

Chapter 1:

Integrating Care for Dually Eligible Beneficiaries: Background and Context

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Key Points

- Individuals who are dually eligible for Medicaid and Medicare represent a diverse population that includes low-income beneficiaries age 65 and older and younger people with disabilities. In 2019, there were 12.2 million dually eligible beneficiaries.
- Medicare is the primary payer for acute and post-acute care services for dually eligible beneficiaries. Medicaid is the secondary payer, assisting with Medicare premiums, cost sharing, and covering services not covered by Medicare, such as long-term services and supports (LTSS).
- On average, dually eligible beneficiaries have greater health care needs and report worse health status than Medicare-only beneficiaries.
- Dually eligible beneficiaries comprise a disproportionate share of Medicaid and Medicare service use and spending. In 2013, 15 percent of Medicaid enrollees were dually eligible, but these enrollees accounted for 32 percent of total Medicaid spending. Similarly, 20 percent of Medicare enrollees were dually eligible, but these enrollees accounted for 34 percent of total Medicare spending.
- Dually eligible beneficiaries must navigate two separate systems that were not designed to work together, which can affect care delivery. For example, although Medicaid's coverage of durable medical equipment (DME) is broader, Medicare is the primary payer. Most states require that Medicare first deny a DME claim before a DME supplier files a claim with Medicaid; this can delay beneficiary receipt of DME.
- The benefit structures of the two programs also lead to cost shifting. Ideally, beneficiaries should receive inpatient care, post-acute care, and LTSS based on their health and social needs and not on which program pays for which services.
- The federal government and states administer a variety of integrated care models to improve the care provided to dually eligible beneficiaries. The level of clinical and administrative integration varies from model to model.
- Recent integration efforts include implementation of Medicare-Medicaid Plans under the Financial Alignment Initiative and increased alignment of dual eligible special needs plans with managed LTSS programs.
- Studies of integrated care models generally find that enrolled beneficiaries have lower rates of hospitalizations and readmissions than those who are not enrolled, while their effect on other services varies. Findings on Medicare savings are mixed, and most evaluations do not assess Medicaid savings due to data limitations.
- Despite considerable efforts at both the state and federal levels, only about 1 million (about 10 percent) of dually eligible beneficiaries are now enrolled in integrated care models.

CHAPTER 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context

In 2019, 12.2 million individuals were enrolled in both Medicaid and Medicare (CMS 2020a).¹ These so-called dually eligible beneficiaries include both those age 65 and older and younger beneficiaries with disabilities. They are a diverse group; while many have complex care needs, including multiple chronic conditions, physical disabilities, behavioral health conditions, and cognitive impairments, others are relatively healthy (MACPAC 2020a). On average, dually eligible beneficiaries use more services than those enrolled in only Medicaid or Medicare with higher per capita costs.

Many also face multiple social risk factors that may affect their health status, such as housing insecurity and homelessness, food insecurity, inadequate access to transportation, and low health literacy (Sorbero et al. 2018). This population may be at particular risk during the COVID-19 pandemic due to their age and underlying medical conditions (CDC 2020).

Combined, Medicaid and Medicare cover a broad range of health care services, including preventive services, primary care, inpatient and outpatient services, long-term services and supports (LTSS), and behavioral health for dually eligible beneficiaries. For most, Medicare is the primary payer for acute and post-acute care services. Medicaid is the secondary payer and wraps around Medicare by providing assistance with Medicare premiums and cost sharing and covering services not covered by Medicare, such as LTSS.

The division of coverage between the two programs, however, can result in fragmented care. For example, beneficiaries admitted to the hospital under their Medicare benefits may need home- and community-based services (HCBS) to safely

transition back into the community. Because HCBS are covered under Medicaid, there may not be a mechanism in place to notify the beneficiary's HCBS provider of a hospital stay, making it more difficult for the HCBS provider to work towards a smooth transition.

Lack of coordination also creates opportunities for cost shifting between the two programs. For example, Medicaid covers LTSS while Medicare covers inpatient stays. Given that these policies were not designed to work together, their structure does not create appropriate incentives to ensure that services are provided based on what is best for the beneficiary.

Integrated care is intended to address these concerns by aligning delivery, payment, and administration of Medicaid and Medicare services. The goal of integrating care is to improve care for dually eligible beneficiaries, eliminate incentives for cost shifting, and reduce spending that may arise from duplication of services or poor care coordination.

Many states use one or more models of integrated care aimed at improving health outcomes and reducing overall spending for dually eligible beneficiaries. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) provided opportunities for the federal government and states to improve coordination between Medicaid and Medicare. Even so, as of 2019, only about 10 percent of dually eligible beneficiaries received care through these integrated models (CMS 2020a). In the Commission's view, more can be done to increase enrollment in integrated products, increase the availability of such models, and encourage greater levels of clinical, financial, and administrative integration.

In Chapter 2 of this report, the Commission examines barriers to integration and some potential solutions and presents initial recommendations. This chapter provides context for that discussion. It begins with background information on dually eligible beneficiaries including pathways for

Medicaid and Medicare eligibility, demographic characteristics, health status, and patterns in use of services and spending. It then outlines the benefits to which dually eligible beneficiaries are entitled and the available forms of health care delivery. The chapter goes on to describe current challenges of receiving care through two distinct systems; it defines integrated care in the context of the dually eligible population; and it identifies the primary models of integrated care used by states. The chapter concludes by describing key findings from available evaluations of these models.

Characteristics of Dually Eligible Beneficiaries

The number of dually eligible beneficiaries has steadily increased over the past decade, from 8.6 million in 2006 to 12.2 million in 2019, an average annual growth rate of 2.9 percent (CMS 2020a, 2019a).² Below we describe how individuals become eligible for both Medicaid and Medicare, their demographic characteristics, and the benefits they receive. We then compare the needs, outcomes, and use of services among dually eligible beneficiaries to Medicare-only beneficiaries, a comparison group more similar to dually eligible beneficiaries than the Medicaid-only population. This is because Medicare generally covers only those over age 65 and people with disabilities, while Medicaid also covers children, pregnant women, and non-disabled adults.

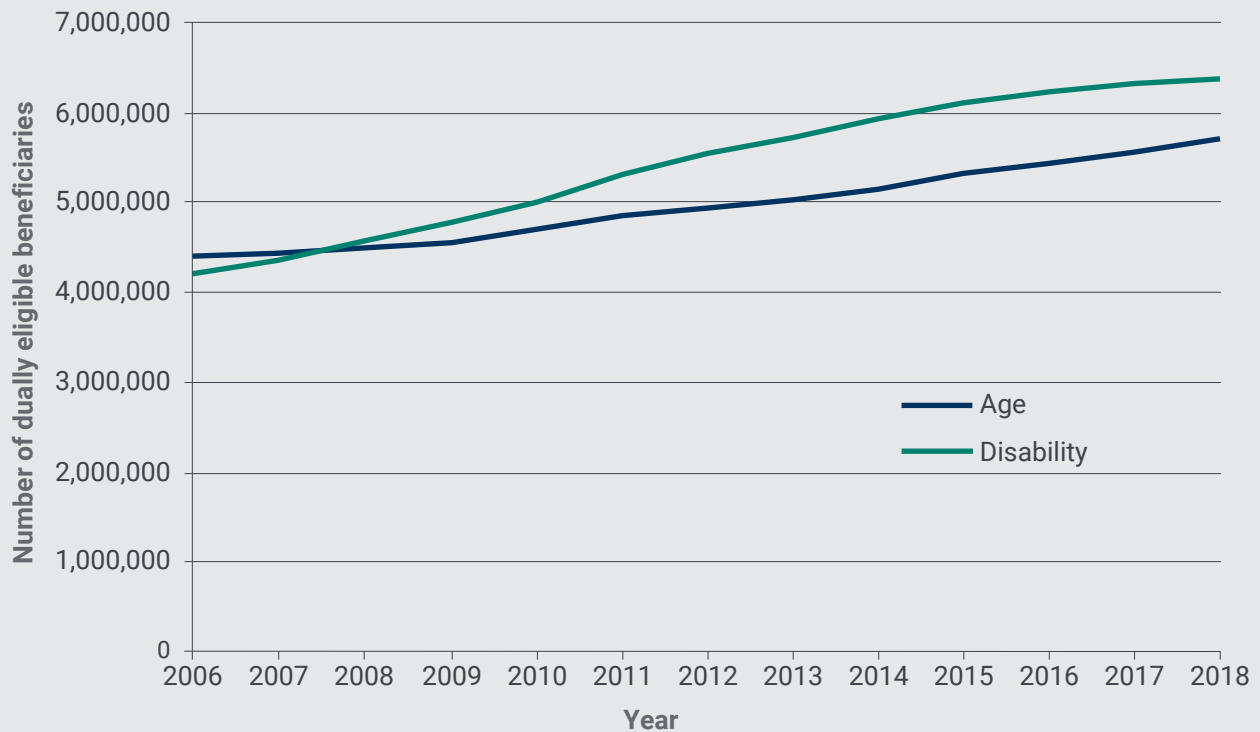
Eligibility

Dually eligible beneficiaries must qualify separately for Medicaid and Medicare. Individuals can qualify for Medicare by virtue of age (65 and older), disability, or, for a small number of individuals (less than 1 percent), because they have end-stage renal disease.³

Medicaid eligibility, which is determined based on both financial and functional criteria, varies from state to state. However, most dually eligible beneficiaries qualify for Medicaid on the basis of income, are designated as medically needy, or receive Supplemental Security Income (MACPAC and MedPAC 2018). The medically needy pathway allows states to cover individuals with high medical expenses relative to their incomes after spending down to a state-set income level. States may offer these beneficiaries full Medicaid benefits or a limited set of benefits as defined by the state, within certain parameters.⁴

In recent years, the number of dually eligible beneficiaries initially qualifying for Medicare on the basis of disability has surpassed that of beneficiaries initially qualifying due to age (CMS 2019a). In 2006, a slight majority of dually eligible beneficiaries qualified on the basis of age, but by 2008 most dually eligible beneficiaries qualified on the basis of disability (Figure 1-1). More recently, this trend has leveled off, with the percentage of beneficiaries initially qualifying on the basis of disability remaining steady at 53 percent from 2012 through 2018.

