

Chapter 4:

Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations

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Key Points

- Dually eligible beneficiaries may experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integrating care has the potential to improve their experience and reduce federal and state spending that may arise from duplication of services or poor care coordination.
- Although Congress has created multiple authorities to improve integration of care, only about 10 percent of dually eligible beneficiaries are enrolled in integrated care and integrated options are not available in many areas of the country.
- Given the inherent limitations of integrating care across two separate programs, some stakeholders have begun to explore how to create a unified program. The idea would be to simplify coverage for beneficiaries, align financial incentives, and improve the ability to meet beneficiary needs for services such as acute care, long-term services and supports, behavioral health, and social services.
- Establishing such a program would require substantial statutory and regulatory changes at the federal and state level, affecting policies including benefits, eligibility, and administration.
- As a first step, policymakers need to consider the overarching goals of a unified program. Those might include ensuring beneficiaries have access to the services they need, can exercise choices about their care, and have adequate consumer protections, as well as advancing health equity.
- Decisions would need to be made about specific parameters for eligibility, beneficiary protections and enrollment, benefits, delivery system, care coordination, administration, and financing.
- This chapter examines many of the policy and design issues that would need to be settled in developing a unified program, highlighting policy choices and trade-offs. In doing so, we draw on the work of two stakeholder groups—the Bipartisan Policy Center and the Dual Eligible Coalition convened by Leavitt Partners—that are promoting a new approach to serving this population.
- The wide availability of managed care options envisioned by these proposals is not yet a reality, and states and the federal government would need substantial time to stand up a new structure of coverage for the dually eligible population.
- The Commission is continuing its work on more immediate ways to improve integration of care for dually eligible beneficiaries and will provide additional insights in its June 2021 report to Congress.

CHAPTER 4: Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations

In 2019, 12.3 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; although 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 only in Medicaid or Medicare and have 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).²

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 care for dually eligible beneficiaries. Medicare is the primary payer for most 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 by covering services not covered by Medicare, such as LTSS.

The division of coverage between the two programs, however, can result in fragmented care and cost shifting. In addition, there are few incentives for ensuring that services are coordinated and provided based on what is best for the beneficiary. For example, beneficiaries admitted to the hospital, a service paid for by Medicare, may need home-

and community-based services (HCBS) paid for by Medicaid to safely transition back into the community. However, the beneficiary's HCBS provider may be unaware of a hospital stay, making it difficult to effect a smooth transition. Because transitions are usually coordinated at the provider level, engaging providers, particularly primary care providers, is critical. Similarly, because hospital readmissions are covered by Medicare, state Medicaid agencies may not have financial incentives to ensure that services that would prevent readmission are provided after the initial discharge because the savings from readmission would accrue to Medicare (Grabowski 2007).

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

Over the past 25 years, Congress has created multiple authorities and demonstration opportunities to promote integration (Appendix 4A). Even so, existing integrated care models have not achieved their full potential. For example, the Medicare-Medicaid Plans (MMPs) in the Financial Alignment Initiative (FAI), which offer high levels of integration, are only available in nine states (MACPAC 2020b). Only about 1 million full-benefit dually eligible beneficiaries, or about 10 percent of the full-benefit dually eligible population, are enrolled in integrated models including MMPs and certain dual eligible special needs plans (D-SNPs) (CMS 2020b).

The COVID-19 pandemic has highlighted the need to improve care for dually eligible beneficiaries. As a group, dually eligible beneficiaries are at particular risk during the pandemic due to their age, underlying medical conditions, and their congregate living situations (Archibald and Soper 2020, CDC 2020). Between January 1 and November 21, 2020, of almost 2 million COVID-19 cases in the

Medicare population, about 40 percent were dually eligible beneficiaries (CMS 2020c). Moreover, dually eligible beneficiaries experienced higher rates of hospitalization due to COVID-19 than those enrolled only in Medicare (CMS 2020c). This was true across age, race and ethnicity, and gender (CMS 2020c). American Indian and Alaska Native, Black, and Hispanic dually eligible beneficiaries had the highest rates of hospitalization due to COVID-19 among racial or ethnic groups, being almost two times more likely to be hospitalized because of COVID-19 than white dually eligible beneficiaries (CMS 2020c).

