

# Exploring the Feasibility of Including Medicare-Medicaid Enrollees in Medicaid Accountable Care Organizations

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## IN BRIEF

As states explore new ways to integrate care for Medicare-Medicaid enrollees, Medicaid accountable care organizations (ACOs) are emerging as a potential approach. This brief, made possible through The Commonwealth Fund, explores the feasibility of incorporating Medicare-Medicaid enrollees in Medicaid ACOs and reviews early state experiences. It offers three key takeaways:

1. To effectively provide services for dually eligible enrollees, ACO programs must operate across Medicare and Medicaid programs. Enrolling Medicare-Medicaid enrollees in Medicaid-only ACOs is unlikely to generate a positive return on investment for states or ACOs or improve care fragmentation across programs.
2. Multi-payer ACOs may offer the best opportunity to generate a return on investment and improve care for Medicare-Medicaid enrollees.
3. When deciding whether to include Medicare-Medicaid enrollees in Medicaid ACO programs, states must weigh the feasibility and potential benefits against potential costs and complexities.

States and the federal government are aggressively pursuing new approaches to improve alignment and coordination between Medicare and Medicaid for individuals who are dually eligible. Coordinating care across two separate publicly financed programs is complicated because Medicare-Medicaid enrollees often have multiple chronic conditions, poor health status, and rely on many different providers to manage their care. This exacerbates the administrative complexity inherent in integrating two major health care programs. By creating financial incentives for providers to coordinate care across multiple services and provide high-quality care, Medicaid accountable care organization (ACO) models may provide an appealing opportunity for states to improve outcomes and reduce expenditures for dually eligible beneficiaries. However, successfully including Medicare-Medicaid enrollees in Medicaid ACO programs requires states to address several complex challenges, especially if these ACOs only include Medicaid services.

As part of The Commonwealth Fund-sponsored *Medicaid ACO Learning Collaborative*, representatives from eight states that established or are actively pursuing Medicaid ACO programs – **Colorado, Maine, Massachusetts, Minnesota, New York, Oregon, Vermont,** and

**Washington** – explored the feasibility and value of including Medicare-Medicaid enrollees in Medicaid ACO programs. This brief describes the challenges identified with incorporating Medicare-Medicaid enrollees in Medicaid ACO programs, reviews state considerations of these barriers, and presents emerging thinking on the potential of using this model for achieving better care for Medicare-Medicaid enrollees at lower costs.

## Background on Medicare-Medicaid Enrollees

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Nearly 10 million individuals in the United States are dually eligible for Medicare and Medicaid. As a group, Medicare-Medicaid enrollees are a high-need, high-cost population and account for a disproportionate share of spending in both programs. Almost 60 percent of Medicare-Medicaid enrollees are age 65 and over, while about 40 percent are under age 65 and usually qualify for Medicare and Medicaid due to a disability.<sup>1</sup> These individuals receive Medicare acute and primary health care services and prescription drugs, while Medicaid covers additional benefits such as long-term services and supports (LTSS), specialized behavioral health care, and other community-based services. Medicaid also covers Medicare premiums and other cost-sharing for Medicare services. The majority (68 percent) of Medicaid beneficiaries requiring LTSS are dually enrolled in Medicare and Medicaid, and Medicare-Medicaid enrollees account for three-quarters of Medicaid spending on LTSS.<sup>2</sup>

Most Medicare-Medicaid enrollees and their providers face challenges in navigating the two programs under their current, largely separate, configurations. These include: (a) uncoordinated and fragmented services; (b) separate policies regarding provider reimbursement, beneficiary protections, benefits, and enrollment; and (c) conflicting financial incentives. These are precisely the kinds of challenges that new federal demonstrations to integrate Medicare and Medicaid are trying to address.<sup>3</sup>

## Background on Medicaid ACOs

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ACO models are becoming increasingly prevalent in Medicaid programs, and are designed to deliver better care for Medicaid beneficiaries at lower costs through improved care coordination at the provider level across the continuum of health services. Thus far, Colorado, Illinois, Iowa, Maine, Minnesota, Oregon, Utah, and Vermont have launched Medicaid ACO programs, with New Jersey slated to begin its program in spring 2015.<sup>4</sup>