FIGURE 1-1. Original Eligibility Pathway for Medicare Enrollment among Dually Eligible Beneficiaries, 2006–2018



Note: Disability includes individuals who qualified for Medicare on the basis of disability alone and on the basis of disability and end-stage renal disease.

Source: MACPAC, 2020, analysis of CMS 2019a.

Demographic characteristics

The dually eligible population differs from the Medicare-only population with respect to age and gender. Dually eligible beneficiaries are younger, with 39 percent under the age of 65, compared to 9 percent of Medicare-only beneficiaries

(Table 1-1). A disproportionate share of dually eligible beneficiaries are female, at 61 percent, compared to Medicare-only beneficiaries, of whom 52 percent are female. Dually eligible and Medicare-only beneficiaries identify themselves as members of four broad racial and ethnic groups in roughly the same proportion.

TABLE 1-1. Demographic Characteristics of Dually Eligible and Medicare-Only Beneficiaries, 2018

| Demographic characteristics | Dually eligible beneficiaries | Medicare-only beneficiaries |
|-------------------------------|-------------------------------|-----------------------------|
| Age | | |
| Under age 65 | 39% | 9% |
| Age 65 and older | 61 | 91 |
| Gender | | |
| Female | 61 | 52 |
| Male | 39 | 48 |
| Race or ethnicity | | |
| Hispanic | 16 | 11 |
| White, non-Hispanic | 57 | 61 |
| Black, non-Hispanic | 21 | 25 |
| Other non-white, non-Hispanic | 7 | 3 |

Note: Percentages in each demographic category may not sum to 100 due to rounding.

Source: MACPAC, 2020, analysis of CMS 2019a.

Health status and social determinants of health

Dually eligible beneficiaries have more health care needs and report worse health status than Medicare-only beneficiaries. Dually eligible beneficiaries have an average of six chronic health conditions, compared to an average of four among Medicare-only beneficiaries (Burke et al. 2016). They are also more likely to have limitations in activities of daily living (ADLs) such as walking, eating, bathing, and getting in and out of bed. Among dually eligible beneficiaries, 28 percent report three or more limitations in ADLs, compared to 9 percent of Medicare-only beneficiaries (MedPAC 2019). Dually eligible beneficiaries are also less likely to self-report excellent or very good health than Medicare-only beneficiaries (22 percent versus 51 percent) (MACPAC and MedPAC 2018).

Dually eligible beneficiaries are more likely than Medicare-only beneficiaries to experience

homelessness, food insecurity, inadequate access to transportation, and low health literacy (Sorbero et al. 2018). As a result, they may have less access to primary and preventive care, which can in turn contribute to adverse health outcomes (Sorbero et al. 2018). Individuals with multiple social risk factors have worse outcomes on preventive care measures, such as screening for cancer, and clinical outcome measures, such as diabetes control and hospital readmission (ASPE 2016). In addition, beneficiaries of color experience additional barriers to access when navigating both Medicaid and Medicare (Sharma 2014).

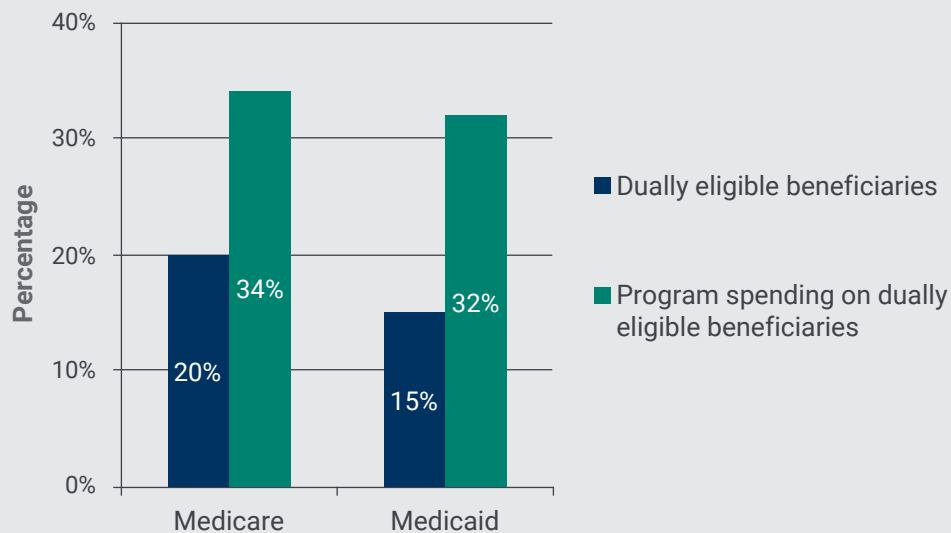
Use of services and spending

Due to their complex needs, many dually eligible beneficiaries require intensive use of services such as hospitalization and LTSS; as a result, spending on dually eligible beneficiaries is disproportionately high in both Medicare and Medicaid (Bynum et al. 2017). In 2013, 20 percent of Medicare enrollees

were dually eligible for Medicaid and Medicare, but accounted for 34 percent of total Medicare spending (MACPAC and MedPAC 2018). Similarly,

15 percent of Medicaid enrollees were dually eligible and accounted for 32 percent of total Medicaid spending (Figure 1-2) (MACPAC 2020a).

FIGURE 1-2. Dually Eligible Beneficiaries as a Share of All Medicare and Medicaid Beneficiaries and Spending, by Program, 2013

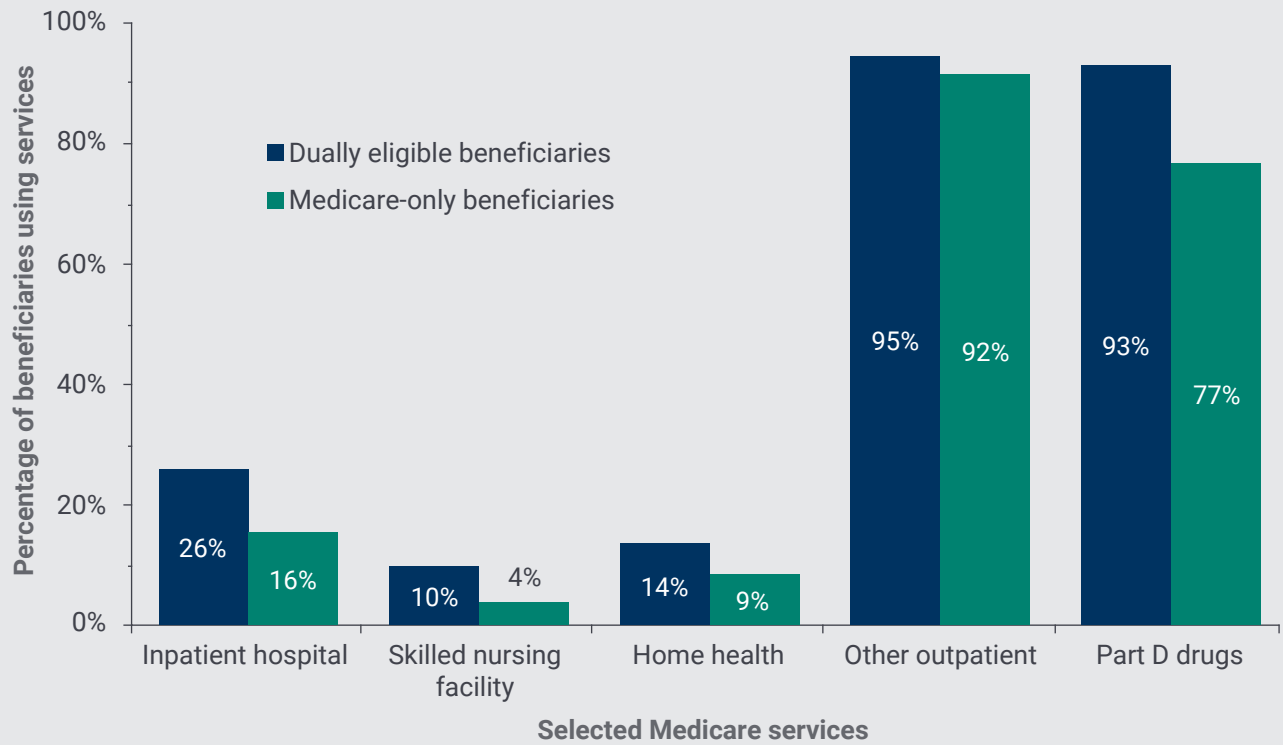


Source: MACPAC and MedPAC 2018.

