and federal policymakers should address in the design of an integrated Medicaid-Medicare ACO model. States have identified these issues as critical to the success of this type of model and its ability to account for state Medicaid landscapes and marketplaces.

1. The Importance of State Partnership in the Design and Implementation of an Integrated ACO for Dually Eligible Beneficiaries

Medicaid programs differ from one another due to variation in political culture, budget parameters, administrative infrastructures, stakeholders, provider capacity, and a host of other factors. A federal/state partnership around an integrated ACO model for duals is essential to ensure that the model is flexible enough to account for these fundamental state-to-state differences. For example, state Medicaid leaders may wish to deploy an integrated ACO model in either or both of their fee-for-service or capitated managed care delivery structures. This is important, given that Medicaid programs are increasingly leveraging capitated managed care for complex populations like duals.

Federal/state partnership in the design and implementation of such a model is necessary to ensure the financial incentives of the model are appropriately aligned for both Medicare and state Medicaid programs. The financial structure needs to ensure efficiencies achieved are realized by both payers, as well as providing adequate incentive to providers to develop the infrastructure required for a successful ACO. For example, a successful financial model would allow both Medicare and Medicaid to realize the financial benefit of Medicaid investing in LTSS and behavioral health in the ACO, which will reduce hospitalizations and emergency department visits financed by Medicare.

2. Medicaid and Medicare Data Availability

One of the most critical elements of an ACO model is the ability for the payers and participating providers to access and leverage timely data on the services delivered to participating beneficiaries. Payers use this data to establish the total cost of care calculation for beneficiaries and to operationalize payment to ACO entities. Likewise, provider entities rely on the utilization and quality data to see the complete picture of care, respond to beneficiary needs, and target their interventions. Given the importance of data to the success of ACOs, Medicare and Medicaid data availability would need to be a key area of focus in the design and implementation of an integrated Medicare-Medicaid ACO model.

For dually eligible individuals, utilization data is generated both by the state and by CMS and not integrated at the beneficiary level, which has created challenges in creating new models of care for this population. A number of states have begun to address this issue through strategies to improve Medicaid data quality and by building tools to make data available to providers and

MCOs participating in innovative models. This work has required a significant investment of time and resources, which in some cases has been supported by the Center for Medicare and Medicaid Innovation’s State Innovation Models grants.

Some states are also partnering with federal policymakers to integrate Medicare utilization data for dually eligible populations. This data analytic work across payers is critical to the success of an integrated Medicaid-Medicare ACO model, but is extremely complex. In recent years, for example, CMS has engaged with states to make Medicare utilization data available to states through CMS’s Innovation Accelerator Program and the Integrated Care Resource Center. These activities are beginning to address the limited access that state Medicaid programs have historically had to close-to-real-time Medicare utilization data. While progress has begun, opportunities remain to spread successes.

Given the importance of Medicare data to an integrated ACO, policymakers should consider ways to spread existing success and address outstanding concerns in the design of an integrated Medicare-Medicaid ACO. For example, CMS could provide model participants with:

- Ongoing support to help access Medicare data;
- Financial resources to enhance state data analytic tools;
- Assistance for integrating and linking Medicaid and Medicare data; and
- Dedicated expertise to assist states with interpreting Medicare data.

Building on, improving and streamlining existing Medicare and Medicaid data analytic efforts will be essential to support an ACO model that functions across programs.

3. Quality Measure Alignment

Another foundational component of ACOs is the performance measurement that assesses the extent to which the provider entity is improving quality and reducing costs. ACOs typically have a wider array of quality measures associated them than do other alternative payment models, largely because the payment model is focused on the total health of a population.¹¹

Given the large number of measures used in ACOs, as well as the other measure reporting requirements placed on providers, state Medicaid programs emphasize that Medicare and Medicaid need to align quality measures in any ACO model for dually eligible individuals. There is currently a lack of alignment in the quality measures on which providers are being asked to report – both across Medicaid-related programs such as Meaningful Use and Federally Qualified Health Center measures, and between Medicaid programs and those of other payers. For example, CMS recently published seven core measure sets designed to support multi-payer value-based purchasing efforts, like ACOs. However, these are minimally aligned with the

¹¹ Baillit Health Purchasing, National Association of Medicaid Directors. “The Role of State Medicaid Programs in Improving the Value of the Health Care System.” March 22, 2016. http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Baillit-Health_Value-Based-Purchasing-in-Medicaid.pdf.

Adult and Child Core Sets that are in use in national voluntary reporting on the Medicaid program.¹²

To operationalize an integrated Medicare-Medicaid ACO model, there needs to be deliberate alignment of quality measures and not just the use of similar measures. Providers are asking state Medicaid leaders for such alignment in order to serve dually eligible individuals in this construct. This type of alignment can be achieved through close collaboration between state and federal policymakers around the objectives and design of an ACO model.

4. Heterogeneity of Dually Eligible Individuals and Model Targeting

The dual eligible population is a very diverse population with significant variation in demographics, health needs, settings of care, and functional status. Those who are dually eligible may qualify for the programs on the basis of either age or disability, and the population is split almost evenly between these two groups.¹³ There are also major differences in the functional status of the disabled and non-disabled dually eligible populations. In 2012, 38 percent of dually eligible beneficiaries had no limitations in their activities of daily living, while 35 percent had limitations in 3-6 activities of daily living.¹⁴ The need to effectively address the clinical needs of such a heterogeneous population is a critical consideration when designing any delivery system or payment reform for this population, including ACO models. Likewise, states need flexibility to target the model to sub-populations of duals in response to stakeholder feedback and other delivery system considerations.