ACO programs typically feature: (a) a value-based purchasing payment arrangement (such as a shared savings arrangement or global payment); (b) a robust set of quality performance metrics tied to payment; and (c) efficient exchange of patient information through electronic health records (EHRs) facilitated by a robust health information technology (HIT) infrastructure. Many Medicaid ACO programs use the Medicare Shared Savings Program (MSSP) methodology as a foundation, and have modified aspects of the program's payment, quality, and governance structures to better accommodate Medicaid beneficiary and state program characteristics.<sup>5</sup> In particular, Medicaid ACO programs have expanded the scope of services provided to Medicaid beneficiaries to include behavioral health and LTSS. Four states – Maine, Minnesota, Oregon, and Vermont – include or plan to include behavioral health services in their total cost of care

calculations and/or will require behavioral health quality metrics. Oregon includes very limited LTSS, and incorporating LTSS is left to the ACO's discretion in Maine. In Colorado, Regional Care Collaborative Organizations (RCCOs) are required to coordinate, and be accountable for certain outcomes that cut across, medical, LTSS, and behavioral health services for Medicare-Medicaid enrollees.

To date, only Colorado, Maine, and Oregon have enrolled dually eligible enrollees in Medicaid ACO models. Colorado expanded its Medicaid-only Accountable Care Collaborative (ACC) to serve Medicare-Medicaid enrollees through its managed fee-for-service financial alignment demonstration, referred to as the ACC: Medicare-Medicaid Program. Oregon allows Medicare-Medicaid enrollees to opt-in to its Coordinated Care Organization (CCO) program, and Maine offers this same opt-in structure, but only if one of its Accountable Communities (ACs) chooses to include Medicare-Medicaid enrollees in its patient population (so far, no AC has chosen to do so). Medicare covers many of the physical health services traditionally included in an ACO shared savings methodology, such as physician visits, inpatient hospital services, and other primary and acute care services. As a result, much of the potential savings from Medicaid investments in behavioral health services and LTSS would accrue to Medicare. Colorado's program for dually eligible individuals includes the potential for shared savings for Medicare and Medicaid costs between the state and Medicare. Conversely, both Maine and Oregon only cover Medicaid benefits through their respective ACO models; thus, Medicare costs are not included in the total cost of care calculations in these payment models.

## Challenges to Including Medicare-Medicaid Enrollees in Medicaid ACOs

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Through their participation in CHCS' *Medicaid ACO Learning Collaborative*, states identified four main challenges to including Medicare-Medicaid enrollees in Medicaid ACO programs:

1. **Achieving return on investment.** States are concerned that adding Medicare-Medicaid enrollees to their Medicaid ACO programs would not produce state-level savings. Since Medicare covers the vast majority of physician, hospital, and post-acute care benefits for Medicare-Medicaid enrollees, these services would be excluded from total cost of care and quality calculations. States worry that the share of savings accrued to Medicaid may be insufficient to justify the added expense of investing in such an endeavor. Therefore, if total cost of care is calculated for only Medicaid services, there is potential for cost-shifting toward Medicare services to achieve Medicaid savings.
2. **Overcoming IT and data complexities.** To effectively care for Medicare-Medicaid enrollees, an ACO needs to have a complete picture of an individual's Medicare and Medicaid care needs and utilization patterns. Medicare and Medicaid data often have different submission requirements, fields, and other data elements, and states and ACOs would need to develop systems capable of integrating these data. Additional challenges reported by states include the lack of EHR and poor connectivity capacity across LTSS providers. Without the necessary resources and infrastructure from federal

and state governments, providers would have difficulties building the needed infrastructure to participate effectively in an ACO.