Over the past two years, MACPAC has been examining how to increase enrollment in integrated models and increase availability of such models across geographic areas. This work is ongoing and we expect to include discussions of policies to promote these goals in our June 2021 report to Congress.

However, given that Medicare and Medicaid are administered and financed differently, and were designed to accomplish different goals, the ability to fully integrate is difficult. For example, many state Medicaid programs require mandatory enrollment in managed care, while Medicare beneficiaries enrolled in Part A or Part B have the right to choose either managed care or remain in fee for service (FFS) where they can access any qualified provider. Although automatic enrollment into integrated care models has led to higher enrollment than health plans could otherwise have attained, some stakeholders view it as infringing on beneficiary rights or discriminating against dually eligible beneficiaries relative to other Medicare beneficiaries (Archibald et al. 2019, MedPAC 2018).

Given the limitations inherent in integrating care across two separate programs, some stakeholders have begun to explore how to create a wholly new, unified, program that would replace the fragmented system we have today. A unified program could simplify coverage for beneficiaries, providing acute care, behavioral health services, LTSS, and other social services under a single umbrella. Such a program would have the potential to align

incentives, eliminate cost shifting that currently occurs between Medicare and Medicaid, and fill existing gaps in coverage, such as access to expanded HCBS.

Establishing such a program would require substantial statutory and regulatory changes at the federal and state level, affecting multiple policies including the benefits package, eligibility, and administration.³ This chapter reviews some of the major choices that would need to be made to establish a unified program and the implications of those decisions. It is important to note that the Commission is not recommending wholesale changes at this time; rather, our goal is to contribute to the conversation regarding unified coverage for dually eligible beneficiaries by highlighting the policy choices and trade-offs that would need to be considered in designing such a program.

In this chapter, the Commission examines key design considerations that would have to be addressed to establish a unified program. The chapter begins with background on existing integrated care models, then offers specific policy considerations for issues related to eligibility, beneficiary protections and enrollment, benefits, delivery system and care coordination, administration, and financing. As context for that discussion, the chapter draws examples from two existing proposals to create a fully integrated system for dually eligible beneficiaries. The chapter does not evaluate or provide an exhaustive description of either proposal but uses examples from each to illustrate possible approaches to addressing certain design features.

Existing Integrated Care Models

As noted above, policymakers have developed models to integrate benefits for dually eligible beneficiaries to address challenges that arise from having two different sets of program rules and funding silos. Although these models all aim

to improve health outcomes and reduce overall spending, integrated care models offer varying degrees of financial and clinical integration, with a focus on financial integration as the first step toward integrating care. Because the experience with these models can inform decisions about different aspects of a new program, we describe them briefly below.

Medicare-Medicaid Plans. MMPs 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 care, with the goal of making coverage between the two programs seamless for the beneficiary.⁴ They operate under a three-way contract—with the state and the Centers for Medicare & Medicaid Services (CMS)—which specifies that the plan provide enrollees with health risk assessments, individual care plans, and access to a care coordinator and an interdisciplinary care team (Ormond et al. 2019). These plans operate under state demonstrations under the FAI that differ in terms of their target population, benefits, and care coordination services. Nine states are using the capitated MMP model, in which plans receive a prospective monthly payment to provide services to enrollees (MACPAC 2020b). Beneficiaries have reported positive experiences with these plans. For example, an analysis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a beneficiary survey that MMPs are required to conduct every year, found that 63 percent of enrollees gave MMPs the highest possible rating in 2017 (MedPAC 2018).

