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 and average spending of about $2,500 per month, 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.

Sources:


2 Authors’ analysis of Medicaid data summaries as reported by Kaiser Family Foundation for FY 2010 and Medicare 5% Sample Dataset for CY 2012.
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). The initiative is run through the Medicare-Medicaid Coordination Office (MMCO). There are currently 12 states participating in the initiative; CMS is not currently accepting new applicants to the Financial Alignment Initiative.

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). 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.

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. In January 2012 and April 2013, CMS issued public guidance to states working on developing managed FFS models under the Financial Alignment Initiative.

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


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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:

- State opportunity to benefit from Medicare savings

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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.*

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. 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.

Melissa Fredericks, FSA, MAAA, is a consulting actuary with the New York office of Milliman. Contact her at melissa.fredericks@milliman.com.

Pamela Pelizzari, MPH, is a healthcare consultant with the New York office of Milliman. Contact her at pamela.pelizzari@milliman.com.

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