Overall, dually eligible beneficiaries have higher rates of service use across all covered services and higher spending per beneficiary than other Medicare beneficiaries (MACPAC and MedPAC 2018). For example, in 2013, 26 percent of full-benefit dually

eligible beneficiaries in Medicare fee for service (FFS) used inpatient hospital care compared to 16 percent of all other Medicare beneficiaries in Medicare FFS (Figure 1-3).

FIGURE 1-3. Percentage of Fee-for-Service Dually Eligible Beneficiaries and Fee-for-Service Medicare-Only Beneficiaries Using Various Medicare Services, 2013



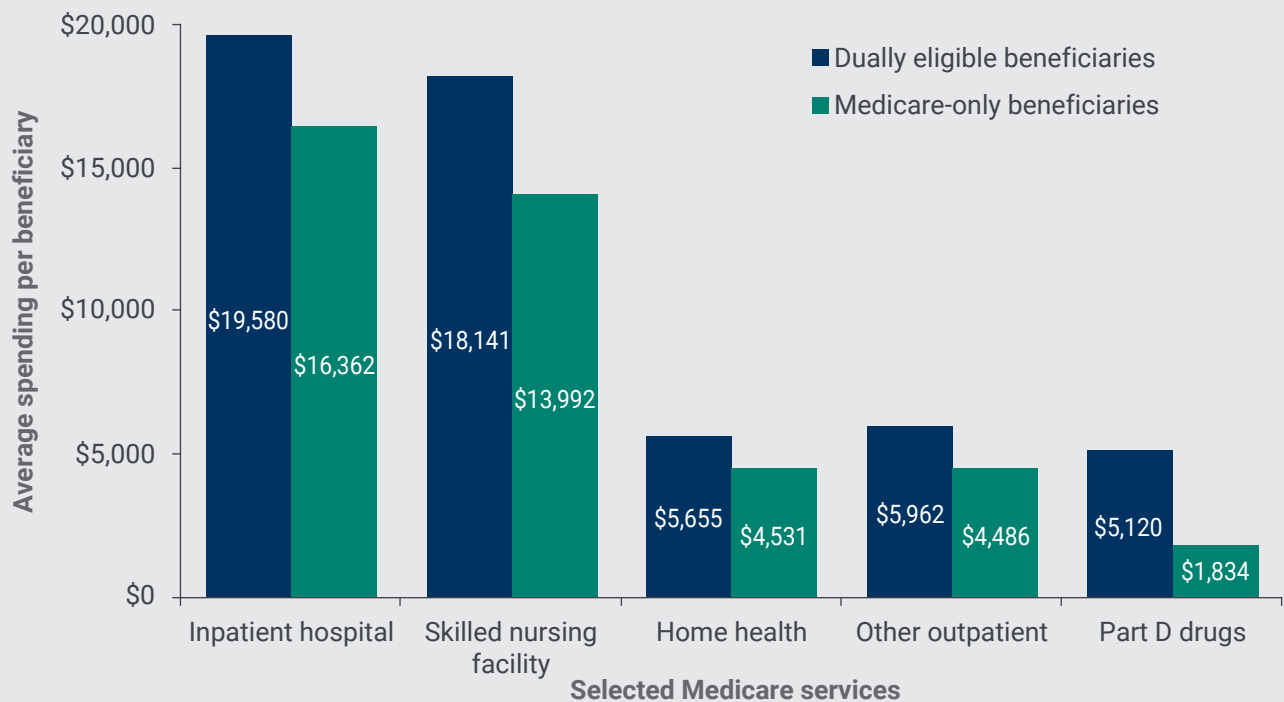
Note: Dually eligible beneficiaries are limited to full-benefit dually eligible beneficiaries for the purposes of this figure.

Source: MACPAC, 2020, analysis of MACPAC and MedPAC 2018.

Full-benefit dually eligible beneficiaries also had higher spending per admission in 2013, with an average of \$19,580 per inpatient hospital stay

compared to \$16,263 among Medicare-only beneficiaries using inpatient care (Figure 1-4) (MACPAC and MedPAC 2018).

FIGURE 1-4. Average Spending per Beneficiary on Medicare Services among Fee-for-Service Dually Eligible Beneficiaries and Fee-for-Service Medicare-Only Beneficiaries, 2013



Note: Dually eligible beneficiaries are limited to full-benefit dually eligible beneficiaries for the purposes of this figure.

Source: MACPAC, 2020, analysis of MACPAC and MedPAC 2018.

Dually eligible beneficiaries also account for a disproportionate share of LTSS use and spending. More than 40 percent of dually eligible beneficiaries use LTSS (Soper and Menelas 2019). They are more than twice as likely to use LTSS as Medicaid-only beneficiaries and more than five times as likely as Medicare-only beneficiaries (CBO 2013). In 2011, 62 percent of Medicaid spending on dually eligible beneficiaries was attributed to LTSS (Reaves and Musumeci 2015).

Benefits

All dually eligible beneficiaries receive the same Medicare benefits: primary care, preventive care, inpatient and outpatient acute care, post-acute skilled care, and most prescription drugs. Medicare

is the primary payer and Medicaid serves as the secondary payer for these services.

However, not all dually eligible beneficiaries receive the same Medicaid coverage. Partial-benefit dually eligible beneficiaries are Medicare beneficiaries who receive Medicaid assistance only with Medicare premiums and, in some cases, Medicare cost sharing, through the Medicare Savings Programs (MSPs). (For more information on MSPs, see Chapter 3 of this report.) In 2018, there were 3.5 million partial-benefit dually eligible beneficiaries, comprising 29 percent of all dually eligible beneficiaries (CMS 2019a).

Full-benefit dually eligible beneficiaries receive all services that are covered by Medicaid that are

not covered by Medicare, but they may or may not receive Medicaid assistance with Medicare premiums and cost sharing. Medicaid services offered to full-benefit dually eligible beneficiaries vary by state, because states have flexibility in whether to cover certain services, and may include nursing facility services, HCBS, and some behavioral health services. In 2018, 8.7 million, or 71 percent, of dually eligible beneficiaries received full Medicaid benefits (CMS 2019a).

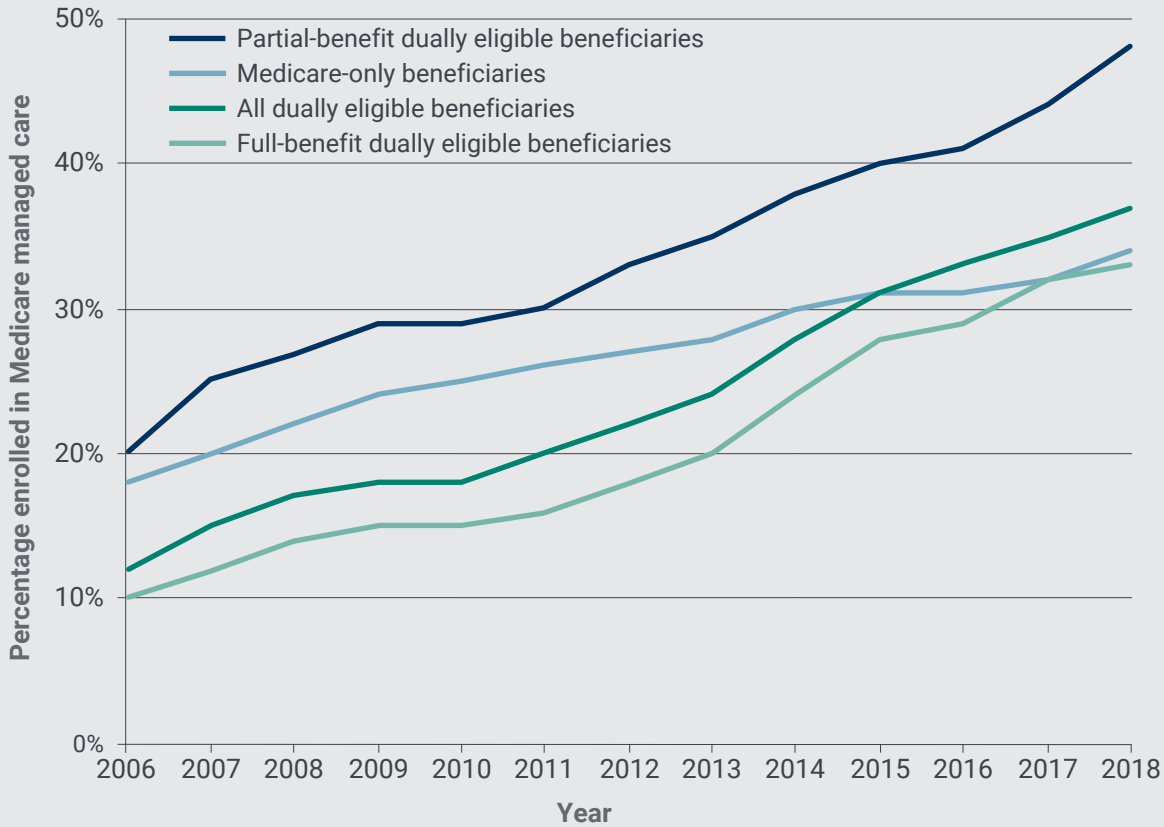
Delivery system

Although Medicaid and Medicare services have traditionally been delivered to beneficiaries through FFS, many beneficiaries now receive services through managed care (CMS 2020b). In managed care arrangements, health plans provide benefits in exchange for a capitated payment, typically paid on a per member per month basis (MACPAC 2020b). Because there are multiple delivery systems for both Medicaid and Medicare, dually eligible beneficiaries may be in FFS for both, may be in managed care for both, or may be in managed care for one program and FFS for the other. However, even when the individual is enrolled in a managed care plan for both Medicare and Medicaid, they may be enrolled in different plans and the plans do not necessarily coordinate with each other.