Financing for MMPs is integrated because CMS and the states jointly develop Medicaid and Medicare capitation rates as part of their contract negotiations (CMS 2019a). MMPs receive a payment that combines Medicaid and Medicare Part A, Part B, and Part D.⁵ The portion of the 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, and generally does not exceed 6

percent (Engelhardt 2021, MACPAC 2018a). MMPs are also subject to a quality withhold in which a portion of the payment rate is withheld pending plans' performance on certain quality measures. The quality withhold typically does not exceed 3 percent but is 4 percent in 2020 in California and Ohio (Engelhardt 2021).⁶

Medicare Advantage dual eligible special needs plans. Statutory changes have incrementally improved the ability to integrate Medicaid and Medicare through D-SNPs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires D-SNPs to hold a contract with the state Medicaid agency in any state in which they seek to operate. Through such MIPPA contracts, states can require D-SNPs operating in their state to offer an aligned managed LTSS (MLTSS) plan and require any MLTSS plan to offer a companion D-SNP (described in greater detail below) (GAO 2020). The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required D-SNPs to meet new information-sharing requirements to further coordinate the delivery of Medicaid services, effective in 2021. For example, certain D-SNPs 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)). Most D-SNPs provide little integration beyond such information sharing. This type of D-SNP is available in many states, but a smaller number of states have an MLTSS program or contracts with D-SNPs that have been designated as fully integrated dual eligible special needs plans (FIDE SNPs) that can offer higher levels of integration (MACPAC 2020a).

Medicare Advantage D-SNPs aligned with MLTSS plans provide a higher level of integrated care by enrolling beneficiaries for their Medicaid and Medicare coverage through the same entity.⁷ MLTSS plans receive a capitated payment from states to provide LTSS covered by Medicaid, which 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. This arrangement can simplify care for enrollees and increase efficiency, while providing greater opportunities for care coordination among services covered by Medicaid and Medicare. D-SNPs are tailored to the unique characteristics and needs of the dually eligible population served and coordinate care and conduct health risk assessments for enrolled beneficiaries (CMS 2016). 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.

Highly integrated dual eligible special needs plans (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, a behavioral health organization, or a Medicaid managed care organization that covers behavioral health services to full-benefit dually eligible beneficiaries (CMS 2020d). In states where behavioral health services are carved out of the capitated rate and provided by a separate plan, FIDE SNPs are not required to cover behavioral health services (CMS 2020d). Likewise, where a limited scope of LTSS coverage is carved out, a D-SNP may still qualify as a FIDE SNP or a HIDE SNP.⁸ HIDE SNPs and FIDE SNPs receive capitated Medicaid payments. FIDE SNPs may also receive an increased 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 the Program of All-Inclusive Care for the Elderly (PACE) (CMS 2016).

Managed fee-for-service model. Beneficiaries enrolled in the FAI's managed FFS model receive both Medicaid and Medicare services under FFS arrangements but are assigned a care coordinator to coordinate benefits and help them meet care needs. Under this model, a state provides the up-front investment in care coordination and is then eligible for a retrospective performance payment from CMS if it meets an established quality threshold and Medicare achieves a target level of

savings (CMS 2012). Washington, the only state currently operating such a model, uses Medicaid health homes to coordinate care for participating dually eligible beneficiaries.⁹ Beneficiaries see any Medicaid-enrolled provider participating in a qualified health home. This demonstration also promotes access to community supports and services such as housing assistance (CMS 2012).

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). PACE sites are designed to serve a specific geographic 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 elsewhere in the community. PACE organizations also contract with primary care providers and specialists in the community to provide health care to beneficiaries (CMS 2020e). 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.

Key Design Considerations for a Unified Program

Designing a unified program of health coverage for dually eligible beneficiaries is a complex undertaking that is starting to get some attention in the policy community. In thinking about the design of such a program, policymakers need to consider both the overarching goals and the parameters for specific policies. From the beneficiary's perspective, these goals might include ensuring that beneficiaries are able to access the services they need, ensuring that beneficiaries are able to exercise choices about their care and have

adequate consumer protections, and advancing health equity and addressing racial and ethnic disparities (Prindiville 2020). Federal and state officials are likely to start from a perspective aimed at both improving care and containing costs and to focus on increasing financial accountability and delivery system integration between Medicare and Medicaid, increasing enrollment in integrated care, and providing flexibility to design a package of services appropriate for different subsets of the dually eligible population (Miller 2020).

Stakeholders have recently begun discussing potential designs for a fully integrated system for this population. These include the Bipartisan Policy Center's (BPC) July 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, and a proposal still in development from the Dual Eligible Coalition, convened by Leavitt Partners (Dual Eligible Coalition 2021, BPC 2020). Both proposals imagine a fully integrated program covering all Medicare and Medicaid benefits with an integrated funding stream to a single entity that manages care for the beneficiary. Both seek to improve care for individuals while providing incentives to reduce spending with the opportunity to reinvest any realized savings.