In the financial alignment demonstrations, states have navigated the heterogeneity of the population by targeting their demonstrations to various segments of dually eligible individuals. For instance, South Carolina's demonstration includes dually eligible individuals age 65 and older who are residing in the community. Massachusetts, on the other hand, has tailored its demonstration to non-elderly duals, while New York is focused on individuals with developmental disabilities requiring a certain level of care.¹⁵

Likewise, an integrated ACO approach would need to reflect the diversity of individuals who are dually eligible for Medicare and Medicaid. The model cannot be a one-sized-fits-all approach to this population, which has a variety of health care needs that require distinct service delivery structures.

¹² National Association of Medicaid Directors. "Value-based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment." June 2016. http://medicaiddirectors.org/wp-content/uploads/2016/06/FINAL-ISSUE-BRIEF_Medicaid-VBP-and-MultiPayer-Alignment.pdf.

¹³ In 2010, 48 percent of dually eligible individuals qualified for Medicare on the basis of age, while 51 percent qualified on the basis of disability. MACPAC and MEDPAC. "Beneficiaries Dually Eligible for Medicare and Medicaid." January 2015. https://www.macpac.gov/wp-content/uploads/2015/01/Duals_DataBook_2015-01.pdf.

¹⁴ Ibid.

¹⁵ MaryBeth Musumeci. Kaiser Family Foundation. "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS." Dec. 7, 2015. <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>.

States should be able to work with CMS to target an ACO to a subset of the dually eligible population, including on the basis of age or disability; on a risk-stratification; or based on setting of care. Similarly, states need flexibility to target a duals ACO model to reflect stakeholder input, geographic features, and gaps in existing integration efforts for duals. Partnership with states – and incorporating lessons learned from the financial alignment demonstrations and Medicaid-only ACO efforts to date – could inform this calculus.

5. State Operational Needs

States often confront operational challenges when designing and deploying payment and delivery system reforms in Medicaid. While these issues are not unique to innovations for dual eligible beneficiaries, they are nevertheless pivotal to the success of this work. Federal policymakers should consider ways to address these operational needs in the design of any duals ACO model, including challenges with staff capacity and gaps in data analytic tools and IT systems.

- **Staff capacity.** Medicaid Directors need the appropriate type and number of staff to meet the demands of payment and delivery system reform.¹⁶ As they drive multiple reforms, states are faced with a dilemma of using limited staff resources to both sustain current Medicaid operations and drive new payment reform efforts, causing a significant strain on existing staff resources.¹⁷ When considering an ACO approach, states have identified the need for staff to oversee contracts with the ACOs, as well as be the dedicated project manager and integration lead. To support states in taking up this type of model, it should provide sufficient financial resources for states to bring on new staff, retrain existing staff, or contract with outside experts.
- **Federal point of contact.** A Medicare-Medicaid ACO model would benefit from a single point of contact at CMS which could serve as a single place for states to address complex issues in collaboration with CMS. This will ease the administrative burden on states and facilitate the operationalization of the model.
- **Data analytic platforms and IT system capacities.** Another operational gap in state payment and delivery system reforms is the data analytic platforms and IT system capabilities to support these models. State Medicaid programs need to be able to share timely and accurate data with providers in order to effectively administer ACOs, which becomes more complex when incorporating Medicare data (see above). Some states point to the need for an integrated data solution that could better support an integrated ACO model for duals. CMS should engage with states to further explore the feasibility of this type of data analytic solution.

¹⁶ National Association of Medicaid Directors. “State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors.” November 2016. http://medicaiddirectors.org/wp-content/uploads/2015/11/namd_4th_annual_operations_survey_report_-_november_2_2015.pdf.

¹⁷ National Association of Medicaid Directors. “Value-based Purchasing in Medicare and Medicaid: Areas of Intersection and Opportunities for Future Alignment.” June 2016. http://medicaiddirectors.org/wp-content/uploads/2016/06/FINAL-ISSUE-BRIEF_Medicaid-VBP-and-MultiPayer-Alignment.pdf.

Conclusion

While there are many issues to consider around the design of an integrated Medicare-Medicaid ACO model, this type of model could provide states with another pathway to improve beneficiary experience and outcomes for dually eligible individuals. **It is important to note that this approach will not be appropriate for all states, given unique differences in state marketplaces and provider landscapes. However, it would add to the menu of innovative models states could build on.** It would also leverage a delivery and payment construct (the ACO) that is in use both across Medicaid and Medicare programs to date and is showing early signs of success. Further, it may facilitate provider participation in multiple ACO initiatives, including Medicare ACO models and a duals ACO initiative. Though the delivery models would differ, provider entities may be able to leverage clinical integration tools and their network across models.

Ultimately, if an integrated ACO is added to the menu of innovations for duals, federal policymakers should be mindful of the key considerations raised in this issue brief. These include: state partnership in the model development/implementation; the need for integrated Medicare and Medicaid data; the alignment of quality measures and measure reporting strategies across payers; the heterogeneity of the dually eligible population and the need for options to target the model; and the need for state infrastructure to implement this type of model. Much of the learning from the financial alignment demonstrations, other existing innovations for duals and Medicaid-led ACOs can provide critical insight into these factors, and serve as a starting place to inform the design of an integrated Medicare-Medicaid ACO model.