Fee for service. Under FFS, providers receive a separate payment for each service provided to a beneficiary. Beneficiaries may receive services through any provider accepting this coverage. A majority of dually eligible beneficiaries, 63 percent, receive their Medicare benefits through FFS (CMS 2020b).

Medicare Advantage. Through Medicare Advantage (MA), also referred to as Medicare Part C, beneficiaries enroll in MA plans that provide coverage of Medicare Parts A and B, and often, Part D drug benefits. MA plans may also cover services such as vision, hearing, and dental that are not otherwise covered by Medicare. Beneficiaries enrolled in MA plans receive care through the plan's closed network.⁵ Enrollment in MA plans has steadily increased in recent years among both dually eligible beneficiaries and Medicare-only beneficiaries. From 2006 to 2018, enrollment of dually eligible beneficiaries in Medicare managed care plans—including MA plans and other integrated products described later in this chapter—increased substantially, from 12 percent to 37 percent (Figure 1-5) (CMS 2020b).

FIGURE 1-5. Percentage of Medicare Managed Care Enrollment by Beneficiary Type, 2006–2018



Note: Full-benefit dually eligible beneficiaries enrolled in Medicare Advantage plans, Medicare-Medicaid Plans, and Program of All-Inclusive Care for the Elderly are included as enrolled in managed care; data are based on December enrollment of each calendar year.

Source: MACPAC, 2020, analysis of CMS 2020b.

Medicaid managed care. States initially used managed care for younger and less complex populations, but many states are now expanding its use to include dually eligible beneficiaries (GAO 2020).

In 2017, just under 25 percent, or 2.6 million dually eligible beneficiaries, received their Medicaid benefits through Medicaid managed care organizations (MCOs) (CMS 2017).

Many states make capitated payments to MCOs to provide managed long-term services and supports

(MLTSS); while some MLTSS models cover only LTSS, others cover the complete range of Medicaid benefits (Lewis et al. 2018). The number of states offering MLTSS has increased from 8 in 2004 to 24 in 2019, although most programs are not statewide (Appendix 1A, Table 1A-1) (Lewis et al. 2018 and ADvancing States 2020). As of 2017, there were 1.8 million Medicaid beneficiaries enrolled in MLTSS programs (Lewis et al. 2018).⁶

Lack of Coordination Creates Challenges

Medicaid and Medicare were not designed to work in tandem. As a result, dually eligible beneficiaries must navigate two separate systems. Several benefits covered by Medicaid and Medicare overlap but are not identical, with rules for coverage that may be difficult to understand. State Medicaid payment policies also often allow states to pay less than the full amount of Medicare cost sharing, which may discourage providers from serving dually eligible beneficiaries. As a result, the beneficiary care experience may be confusing and disjointed and lead to poor health outcomes and high costs (MACPAC 2015).

Misaligned program rules

There are several misalignments between Medicaid and Medicare. In some instances, services are covered by both programs but operate under different sets of rules. For example, durable medical equipment (DME) is covered by both Medicaid and Medicare, but Medicare has more restrictive coverage than Medicaid and limits DME coverage to items used primarily in the home. Medicaid's more expansive coverage includes equipment and supplies that can also be used in the community, that is, wherever normal life activities take place (42 CFR 440.70(b)(3)). Because Medicare is the primary payer for dually eligible beneficiaries, most state Medicaid programs require DME suppliers to first submit a claim to Medicare and receive a payment denial before they can request payment from Medicaid. As a result of this complex process, beneficiaries may face longer wait times to receive DME, and suppliers may be reluctant to supply DME to dually eligible beneficiaries (ICRC 2020a).

Navigating Medicaid and Medicare appeals processes can also be confusing to beneficiaries. For example, Medicaid covers some DME that Medicare does not. If beneficiaries must first receive a Medicare denial before Medicaid will cover the service, they may receive a Medicare denial

notice and not be aware that they are still eligible for the DME under their Medicaid coverage.

Insufficient care coordination

Care coordination typically involves a person or team that helps a beneficiary manage care transitions, coordinate Medicaid and Medicare benefits, and address social needs. Beneficiaries could have an improved experience if all services were coordinated, a key goal of integrated care approaches (Barth et al. 2019). For example, Medicare covers inpatient stays but not any subsequent HCBS that a beneficiary may need to safely transition back to the community. In the absence of care coordination, there may be no mechanism in place for the HCBS provider to participate in the beneficiary's care transition.

Cost shifting between programs

In some circumstances, Medicaid and Medicare may avoid certain actions that, if undertaken, could reduce spending in the other program and improve outcomes for the beneficiary. For example, hospital readmissions are covered by Medicare, so state Medicaid agencies may not have financial incentives to provide additional services after the beneficiary is initially discharged from the hospital that would prevent readmission. This is because the financial risks of subsequent hospitalizations are borne by Medicare, not Medicaid. Incentives to shift costs can also exist between Medicaid and Medicare health plans (Grabowski 2007).

Similarly, providers face different incentives depending upon which program is paying for care. For example, because Medicaid covers LTSS while Medicare covers inpatient stays and limited post-acute care, beneficiaries may move among multiple settings as a function of those incentives (Grabowski 2007). Ideally these incentives should work so that beneficiaries receive inpatient care, post-acute care, and LTSS based on their health and social needs, rather than considerations such as who will pay for which services.

Medicaid policies for covering Medicare cost sharing

As noted above, many states do not cover the full amount of Medicare cost sharing. The Balanced Budget Act of 1997 (P.L. 105-33) allowed state Medicaid programs to pay less than the full Medicare cost-sharing amount if paying the full amount would cause a provider to receive more than the state's Medicaid rate for the service. For a given Medicare service received by a dually eligible beneficiary, states have the option to pay the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount by which Medicaid's rate for the same service exceeds what Medicare has already paid (known as a lesser-of policy). If the Medicaid rate is lower than the Medicare payment, states pay nothing. When Medicaid does not cover the full cost-sharing amount, dually eligible beneficiaries cannot be charged the remaining balance, which is generally absorbed by the provider. Lesser-of policies vary across service types with nine states covering the full payment for hospital inpatient services, eight covering the full payment for hospital outpatient services, eight covering the full payment for nursing facility services, and six covering the full payment for physician services (MACPAC 2018a).

Providers may be less inclined to provide services to dually eligible beneficiaries in states that use lesser-of policies, limiting beneficiary access to care. A study conducted for MACPAC by Haber and colleagues (2014) compared use among dually eligible beneficiaries whose providers were paid a high cost-sharing payment amount (100 percent) and a low cost-sharing payment amount (66 percent) to Medicare-only beneficiaries. When providers were paid the full amount of Medicare cost sharing, dually eligible beneficiaries had a small but statistically significant increase in the likelihood of having an office or other outpatient evaluation and management visit than Medicare-only beneficiaries (84.8 percent compared to 84.2 percent). When providers were paid 66 percent of Medicare cost sharing, dually eligible beneficiaries were statistically less likely to receive these services (83.9 percent compared to 85.6 percent). The report

also found that although dually eligible beneficiaries were less likely to receive a flu shot than Medicare-only beneficiaries, dually eligible beneficiaries were more likely to receive a flu shot when providers were paid 100 percent of cost-sharing liability. A similar, but smaller, effect was noted for mammogram services (Haber et al. 2014).

Defining Integrated Care

To address challenges that arise when individuals are dually enrolled in Medicaid and Medicare, policymakers have developed models to integrate benefits for dually eligible beneficiaries. We define integrated care as an approach that is intended to align the delivery, payment, and administration of Medicaid and Medicare services with the goals of improving care, eliminating incentives for cost shifting, and reducing spending that may arise from duplication of services or poor care coordination.