These proposals differ, however, in the envisioned structure. The BPC proposal builds on the current structure, retaining Medicaid and Medicare as separate programs, but requiring states to adopt a fully integrated program within 10 years after enactment of a new law, to give states time to set up the fully integrated program. States would choose from three existing models: a modified version of FIDE SNPs, PACE, or a new model building off the managed FFS model used in Washington's demonstration. States must notify the Secretary of the U.S. Department of Health and Human Services (the Secretary) of their intention one year after enactment. If states do not establish their own integrated care programs, the federal government would establish one for them in what is referred to as a federal fallback option, within five years of enactment (BPC 2020). Whether the program is operated by states or the

federal government, beneficiaries would receive a single set of benefits including medical, behavioral health, and LTSS; a single point of contact; a single set of marketing materials; and a single set of enrollee materials. The proposal would grant full regulatory authority over all programs serving the dually eligible population to the Medicare-Medicaid Coordination Office (MMCO) at CMS.

The Dual Eligible Coalition would establish an entirely new program, under a new title of the Social Security Act, and move all dually eligible beneficiaries into this program along with the Medicare and Medicaid funding that currently pays for their coverage (Dual Eligible Coalition 2021). Those dollars would cease to be Medicare or Medicaid funds and instead would be dedicated to a program uniquely for dually eligible beneficiaries. Although details of this proposal are still under development, a few features are known: There would be a core benefit package including all current Medicaid and Medicare benefits. States choosing to participate would be responsible for delivering care following a set of federal minimum standards. They would use capitated managed care plans or, if requested by the state and approved by the Secretary, what the Dual Eligible Coalition calls at-risk, value-based, alternative fully integrated delivery systems. Financing from Medicare and Medicaid, including the state share of Medicaid expenditures, would be combined into a single funding stream to cover the costs of care for dually eligible beneficiaries. Similar to the BPC proposal, the Dual Eligible Coalition would assign oversight authority to the Secretary, acting through MMCO (Dual Eligible Coalition 2021).

In the sections that follow, we draw out the policy and design issues that would need to be settled in developing a new approach to serving dually eligible beneficiaries. We begin with current policies, then draw on the ongoing work of both BPC and the Dual Eligible Coalition, to the degree that their proposals have addressed each issue. Specifically, we look at issues related to eligibility, beneficiary protections and enrollment, benefits, delivery system and care coordination, administration, and financing.

Eligibility

Eligibility standards for Medicare are uniform while those for Medicaid vary by state. Dually eligible beneficiaries must qualify separately for each program. They can qualify for Medicare by virtue of age (age 65 and older), disability, or, for a small number of individuals (less than 1 percent), because they have end-stage renal disease.¹⁰ Medicaid eligibility is determined based on both financial and functional criteria. However, most dually eligible beneficiaries qualify for Medicaid on the basis of income because they 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.¹¹

There are a number of eligibility provisions to consider in designing a unified program. The Dual Eligible Coalition would assign responsibility for establishing minimum eligibility standards to the federal government, and MMCO in particular. The proposal specifies, however, that eligibility would be limited to Medicare beneficiaries who are also eligible for full Medicaid benefits and are age 21 and over. It would allow states to choose to go above federally set thresholds and provide more generous coverage, as allowed under current law. The BPC proposal has three specific parameters on eligibility: limiting eligibility to full-benefit dually eligible beneficiaries, allowing automatic enrollment with beneficiary opt outs, and permitting and encouraging states to implement 12-month continuous eligibility for dually eligible beneficiaries. Both proposals appear to allow states to continue setting their own eligibility levels as long as they meet federal thresholds.

Below we discuss several eligibility-related issues that policymakers would need to consider in designing a unified program.