3. **Aligning existing programs for Medicare-Medicaid enrollees.** Several states are pursuing financial alignment demonstrations to better integrate Medicare and Medicaid services through new managed care arrangements. Other states have comprehensive contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) that provide or arrange for some degree of a coordinated Medicare-Medicaid benefit package.<sup>6</sup> Some states believe that adding a Medicaid ACO program to the mix would provide a duplicative level of care management with existing managed care programs. Adding to the complexity, these existing programs have different: (a) degrees of alignment or coordination; (b) program rules related to grievances and appeals; (c) enrollment timelines and systems; (d) claims submission processes; (e) reporting requirements; and (f) utilization management approaches.
4. **Addressing the diverse needs of Medicare-Medicaid enrollees.** In addition to diverse chronic, physical health needs, Medicare-Medicaid enrollees are a heterogeneous population using substantial behavioral health services and LTSS. Unless a broad range of providers are participating in a Medicaid ACO and a comprehensive set of services are provided as part of the model, states and providers will not be able to effectively manage the full range of services that these patients require. Including LTSS in Medicaid ACOs may be especially challenging, because this coordination would require primary care and specialty medical providers to bridge potential differences in culture, quality measurement approaches, data and system capabilities, and clinical models.

#### COLORADO'S ACCOUNTABLE CARE COLLABORATIVE: MEDICARE-MEDICAID PROGRAM

Colorado launched a Medicare-Medicaid financial alignment demonstration in September 2014 that builds on the existing infrastructure and resources of the state's ACC program. Through the ACC: Medicare-Medicaid Program, Colorado began enrolling dually eligible individuals in RCCOs, which are required to coordinate physical, behavioral health, and LTSS needs across Medicare and Medicaid. The program provides:

- Care coordination across the entire delivery system through its RCCOs;
- Collaboration among medical and LTSS providers serving dually eligible individuals;
- Use of linked Medicare-Medicaid data; and
- Enhanced care management rates for RCCOs to coordinate delivery of high-quality care across the Medicare and Medicaid programs for dually eligible individuals.

Since Colorado is operating through a financial alignment demonstration, the state is eligible to receive a percentage of savings generated across Medicare and Medicaid services for its dually eligible beneficiaries. Through the ACC: Medicare-Medicaid Program, Colorado has begun to address some of the challenges inherent in including dually eligible individuals in Medicaid ACOs by working closely with CMS on the demonstration design and implementation.

## Recommendations for Supporting Medicare-Medicaid Enrollees in Medicaid ACOs

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Discussions with *Medicaid ACO Learning Collaborative* participants identified four key program elements necessary to support Medicare-Medicaid enrollees within Medicaid ACO programs. These program elements can potentially address some of the barriers discussed earlier.

1. **Medicaid ACO programs must coordinate care with Medicare providers to achieve a complete picture of an individual’s care needs and service utilization patterns.** Comprehensive integrated care programs, like financial alignment demonstrations, coordinate care across both Medicare and Medicaid to account for a “whole person” versus just the Medicaid “half” of each person. This is achieved by including the full range of primary, acute, and post-acute care in total cost of care, quality, and care coordination activities. While both Oregon and Maine have included Medicare-Medicaid enrollees in their Medicaid ACO programs, only Medicaid services are covered under these arrangements. In addition, Medicaid ACO quality metrics may need to be revised to accurately reflect the full range of services required for Medicare-Medicaid enrollees. Through its financial alignment demonstration, Colorado requires its RCCO providers to coordinate services across Medicare and Medicaid providers and establish communication protocols with each LTSS provider type, including nursing facilities and disability service providers.
2. **States need to assess whether or not their Medicaid ACOs have access to Medicare data as well as the capability to link and analyze data across the two programs and multiple settings.** For Medicaid ACOs serving dually eligible enrollees, a system must be devised to assure timely and accurate data feeds from both Medicaid and Medicare data sources and to link data to create complete patient profiles. LTSS providers may not have access to EHRs or a robust HIT infrastructure, and thus, states may need to consider investing in technology for these providers.
3. **To effectively serve Medicare-Medicaid enrollees, Medicaid ACOs should be accountable for behavioral health services and LTSS.** Because LTSS and behavioral health services account for the majority of Medicaid utilization and spending for dually eligible enrollees, states must include these services in their Medicaid ACO programs to effectively serve this population. This could be done by either holding Medicaid ACOs accountable for behavioral health and LTSS metrics, and/or including these services in an ACO’s total cost of care.
4. **Medicaid ACO models may consider whether to target care delivery models to subpopulations of Medicare-Medicaid enrollees to address specific care needs.** States might consider whether to serve one or both the under 65 and over 65 sub-populations in their Medicaid ACO programs, which as a group have different clinical, care management, and social support needs. The under-65 population is more likely to qualify for both Medicare and Medicaid on the basis of a physical or mental disability, and have a higher prevalence of behavioral health disorders. Dually eligible individuals

who are age 65 and older are more likely to have age-related chronic condition comorbidities and functional impairments.