Beneficiaries enrolled in integrated care models may have better access to the full range of covered services in both programs. A key feature of integrated plans is use of care coordinators or care teams that establish person-centered care plans that meet the unique needs of individuals; such care plans are meant to be shared with other service providers to ensure that they are aware of all beneficiary needs and who is involved in addressing them.

Integrated Care Authorities

Congress has created a number of authorities to encourage integration of Medicaid and Medicare and provide a more seamless experience for beneficiaries (Table 1-2). These include establishing the Program of All-Inclusive Care for the Elderly (PACE); creating and refining dual eligible special needs plans (D-SNPs), a type of MA plan; and designating offices within the Centers for Medicare & Medicaid Services (CMS) that coordinate Medicaid and Medicare and develop innovative payment and delivery models.

TABLE 1-2. Federal Legislative Milestones: Integrated Care for Dually Eligible Beneficiaries, 1997–2018

| Year | Legislative milestone and key provisions |
|-------------|--|
| 1997 | Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) <ul style="list-style-type: none"> Establishes the Program of All-Inclusive Care for the Elderly (PACE) as a permanent Medicare program. (Previously, PACE had operated as a pilot program.) |
| 2003 | Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) <ul style="list-style-type: none"> Establishes Medicare Advantage. Authorizes three types of special needs plans (SNPs) to serve the needs of subsets of the Medicare population, including dual eligible special needs plans (D-SNPs). SNPs initially authorized to operate from 2006 through December 31, 2008, but the authority has been extended repeatedly through subsequent legislation. |
| 2008 | Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) <ul style="list-style-type: none"> Requires all D-SNPs to have contracts with the states in which they operate by 2013. MIPPA regulations require these contracts to have eight elements, including, but not limited to, the organization’s responsibility to provide or arrange for Medicaid benefits, the Medicaid benefits covered under the D-SNP, the cost-sharing protections, and the identification and sharing of information on Medicaid provider participation. |
| 2010 | Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) <ul style="list-style-type: none"> Section 2602 of the ACA creates the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), within CMS. MMCO is designed to improve care and reduce spending on care for dually eligible beneficiaries. Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation within CMS to test innovative payment and delivery models. |
| 2018 | Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) <ul style="list-style-type: none"> Permanently authorizes SNPs. BBA 2018 requires D-SNPs to meet one of three criteria to improve integration or coordination of care beyond what was required in MIPPA and unifies the grievance and appeals process for some D-SNPs. Strengthens the authority of MMCO to develop rules and guidance related to D-SNPs, with the goals of improving integration, coordinating grievances and appeals, and providing resources to states to support integrated models. |

Source: MACPAC, 2020, analysis of legislation and 42 CFR 422.107.

The main focus of integrating care is on full-benefit dually eligible beneficiaries. It is more difficult to design integrated models for partial-benefit dually eligible beneficiaries because they are not eligible for Medicaid services that could be coordinated with Medicare.

States may choose how they will deliver care to full-benefit dually eligible beneficiaries. Some states use more than one model of integrated care to address the needs of different types of beneficiaries, due to differences between geographic regions in the state, or to offer choices to beneficiaries (Appendix 1A, Table 1A-1).

In 2010, the ACA created within CMS the Federal Coordinated Health Care Office, commonly referred to as the Medicare-Medicaid Coordination Office (MMCO). MMCO is charged with improving coordination between the federal government and states to improve access to care for beneficiaries and to make the system as cost-effective as possible (CMS 2020c). Since its establishment, MMCO has encouraged states to offer integrated care through a variety of models.

Enrollment into integrated care plans has increased over the past several years, from 160,000 dually eligible beneficiaries enrolled in integrated care programs in 2011 to just over 1 million enrolled in 2019 (CMS 2020a).⁷ We discuss each model of integrated care in greater detail below.

Integrated Care Models

Integrated care models offer varying degrees of clinical and administrative integration. Managed fee for service (MFFS) offers care coordinated through a single point of contact. D-SNPs aligned with MLTSS provide more integration. Highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs) are D-SNPs that cover some or all Medicaid services and typically provide a greater level of integration than D-SNPs without these designations. Medicare-Medicaid Plans (MMPs) and PACE provide the highest level of integration, because all services are provided by a single organization that receives capitated payments from Medicaid and Medicare. Below we describe each of these integrated care models, beginning with MMPs, a widely used model that offers the highest level of integration.

The Financial Alignment Initiative's Medicare-Medicaid Plans

The Financial Alignment Initiative (FAI) is a demonstration program authorized under Section 1115A of the Social Security Act (the

Act) designed to improve the way dually eligible beneficiaries receive health care and to align financial incentives in Medicaid and Medicare (CMS 2020c). State participation in the FAI is optional, and currently 11 states participate (Table 1-3). The earliest demonstrations began in July 2013, and several have been extended beyond the initial demonstration period. CMS has also encouraged more states to participate in the FAI through existing or new demonstration models (CMS 2019c).

The FAI offers multiple models of integrated care, including a capitated model that establishes MMPs, an MFFS model, and an option for states to develop an alternative model.⁸ Because each demonstration is developed and implemented through a partnership between the state and MMCO, each demonstration differs in terms of its target population, benefits, and care coordination services. Most participating states have chosen the capitated MMP model in which plans receive a capitated prospective monthly payment to provide services to enrollees.

MMPs are health plans that provide a high level of integration by enabling dually eligible individuals to enroll in a single plan that is responsible for all aspects of their coverage. MMPs operate under a three-way contract with the state and with CMS (Ormond et al. 2019). All MMP contracts specify that enrollees must have health risk assessments, individual care plans, and access to a care coordinator and an interdisciplinary care team (Ormond et al. 2019).

MMPs operate under a capitated arrangement. They receive a blended payment that combines Medicaid and Medicare Part A, Part B, and Part D. The portion of that payment related to Medicaid and Medicare Parts A and B is reduced by a percentage based on the amount of expected savings the demonstration will generate. The percentage reduction is set by CMS and each participating state for each year of the demonstration. The savings percentage varies but is generally 1 percent in the first year, from 1 to 2 percent in the second year, and 2 to 5 percent in subsequent years (MACPAC 2018b). MMPs are

also subject to a quality withhold in which a portion of the payment rate is withheld pending plans' performance against certain quality measures. The quality withhold is typically 1 percent in the first year, 2 percent in the second year, and 3 percent in years thereafter. For more information on the payment framework in the FAI capitated model, see MACPAC's January 2018 issue brief, *The Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare* (MACPAC 2018b).

MMPs are the most common FAI model and they operate in nine states (Table 1-3). Minnesota developed an alternative model focused on administrative alignment, and Washington is using an MFFS model. The New York Fully Integrated Duals Advantage and Virginia MMP demonstrations have already ended. Colorado's MFFS demonstration has also ended.

TABLE 1-3. Active Financial Alignment Initiative Demonstrations, February 2020

| State | Type of model | Beneficiaries enrolled | Scheduled end date |
|--------------------|---------------|------------------------|--------------------|
| California | Capitated | 110,690 | December 31, 2022 |
| Illinois | Capitated | 57,415 | December 31, 2022 |
| Massachusetts | Capitated | 26,590 | December 31, 2020 |
| Michigan | Capitated | 40,182 | December 31, 2020 |
| Minnesota | Alternative | 39,315 | December 31, 2020 |
| New York, FIDA-IDD | Capitated | 1,593 | December 31, 2020 |
| Ohio | Capitated | 73,365 | December 31, 2022 |
| Rhode Island | Capitated | 13,578 | December 31, 2020 |
| South Carolina | Capitated | 18,016 | December 31, 2020 |
| Texas | Capitated | 42,902 | December 31, 2020 |
| Washington | MFFS | 11,544 | December 31, 2020 |

Notes: FIDA-IDD is Fully Integrated Duals Advantage-Intellectual and Developmental Disabilities. MFFS is managed fee for service. Enrollment totals are for February 2020. Demonstration scheduled end dates may be extended at the joint discretion of CMS and the state.

Source: MACPAC, 2020, analysis of CMS monthly enrollment reports and state memoranda of understanding, Minnesota Department of Human Services health care programs managed care enrollment totals as of February 2020, and Washington State Health Care Authority FFS dual eligible demonstration monthly report as of February 2020.

Under the demonstration waiver authority, states may try to increase participation in MMPs by using passive enrollment, in which an eligible beneficiary is automatically enrolled in an MMP but maintains the ability to opt out.⁹ Prior to the use of passive enrollment by MMPs, dually eligible beneficiaries had not typically been subject to passive enrollment into MA plans. Several states, however, have

mandated enrollment into Medicaid MCOs. At the start of the demonstrations, all participating states used passive enrollment (MedPAC 2018). Passive enrollment in the MMPs has been controversial, however, due to concerns that it limits beneficiary choice (Stein 2019). Many beneficiaries have opted out of the MMP or left the MMP shortly after passive enrollment (MedPAC 2018).