Limiting eligibility to full-benefit dually eligible beneficiaries. Existing integrated care models may include both full- and partial-benefit dually eligible beneficiaries. In MMPs, which offer a high level of integration, enrollment is limited to full-benefit dually eligible beneficiaries, while D-SNPs enroll both groups. As partial-benefit enrollees do not qualify for full Medicaid benefits (their Medicaid coverage provides assistance only with their Medicare premiums and in some cases cost sharing), including them in integrated care models may prevent health plans from offering a single model of care to all enrolled beneficiaries. We discuss this issue in more detail in the delivery system and model of care section below.

Eligibility for a unified program could be limited to individuals who are eligible for full Medicaid benefits. Such beneficiaries are the most likely to benefit from integrated care because they have Medicaid benefits to integrate with their Medicare coverage, while partial-benefit dually eligible beneficiaries do not. Both the Dual Eligible Coalition and the BPC proposals limit eligibility in this way; the Medicare Payment Advisory Commission (MedPAC) has contemplated doing the same for D-SNPs (MedPAC 2019).

In designing a unified program, a decision must be made about how to structure coverage for the partial-benefit population. Issues to be resolved include whether they will continue to enroll in existing integrated models (such as D-SNPs) and the treatment of so-called crossover claims to Medicaid for Medicare coinsurance and deductibles. Providers submit claims to Medicare first, because it is the primary payer, which pays for the service and then crosses over the claim to state Medicaid programs to pay the cost-sharing amounts (MACPAC 2013). States are not obligated to pay the full amount of Medicare cost sharing if the total payment to the provider would exceed the state's Medicaid rate. Instead, states may limit their payment to the lesser of either the Medicare deductibles and coinsurance or the difference between the Medicaid rate and the amount already paid by Medicare (MACPAC 2013).

Continuous eligibility for Medicaid. Eligibility differences between Medicaid and Medicare have long created challenges for coordinating services. While Medicare eligibility, once conferred, does not change over time, most Medicaid beneficiaries must regularly renew their eligibility to account for changes in certain circumstances, such as income, on which their eligibility is based. Because the eligibility renewal process can be cumbersome, even beneficiaries whose circumstances have not changed may lose Medicaid eligibility temporarily, creating gaps in coverage for services not covered by Medicare, such as LTSS.¹² One study found that about 29 percent of full-benefit dually eligible beneficiaries who transitioned to dual status from 2007 to 2009 lost Medicaid coverage for at least one month in the 12 months after transition (Feng et al. 2019). Individuals who transitioned into dual status from Medicaid had a 37 percent lower risk of losing Medicaid coverage than individuals who transitioned into dual status from Medicare (Feng et al. 2019).

Both the BPC and Dual Eligible Coalition proposals would allow states to implement 12-month continuous Medicaid eligibility for the dually eligible population without obtaining a waiver. This would limit the number of renewals for dually eligible beneficiaries to once per year and promote continuity of care. This approach is consistent with current policy for certain Medicaid enrollees, most often children (unless the state has obtained a waiver for adults), who can retain Medicaid eligibility for a specified period of time (typically 12 months) before their eligibility is redetermined. Such continuous eligibility policies help promote continuity of care and reduce the burden on beneficiaries, states, and health plans.

Population carve-outs. States often exclude certain beneficiaries from coverage under their Medicaid managed care plans. For example, dually eligible beneficiaries with intellectual or developmental disabilities (ID/DD) are typically carved out of Medicaid managed care and receive services through FFS. As a result, these dually eligible beneficiaries cannot participate in integrated care models.

States have typically excluded this population from managed care (MACPAC 2018b). Managed care plans and ID/DD service providers often lack experience with each other because Medicaid has typically been the dominant payer for services for this population and those services have been covered under FFS. Lack of experience with managed care has sometimes led to stakeholder mistrust and resistance to efforts to move such beneficiaries to managed care. Individuals with ID/DD may be enrolled in LTSS for much longer periods of time than other LTSS beneficiaries, sometimes for decades, and they often use different types of services, such as employment supports (MACPAC 2018b). Only Arizona and Wisconsin enroll their ID/DD population into MLTSS (MACPAC 2018b). Arizona set up an MLTSS program in 1988 to coordinate care, focus on HCBS, and avoid creating a long waiting list (Lewis et al. 2018). For Wisconsin, setting up MLTSS was important to the state to end the waiting list, improve access and choice, increase quality, and achieve cost efficiencies (Lewis et al. 2018).