## The Feasibility of Including Medicare-Medicaid Enrollees in Medicaid ACOs

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There are potential benefits of including Medicare-Medicaid enrollees in Medicaid ACO models, but these benefits may be outweighed by the costs and complexities of implementing such an arrangement. Medicaid-only ACO programs that include Medicare-Medicaid enrollees would benefit by including Medicare at the table. Without partnership and investment from Medicare, states may not have the capacity to make ACOs work for the dually eligible population. Unless Medicare providers and services are reflected in performance measurement and total cost of care calculations, it is unclear whether Medicaid ACO programs can achieve cost and quality objectives sought by ACO programs and achieve a sustainable return on investment for states. Lastly, without incentives for Medicare and Medicaid providers to reduce costs for their respective services, adding another layer of administrative and service delivery coordination could further fragment care for these individuals, create prohibitive burdens on ACOs, and fail to move the needle on overall patient outcomes.

Multi-payer ACOs that include a full range of providers and aligned financial incentives may offer the best option for effectively providing care to Medicare-Medicaid enrollees. Multi-payer ACOs are more likely to capture savings from both programs than those that only include Medicaid or Medicare benefits in their total cost of care. Therefore, multi-payer ACOs that serve Medicare, Medicaid, and Medicare-Medicaid enrollees are best positioned to coordinate care, improve patient outcomes, and reduce costs across payers.

Despite the substantial challenges, there are instances where states can include Medicare-Medicaid enrollees in Medicaid ACOs to complement program goals. The approaches taken by Colorado, Oregon, and Maine offer good examples. In Oregon and Colorado's regional models, the inclusion of Medicare-Medicaid enrollees is crucial to each program's goal of managing the region's health as a whole, even if it requires additional coordination with Medicare. Because much of Maine's AC model is flexible in terms of scope of services, population size, and attributes, ACs can each choose whether they are ready to include Medicare-Medicaid enrollees. For instance, ACs that already participate in the MSSP and have multi-payer capability can more easily opt to include Medicare-Medicaid enrollees, while ACs that do not have the ability to coordinate with Medicare may opt to serve only Medicaid beneficiaries.

Ultimately, while many states are implementing Medicaid ACO programs, they are unlikely to unilaterally design an ACO program that can effectively serve Medicare-Medicaid enrollees. An aligned ACO solution for Medicare-Medicaid enrollees will likely need to be achieved through federal-state collaboration and/or driven by provider-led multi-payer ACO arrangements.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).

## ENDNOTES

- <sup>1</sup> Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC). “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.” January 2015.
- <sup>2</sup> Medicaid and CHIP Payment and Access Commission. “MACPAC June 2014 Report to the Congress. Chapter 2: Medicaid’s Role in Providing Assistance with Long-Term Services and Supports.” June 2014.
- <sup>3</sup> State Medicaid Director Letter # 11-008. Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. Center for Medicare & Medicaid Services. July 8, 2011.
- <sup>4</sup> For more information, please see <http://www.chcs.org/project/medicaid-accountable-care-organization-learning-collaborative-phase-iii/>
- <sup>5</sup> R. Houston and T. McGinnis. *Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations*. Center for Health Care Strategies, March 2013. Available at <http://www.chcs.org/resource/adapting-the-medicare-shared-savings-program-to-medicaid-accountable-care-organizations/>.
- <sup>6</sup> *Update on Medicare-Medicaid Integration*. Center for Health Care Strategies, February 2015. Available at <http://www.chcs.org/resource/update-medicare-medicaid-integration/>.