Despite efforts to increase participation in MMPs, enrollment has been lower than expected. As of June 2017, about 28 percent of eligible beneficiaries were enrolled across the nine participating states (MedPAC 2018). Ohio had the highest participation rate, at about 68 percent. The Medicare Payment Advisory Commission (MedPAC) found that from October 2013 to April 2016, about 41 percent of passively enrolled beneficiaries opted out, although the rate varied across states (MedPAC 2018). With the exception of the California and New York demonstrations, all MMP demonstrations continue to use passive enrollment in some form, generally for people who become newly eligible for coverage under both programs (MedPAC 2018).

MA dual eligible special needs plans aligned with managed long-term services and supports

MA D-SNPs were introduced under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) as a type of MA plan designed to serve the specific needs of dually eligible beneficiaries. They were made permanent under the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123). Each D-SNP must develop a model of care that describes the unique characteristics and needs of the dually eligible population served and establishes processes for coordinating care and conducting health risk assessments for enrolled beneficiaries (CMS 2016).

MLTSS plans receive a capitated payment from states to provide LTSS covered by Medicaid. These services and supports can include long-stay nursing facility services and services provided at home and in the community, such as personal care, respite care, meal delivery, adult day care, and transportation.

A D-SNP and MLTSS plan can be aligned, meaning beneficiaries can be enrolled for their Medicare and Medicaid services through the same entity.¹⁰ This arrangement can simplify care for enrollees and increase efficiency, while providing greater

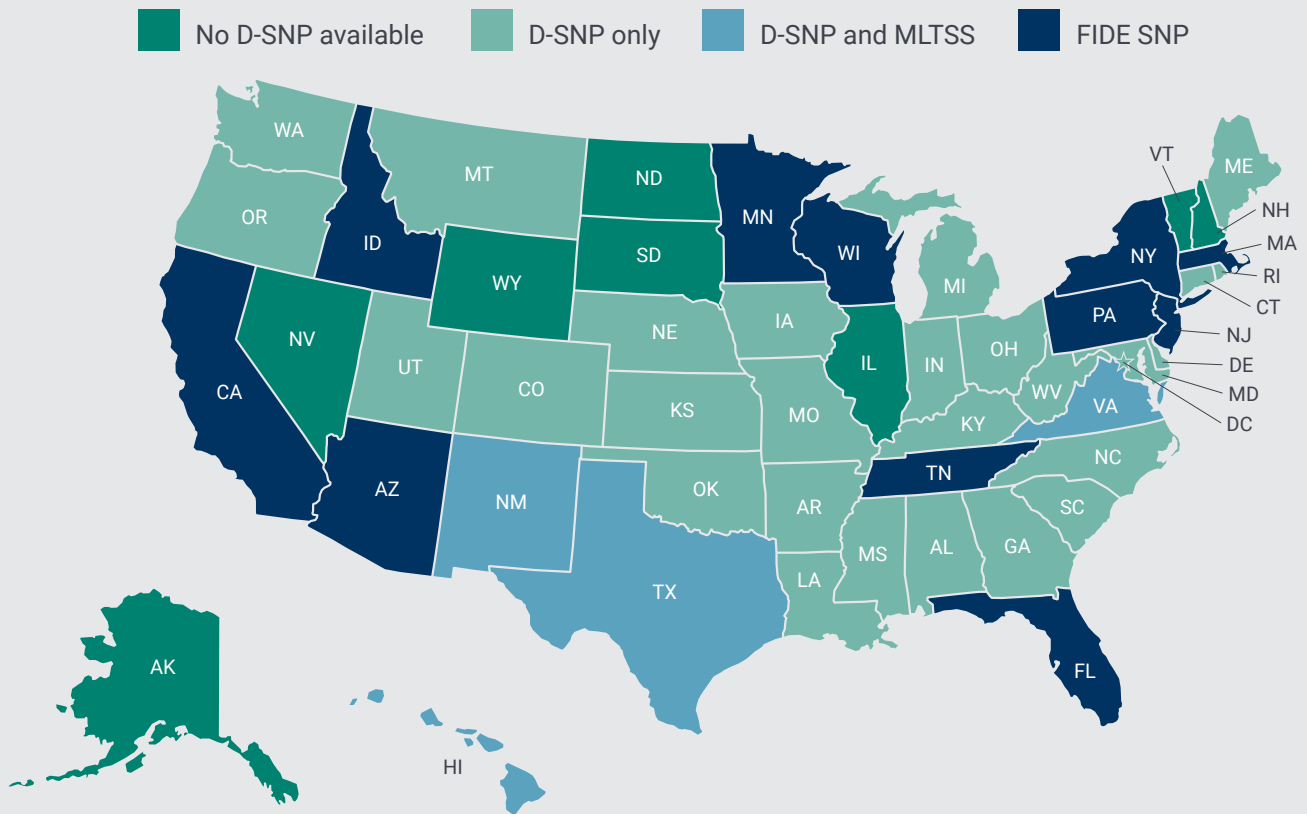
opportunities for care coordination among services covered by Medicaid and Medicare.

Statutory changes have incrementally improved the ability to integrate Medicaid and Medicare through D-SNPs. The Medicare Improvements for Patients and Providers Act 2008 (MIPPA, P.L. 110-275) and BBA 2018 both sought to increase care coordination for full-benefit dually eligible beneficiaries. MIPPA requires D-SNPs to hold a contract with the state Medicaid agency in any state in which they seek to operate (Table 1-2). Thus, such contracts are sometimes referred to as MIPPA contracts. This requirement expanded states' ability to integrate care for dually eligible beneficiaries. For example, in their MIPPA contracts, states can require D-SNPs operating in their state to offer an aligned MLTSS plan. Alternatively, states can require any MLTSS plan to offer a companion D-SNP (GAO 2020).

BBA 2018 made the authority for special needs plans, including D-SNPs, permanent. In addition, beginning in 2021, D-SNPs must meet new information-sharing requirements to further coordinate the delivery of Medicaid services. Within the parameters set forth in federal regulations, D-SNPs that are not designated as a FIDE SNP or HIDE SNP must identify within their MIPPA contracts a process to share information with the state or its designee when certain full-benefit dually eligible beneficiaries are admitted to a hospital or skilled nursing facility (42 CFR 422.107(d)). The state must specify the group of high-risk individuals for whom a notification must be sent and the time frame and process for sending notifications to either the state or a designee of the state's choosing.¹¹

In 2020 there are D-SNPs, including FIDE SNPs, operating in 42 states and the District of Columbia, with enrollment totaling 2.6 million beneficiaries (CMS 2020d).¹² Although D-SNPs are available in most states, companion MLTSS programs may not operate in the same areas, limiting opportunities for integration through a D-SNP (Figure 1-6).

FIGURE 1-6. Availability and Type of Dual Eligible Special Needs Plan Model, by State, 2020



Notes: D-SNP is dual eligible special needs plan. MLTSS is managed long-term services and supports. FIDE SNP is fully integrated dual eligible special needs plan. Figure shows highest level of integration available in each state. FIDE SNPs represent the highest level of D-SNP integration.

Source: MACPAC, 2020, analysis of Medicare Advantage special needs plan landscape file for 2020, *ADvancing States 2020*, Kruse and Soper 2020, Lewis et al. 2018, and state websites.

HIDE SNPs and FIDE SNPs. HIDE SNPs and FIDE SNPs are D-SNPs that meet a higher level of integration by covering at least some Medicaid benefits or by providing a companion MLTSS plan, behavioral health organization, or Medicaid MCO that covers behavioral health services to full-benefit dually eligible beneficiaries (CMS 2020e).

CMS has changed the definition of HIDE SNPs beginning in 2021. To meet the new CMS criteria for designation as a HIDE SNP, the D-SNP, or a Medicaid plan affiliated with the D-SNP, must hold a MIPPA

contract with the state to cover either Medicaid LTSS or behavioral health services.¹³

To meet the criteria for designation as a FIDE SNP, a D-SNP or companion MCO under the same legal entity must cover Medicaid MLTSS, establishing its coordination through a state MIPPA contract. However, in states where behavioral health services are carved out of the capitated rate, FIDE SNPs are not required to cover behavioral health services (CMS 2020e). Likewise, where a limited scope of LTSS coverage is carved out, a D-SNP may still

qualify as a FIDE SNP or HIDE SNP.¹⁴ FIDE SNPs must also cover at least 180 days of nursing facility services per plan year. Plans that meet these additional requirements to be designated by CMS as a FIDE SNP are considered to be more integrated than a regular D-SNP. They can further integrate benefits and increase administrative alignment.

HIDE SNPs and FIDE SNPs receive capitated payments. FIDE SNPs may also receive additional Medicare payment through a frailty adjustment if CMS determines that the beneficiaries enrolled in a FIDE SNP have an average level of frailty similar to that of enrollees in PACE (CMS 2016). States may require some or all D-SNPs operating in the state to provide capitated Medicaid benefits under a Medicaid MCO; these D-SNPs may meet the criteria for designation as a HIDE SNP or FIDE SNP (CMS 2020e).