The Dual Eligible Coalition proposal would eliminate such carve-outs because it seeks to extend integrated care to most, if not all, full-benefit dually eligible beneficiaries. Recognizing that states and beneficiaries are likely to need time to adapt to a fully inclusive model, the proposal notes that the Secretary should have discretion to allow states to phase in certain populations not typically covered under integrated models over a defined period of time (Dual Eligible Coalition 2021). The BPC proposal does not specify whether states would be allowed to carve out certain populations under a fully integrated program although it notes that the ID/DD population is commonly excluded from managed care (BPC 2020).

Maintenance of effort. A maintenance of effort (MOE) provision would require states to continue existing Medicaid eligibility levels while giving them the opportunity to increase eligibility above current levels. This is designed to keep coverage levels from declining relative to prior law but it limits state flexibility to reduce levels based on individual

state circumstances. For example, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) included an MOE so that states would not reduce their Medicaid eligibility levels in response to the roll-out of new coverage options. The Dual Eligible Coalition would establish an MOE for states for income and asset levels for dually eligible beneficiaries.

Beneficiary protections and enrollment

Under current law, eligible individuals enroll in Medicaid through their state or local Medicaid offices and in Medicare through the federal government. Local organizations like State Health Insurance Assistance Programs (SHIPs) and area agencies on aging (AAAs) are available to assist individuals in understanding their coverage options, particularly in Medicare. In addition, Medicaid enrollment brokers under contract with the state and Medicare agents and brokers under contract with Medicare Advantage plans also provide choice counseling and enrollment assistance. In Medicaid, beneficiaries typically have choices between at least two health plans, except in certain rural areas where beneficiaries only have a choice of provider within a health plan (MACPAC 2020c). In Medicare, they may always choose between receiving care under FFS or from available managed care plans under Medicare Advantage.

Beneficiary choice. The opportunity for individuals to choose their own coverage has been a long-standing policy in Medicare. In Medicaid, choices are more constrained, with states often automatically enrolling beneficiaries into managed care plans, but allowing them to opt out and choose a different plan, thus maintaining a degree of beneficiary choice. Under current law, beneficiaries in both MMPs and D-SNPs who do not select a plan on their own prior to a certain date may be automatically enrolled in a plan that is selected to meet their needs. Following auto-enrollment, beneficiaries typically have 30 days to opt out of that plan and join another plan or enroll in Medicare FFS. This type of automatic enrollment occurs in the

MMPs through passive enrollment and into D-SNPs through default enrollment (previously referred to as seamless conversion).¹³

Automatic enrollment is commonplace in Medicaid but controversial in Medicare because it is perceived as limiting beneficiary choice. The Dual Eligible Coalition proposal would maintain existing enrollment flexibilities, such as the option to use default enrollment (Dual Eligible Coalition 2021). The BPC proposal would allow auto-enrollment into fully integrated models while allowing beneficiaries to opt out at any time (BPC 2020).

Another aspect of beneficiary choice relates to the number and types of plans available. Although beneficiary advocates note that maintaining a choice of plans is important, the number of choices currently available may be overwhelming (Prindiville 2020). For example, one study found as many as 43 combinations of coverage available to dually eligible beneficiaries nationwide, although this number varies substantially at the state or county level and in Medicare compared to Medicaid (Rizer 2020). For example, on the Medicaid side, choice is limited by the delivery system the state selects to integrate care, such as an MMP model and the plans participating in that model. Choice on the Medicare side is more complex given the number of individual plan options available to dually eligible beneficiaries, including regular Medicare Advantage plans, stand-alone Part D plans that offer prescription drug coverage only, and a range of Medicare Advantage special needs plans. These include D-SNPs as well as chronic condition special needs plans (C-SNPs) and institutional special needs plans (I-SNPs). D-SNPs are further subdivided into FIDE SNPs and HIDE SNPs, depending on their level of integration. The presence of D-SNPs varies by state because they are required to contract with states to operate there. This requirement does not apply to C-SNPs or I-SNPs.

Policy makers have debated the merits of making fewer plans available. A narrower set of options could make it easier for beneficiaries to compare plans and make an informed choice while still

maintaining their ability to choose a plan (Miller 2020, Prindiville 2020). A narrower set of options may also reduce beneficiary churning among plans that results from individuals disenrolling because the plan does not meet their needs. For example, once they are enrolled, beneficiaries may realize that a particular prescription drug is not covered under the plan and switch to a different plan. Churning also poses challenges for health plans and providers trying to ensure continuity of care for their enrollees. The Dual Eligible Coalition would help beneficiaries navigate their coverage options by requiring states to establish a dedicated ombudsman to help dually eligible individuals, specifically, enroll in coverage. Individuals who choose to opt out of the fully integrated model established under either proposal would typically be enrolled in FFS. The BPC proposal recommends better coordination and education between federal agencies responsible for beneficiary outreach and education and proposes increased funding to states and SHIPs for information and counseling for dually eligible beneficiaries. The BPC proposal does not explicitly address the issue of limiting the number of choices.

A beneficiary's choice of plan may also be affected by the marketing materials used by Medicaid and Medicare. Beneficiaries may receive different marketing materials from each program and may be confused by benefits that overlap between them, such as home health. Both proposals would require one set of marketing materials that provides a clear description of the comprehensive set of benefits covered.

Access to existing providers. Maintaining access to existing providers has been a key concern of beneficiaries when managed care is introduced or when considering plan changes. In California, where eligible beneficiaries have opted out of integrated care at a high rate, the primary reason given was concern over losing access to a provider (Graham et al. 2016). A focus group in California noted that continued access to an existing provider was of primary importance for decisions about enrolling in integrated coverage (Graham et al. 2016).

In establishing a unified program, the composition of provider networks and the feasibility of helping eligible beneficiaries maintain access to their existing providers will be important design considerations. Individuals who are newly dually eligible may rely on a network of providers for their complex care needs that differs from the providers serving the organization's regular Medicare Advantage or commercial populations. Providers have chosen not to participate in integrated care models for a number of reasons including general opposition to managed care and a perception that the requirements of integrated care are overly burdensome (MedPAC 2018, 2016). Some providers opposed to participating in integrated care have also encouraged their patients to opt out (MedPAC 2018). Policymakers could consider whether increasing provider education could improve their participation in integrated care. One state, California, set up a continuity of care period of 12 months during which enrollees in the MMPs could continue to see their existing provider after enrolling in the demonstration if the provider was willing to work with the MMP (CA DHCS 2021).

Enrollment processes. Policymakers need to consider how beneficiaries would voluntarily enroll in a unified program. There may be interest in establishing a so-called no wrong door policy under which eligible individuals could enroll through the state Medicaid program, through Medicare, or through other entities such as AAAs or SHIPs. The ACA created a similar policy for enrollment in Medicaid and the health insurance exchanges that was designed to reduce barriers to enrollment for those seeking coverage. The design of a no wrong door policy should take into account the capacity of existing organizations. For example, SHIPs have small staffs and may have insufficient resources to take on more work unless additional funding is provided.

Dually eligible beneficiaries may receive assistance from Medicare agents and brokers or others in selecting coverage, but concerns have been raised about the role played by such agents and brokers in potentially steering dually eligible beneficiaries away

from integrated products (Lipson et al. 2018). CMS limits the types of products Medicare agents and brokers can sell and their knowledge is generally limited to coverage options they are permitted to market and sell. Incentive structures are such that certain products are more likely to be marketed and sold by Medicare agents and brokers than others. For example, plans are unlikely to market MMPs because Medicare agents and brokers are not permitted to sell them and are not compensated if a beneficiary working with an agent or broker enrolls in an MMP (Lipson et al. 2018). At the same time, their expertise in Medicare Advantage products is often useful in helping beneficiaries navigate a complex system of coverage options, especially individuals coming into dual status from Medicaid who are likely to be less familiar with Medicare products. Medicaid enrollment brokers under contract with the state are independent entities but they may lack expertise in Medicare benefits and in integrated options available to the dually eligible population (Verdier and Chelminsky 2017).¹⁴

Given these issues, policymakers may want to consider new approaches to helping beneficiaries choose the plan that best meet their needs, such as establishing an independent entity with expertise in both Medicare and Medicaid who can help beneficiaries meaningfully compare integrated care options. Both proposals we reviewed called for increased enrollment assistance for dually eligible beneficiaries. The Dual Eligible Coalition proposal would require states to contract with an independent broker to assist beneficiaries in selecting coverage, and the BPC proposal directs the Secretary to expand training for insurance brokers to include training on fully integrated plans (Dual Eligible Coalition 2021, BPC 2020).