The reach of FIDE SNPs is limited but is increasing. As of February 2020, there were FIDE SNPs in 11 states, enrolling 280,000 beneficiaries, up from 9 states and 131,471 enrollees in 2016 (Figure 1-6) (CMS 2020d and Verdier et al. 2016).¹⁵

The Financial Alignment Initiative's managed fee-for-service model

MFFS is a FAI demonstration model for integrating care. As the name implies, beneficiaries enrolled in this model receive care through FFS, rather than through a capitated arrangement. Each beneficiary is assigned a care coordinator to coordinate benefits and help the beneficiary meet care needs. Under MFFS, a state provides the up-front investment in care coordination and is then eligible for a retrospective performance payment if it meets an established quality threshold and Medicare achieves a target level of savings (CMS 2012).

To date, the MFFS model has only been used by two states. Washington initiated its demonstration in 2013 and continues to use the model. Colorado's demonstration began in 2014 and ended in December 2017 when enrollees transitioned to

Colorado's Accountable Care Collaborative delivery system (CMS 2019d).

Under the Washington demonstration, the state uses Medicaid health homes to coordinate care for participating dually eligible beneficiaries.¹⁶ The state launched the FAI demonstration and the health homes program at the same time, making it possible to use the enhanced Medicaid matching rate available under the health homes option to fund some of the up-front investment.¹⁷ The beneficiary has a multidisciplinary care team, which includes a care coordinator. Because the program uses FFS Medicaid, beneficiaries may be seen by any Medicaid-enrolled provider participating with a qualified health home. This demonstration also promotes access to community supports and services such as housing assistance (CMS 2012). The demonstration operates statewide and, as of February 2020, had enrolled 11,544 dually eligible beneficiaries, or 39 percent of those eligible (HCA 2020).

Program of All-Inclusive Care for the Elderly

PACE provides health care services to certain frail individuals age 55 and older who meet criteria for a nursing home level of care but are able to live safely in the community. Almost all PACE beneficiaries—90 percent—are dually eligible for Medicaid and Medicare (NPA 2019).

The first PACE site opened in the 1970s as a demonstration, and the program was permanently authorized by the Balanced Budget Act of 1997 (P.L. 105-33). PACE sites are designed to serve a specific geographical area, providing a range of care needs, including primary care, social services, and meals. PACE organizations have a physical site and staff who provide many services through an adult day program that serves beneficiaries at the site, in their homes, and in the community. PACE organizations also contract with providers and specialists in the community to provide health care to beneficiaries (CMS 2020h).

PACE operates through a three-way partnership between CMS, the state, and the PACE organization. Programs receive separate capitated payments from Medicare and the state Medicaid agency.

PACE programs operate in 31 states. The number of PACE organizations available varies by state, ranging from 1 organization operating in 12 states to 19 organizations operating in Pennsylvania (ICRC 2020b).

PACE serves relatively few beneficiaries; in April 2020, total PACE enrollment was about 49,000, less than 1 percent of dually eligible individuals, and the average PACE site serves fewer than 200 members (ICRC 2020b, NPA 2019). Low enrollment reflects both the resource intensity of establishing a PACE site and competition with state-operated programs (Gross et al. 2004).

Evaluations of Integrated Care Models

There is a limited but growing body of evidence examining whether models of integrated care improve health outcomes and access to care and reduce spending.¹⁸ Studies to date have generally found decreased rates of hospitalization and readmission for dually eligible beneficiaries. Findings regarding use of other services, such as emergency department (ED) visits and LTSS, have been mixed. Several studies estimated effects on per-person Medicare spending. However, due to a lack of recent Medicaid data, most evaluations to date are not able to evaluate effects on Medicaid spending. For more information on integrated care evaluations, see MACPAC's July 2019 issue brief (MACPAC 2019b).

Medicare-Medicaid Plans

CMS has funded formal evaluations of the FAI, which are published on a rolling basis, with evaluations planned for every year of each

demonstration. Preliminary results have been mixed (MACPAC 2019b).

MMP enrollment is associated with decreased inpatient admissions, decreased skilled nursing facility admissions, and reductions in ED use across several demonstrations (CMS 2020i). Effects on other services, such as nursing facility admissions and experiences with care coordination, vary. For example, the evaluation report for the first year of Michigan's demonstration found decreases in inpatient admissions, ambulatory care sensitive condition admissions, ED visits, preventable ED visits, and physician evaluation and management visits (Holladay et al. 2019). There was no change in the rate of 30-day all-cause readmission rates or the probability of a follow-up visit after mental health inpatient discharge within 30 days. The evaluation found that the rate of long-stay nursing facility admissions increased and also found reduced barriers to accessing prescription drugs (Holladay et al. 2019).

Where preliminary results regarding spending are available, the results are also mixed. Some demonstrations reported reduced Medicare spending while others did not (MACPAC 2019b).¹⁹ For example, the evaluation report of Ohio's FAI found Medicare savings in the first demonstration period, but showed no statistically significant changes in Medicare spending when the first and second demonstration periods were combined (Bayer et al. 2018).

Dual eligible special needs plans

Evaluations of integrated care under D-SNPs have found evidence of reduced hospitalizations, readmissions, and nursing facility admissions. For example, in a study of Visiting Nurse Services of New York's CHOICE health plan, which uses continuous care management for dually eligible beneficiaries, hospitalization for enrollees decreased by 54 percent over 24 months, readmissions within 30 days dropped by 24 percent, and ED visits decreased by 27 percent. There was

also a 21 percent relative reduction in the trend for the 30-day all-cause readmission rate between 2009 and 2011 (Bihle Johnson and McCarthy 2013).

There is also some evidence of decreased per-person Medicare spending. One study found that increased D-SNP penetration (the share of dually eligible beneficiaries enrolled in D-SNPs) was associated with reduced Medicare per-person spending (Zhang and Diana 2017). A 1 percent increase in D-SNP penetration was associated with a 0.2 percent reduction in Medicare spending per-person. The study found no effect on Medicaid spending.

Managed fee for service

The most recent formal evaluation of Washington State's MFFS demonstration shows mostly positive results, including decreased inpatient admissions, skilled nursing facility admissions, and long-stay nursing facility use (Justice et al. 2019). However, there has been an increase in the all-cause readmission rate and the rate of preventable ED visits. The evaluation report also identified gross reductions in Medicare spending of \$213.9 million during the initial 42 months of the demonstration (Justice et al. 2019).²⁰ Washington was able to share in these Medicare savings.

An evaluation of the Colorado MFFS demonstration, which ended in December 2017, found that Medicare spending per member per month increased in the first demonstration period, decreased in the second, and afterward returned to baseline spending (Sandler et al. 2019b, Wilkin et al. 2017).

Program of All-Inclusive Care for the Elderly

A number of studies found that PACE was associated with lower inpatient hospital use (Segelman et al. 2017, Jones et al. 2013, Meret-Hanke 2011, Beauchamp et al. 2008). However, there are mixed results on nursing facility use among PACE participants. Some studies have

shown increases in nursing facility use (Ghosh et al. 2015, Beauchamp et al. 2008). But one study found a decrease on this measure (Segelman et al. 2017).

Similarly, some evaluations find increased Medicaid spending (Ghosh et al. 2015, Foster et al. 2007). Others show decreased spending (Wieland et al. 2013, Foster et al. 2007). Considering the comprehensiveness of the PACE benefit and the level of impairment among participants, a showing of comparative savings in a given study may be dependent on whether the study compares PACE participants to HCBS waiver enrollees or to nursing facility residents.

The Future of Integrated Care

Despite the development of multiple models for integrating care and the considerable work at both the state and federal levels, only about 10 percent of dually eligible beneficiaries are now enrolled in integrated care, that is, about 1 million beneficiaries (CMS 2020a). In the Commission's view, integrated care can lead to better care for individuals and more effective and efficient coordination between Medicaid and Medicare. In the next chapter, we discuss policy mechanisms to achieve these goals and make initial recommendations aimed at increasing enrollment in and availability of integrated care models.

Endnotes

¹ This count is on an ever-enrolled basis. Individuals are counted as ever-enrolled if they were enrolled in Medicare and Medicaid at the same time for at least one month of the calendar year.

² This growth rate outpaces the rate of growth for Medicare-only beneficiaries, which was 2.7 percent over the same time period, increasing from 37.0 million to 50.7 million individuals. Unless otherwise noted, dually eligible beneficiaries refers to both full-benefit dually eligible beneficiaries and partial-benefit dually eligible beneficiaries.

³ Individuals must pay Medicare taxes through work for at least forty quarters (10 years) for the individual and his or her spouse to qualify for coverage of Medicare Part A premiums at age 65. Individuals eligible for Social Security Disability Insurance (SSDI) benefits or Railroad Retirement Board (RRB) benefits are eligible for Medicare after qualifying for SSDI or RRB for 24 months (CMS 2019b).

⁴ For more information on the pathways to Medicaid eligibility for dually eligible beneficiaries, see the eligibility topic page on the MACPAC website at <https://www.macpac.gov/subtopic/dually-eligible-beneficiaries-eligibility/>.

⁵ MA plans were first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), replacing the previous Medicare+Choice program that was authorized under the Balanced Budget Act of 1997 (P.L. 105-33).

⁶ Most programs limit enrollment to older adults and people with physical disabilities; dually eligible beneficiaries with intellectual or developmental disabilities are enrolled in MLTSS in only a few states.

⁷ Integrated care programs include Medicare-Medicaid Plans (MMPs), fully integrated dual eligible special needs plans (FIDE SNPs), Program of All-Inclusive Care for the Elderly (PACE), managed fee for service (MFFS), and integrated dual eligible special needs plans (D-SNPs) where enrollees receive Medicaid and Medicare services from companion or aligned Medicaid managed care plans and D-SNPs.

⁸ Minnesota chose to continue its longstanding program called Minnesota Senior Health Options in partnership with MMCO under the FAI to increase administrative alignment. MFFS uses the original Medicaid and Medicare payment model, and pays providers based on the services used.

⁹ The use of passive enrollment differs across Medicaid and Medicare. In Medicaid, it is common for non-dually eligible populations to be automatically enrolled in managed care. States can automatically enroll dually eligible beneficiaries under a waiver, but are prohibited from doing so otherwise. In Medicare Advantage, automatic enrollment is not widely used for any population.

¹⁰ To be considered aligned, the state's MLTSS plan contract may be held either with the legal entity providing the D-SNP, the parent organization of the D-SNP, or a subsidiary owned and controlled by the parent organization of the D-SNP.

¹¹ An example of a state already imposing a D-SNP data-sharing requirement is Pennsylvania. The state requires D-SNPs to send a notification of hospital and skilled nursing facility admissions for all D-SNP enrollees. The D-SNP shares information directly with the beneficiary's MLTSS plan within 48 hours of admission (ICRC 2019).

¹² This count excludes the 20 D-SNPs operating in Puerto Rico, which enroll 277,000 beneficiaries (CMS 2020d).

¹³ To qualify as a HIDE SNP, a D-SNP must cover LTSS or Medicaid behavioral health services under a state contract, either directly with the legal entity providing the D-SNP, the parent organization of the D-SNP, or a subsidiary owned and controlled by the parent organization of the D-SNP (CMS 2019c).

¹⁴ Such carve outs must be consistent with state policy. CMS will determine whether a plan may be designated as a FIDE SNP or HIDE SNP based on the specific circumstances (CMS 2020e).

¹⁵ As of February 2020, FIDE SNPs operate in Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Tennessee, and Wisconsin. However, the FIDE SNPs in Florida had not yet enrolled any beneficiaries (CMS 2020d).

¹⁶ Health homes must provide six core services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) comprehensive transitional care and follow-up; (5) individual and family support; and (6) referral to community and social services. Health homes use an interdisciplinary care team that may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or other professionals that would provide services to the enrolled population (CMS 2020f).

¹⁷ Section 1945 of the Act (established in section 2703 of the ACA) gives states the option under their state plans to establish health homes to coordinate care for people with chronic conditions. States choosing this option receive 90 percent federal match for the first eight quarters that the program is in operation (CMS 2020g).

¹⁸ To assess the status of research on the performance of integrated care models, MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to compile an inventory of existing evaluations of integrated care models. SHADAC conducted a systematic review to identify peer-reviewed studies and gray literature (i.e., government-sponsored and other non-peer reviewed reports) published between January 2004 and November 2018. We updated the inventory to July 2019 with evaluations of the FAI (MACPAC 2019a).

¹⁹ Savings and loss calculations for the MMPs are calculated based on the capitated payment made to the MMPs, and are not based on the cost of services used (MACPAC 2019b).

²⁰ The Washington MFFS demonstrations began on July 1, 2013, and the initial evaluation period ended on December 31, 2016. Separate Medicare savings are calculated for the Washington MFFS demonstration using an actuarial approach. Although the purpose and methods of calculating these savings differ, both show statistically significant savings as a result of the Washington demonstration (Sandler et al. 2019a).

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[serving-dually-eligible-beneficiaries-health-plan-standards-challenges-and-evolving-approaches/](https://www.macpac.gov/publication/care-coordination-in-integrated-care-programs-serving-dually-eligible-beneficiaries-health-plan-standards-challenges-and-evolving-approaches/).

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APPENDIX 1A: Integrated Care Models

TABLE 1A-1. Models of Integrated Care for Dually Eligible Beneficiaries, by State, 2020

| State | D-SNP | MLTSS | Aligned D-SNP and MLTSS | FIDE SNP | FAI | PACE |
|----------------------|-----------|-----------|-------------------------|----------------|----------------|-----------|
| Total | 43 | 24 | 12 | 11 | 11 | 31 |
| Alabama | ✓ | — | — | — | — | ✓ |
| Alaska | — | — | — | — | — | — |
| Arizona | ✓ | ✓ | ✓ | ✓ | — | — |
| Arkansas | ✓ | — | — | — | — | ✓ |
| California | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Colorado | ✓ | — | — | — | — | ✓ |
| Connecticut | ✓ | — | — | — | — | — |
| Delaware | ✓ | ✓ | — | — | — | ✓ |
| District of Columbia | ✓ | — | — | — | — | — |
| Florida | ✓ | ✓ | ✓ | ✓ ¹ | — | ✓ |
| Georgia | ✓ | — | — | — | — | — |
| Hawaii | ✓ | ✓ | ✓ | — | — | — |
| Idaho | ✓ | ✓ | — ² | ✓ | — | — |
| Illinois | — | ✓ | — | — | ✓ | — |
| Indiana | ✓ | — | — | — | — | ✓ |
| Iowa | ✓ | ✓ | — | — | — | ✓ |
| Kansas | ✓ | ✓ | — | — | — | ✓ |
| Kentucky | ✓ | — | — | — | — | — |
| Louisiana | ✓ | — | — | — | — | ✓ |
| Maine | ✓ | — | — | — | — | — |
| Maryland | ✓ | — | — | — | — | ✓ |
| Massachusetts | ✓ | ✓ | — ² | ✓ | ✓ | ✓ |
| Michigan | ✓ | ✓ | — | — | ✓ | ✓ |
| Minnesota | ✓ | ✓ | ✓ | ✓ | ✓ ³ | — |
| Mississippi | ✓ | — | — | — | — | — |
| Missouri | ✓ | — | — | — | — | — |
| Montana | ✓ | — | — | — | — | — |
| Nebraska | ✓ | — | — | — | — | ✓ |
| Nevada | — | — | — | — | — | — |

TABLE 1A-1. (continued)

| State | D-SNP | MLTSS | Aligned D-SNP and MLTSS | FIDE SNP | FAI | PACE |
|----------------|-------|----------------|-------------------------|----------|-----|------|
| New Hampshire | — | — | — | — | — | — |
| New Jersey | ✓ | ✓ | — ² | ✓ | — | ✓ |
| New Mexico | ✓ | ✓ | ✓ | — | — | ✓ |
| New York | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| North Carolina | ✓ | ✓ ⁴ | — | — | — | ✓ |
| North Dakota | — | — | — | — | — | ✓ |
| Ohio | ✓ | ✓ | — | — | ✓ | ✓ |
| Oklahoma | ✓ | — | — | — | — | ✓ |
| Oregon | ✓ | — | — | — | — | ✓ |
| Pennsylvania | ✓ | ✓ | ✓ | ✓ | — | ✓ |
| Rhode Island | ✓ | ✓ ⁵ | — | — | ✓ | ✓ |
| South Carolina | ✓ | ✓ ⁵ | — | — | ✓ | ✓ |
| South Dakota | — | — | — | — | — | — |
| Tennessee | ✓ | ✓ | ✓ | ✓ | — | ✓ |
| Texas | ✓ | ✓ | ✓ | — | ✓ | ✓ |
| Utah | ✓ | — | — | — | — | — |
| Vermont | — | — | — | — | — | — |
| Virginia | ✓ | ✓ | ✓ | — | — | ✓ |
| Washington | ✓ | — | — | — | ✓ | ✓ |
| West Virginia | ✓ | — | — | — | — | — |
| Wisconsin | ✓ | ✓ | ✓ | ✓ | — | ✓ |
| Wyoming | — | — | — | — | — | ✓ |

Notes: D-SNP is dual eligible special needs plan. MLTSS is managed long-term services and supports. FIDE SNP is fully integrated dual eligible special needs plan. FAI is Financial Alignment Initiative. PACE is Program of All-Inclusive Care for the Elderly.

✓ Check mark indicates the model is available in the state.

— Dash indicates the model is not available in the state.

¹ Florida has a FIDE SNP, but as of March 2020, there are no reported enrolled beneficiaries.

² All D-SNPs in Idaho, Massachusetts, and New Jersey are FIDE SNPs, and therefore are not categorized as Aligned D-SNPs and MTLSS.

³ Minnesota has developed a demonstration outside the capitated or managed fee-for-service models and is focused on administrative alignment.

⁴ North Carolina currently limits its MLTSS program to beneficiaries with intellectual and developmental disabilities.

⁵ In Rhode Island and South Carolina, MLTSS programs only serve enrollees in the Financial Alignment Initiative, and do not align with D-SNPs.

Sources: MACPAC, 2020, analysis of Medicare Advantage special needs plan landscape file for 2020, ADvancing States 2020, ICRC 2020b, and state websites.