Appeals and grievances. Medicare and Medicaid currently use different processes for filing appeals and grievances. This can create confusion and lead to gaps in coverage during an appeal. For example, Medicaid requires health plans to continue benefits during an appeal; this is not the case in Medicare (42 CFR 438.420).¹⁵ The BPC proposal includes a unified appeals process, and

the Dual Eligible Coalition proposal would also establish a unified appeals process and establish a minimum set of federal standards for administering the unified program that includes appeals and grievances. In the MMP models, the process for appeals and grievances is unified. CMS regulations implementing the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) required a unified process in certain HIDE SNPs and FIDE SNPs (42 CFR 422.629–634) (Stringer and Tourtellotte 2020). The FAI also established a dedicated ombudsman program to provide support to beneficiaries with their insurance options, including issues such as appeals and grievances (CMS 2021).

Benefits

Under current law, Medicare covers primary and acute care services and Medicaid wraps around Medicare to cover benefits Medicare does not cover, such as LTSS and non-emergency medical transportation (NEMT). MMPs cover all Medicare and Medicaid benefits under a single plan. FIDE SNPs cover Medicare and some or all Medicaid benefits under one plan including the Medicare acute care package (which covers hospital stays and physician and other outpatient visits), as well as Medicaid-covered LTSS and NEMT. This is a more comprehensive benefit than less integrated D-SNPs in that it covers Medicaid services in addition to Medicare.

A unified program could offer a single benefit package that matches the benefits currently provided by MMPs or FIDE SNPs. In addition to including all existing benefits permitted under current law, policymakers may want to consider whether to expand benefits to services the population is likely to need but that are not typically covered, such as oral health care or additional HCBS that some states currently do not cover (e.g., personal care services that provide assistance with self-care tasks such as bathing or preparing meals). The move away from institutional services to HCBS in recent years reflects both state and beneficiary preferences for these services as well as efforts by CMS to rebalance LTSS. Access to

HCBS has been particularly important during the COVID-19 pandemic because nursing facilities have been vulnerable to high rates of infection, causing beneficiaries and their families to look to alternative community-based options for their care.

Uniform benefit package. A key difference between Medicaid and Medicare under current law is that in Medicare, all beneficiaries are entitled to the same benefit package, but in Medicaid, different types of beneficiaries receive different benefits and benefits vary across states depending on which optional benefits states choose to cover. For dually eligible beneficiaries, Medicare benefits are the same no matter where beneficiaries live, but Medicaid benefits differ depending on their state of residence and sometimes even where they live in the state. For example, in some states, HCBS benefits delivered through a waiver cover only a particular region, rather than the whole state.

A new program may simplify this type of complexity for beneficiaries by providing the same benefit package to all full-benefit dually eligible beneficiaries enrolled in the program. For example, both proposals the Commission reviewed would establish a single set of benefits for all full-benefit dually eligible beneficiaries. The BPC proposal would establish a benefit package that includes medical care, behavioral health, and LTSS, but it is unclear whether state variation would persist, because the proposal would allow states to choose from three different models of care. It is possible that benefits could vary by state either because of the type of model a state selects (e.g., FIDE SNP or PACE) or because a state may choose to be more generous than the requirements (BPC 2020). The Dual Eligible Coalition would establish a core benefit package that covers medical, behavioral, LTSS, and social needs. It would specifically include Medicare Parts A, B, and D; all Medicaid mandatory benefits; and additional behavioral health and social and supportive services that enable flexibility for beneficiaries to achieve better outcomes (Dual Eligible Coalition 2021). Although there are core benefits that would apply to any state that participates in this program, each state would have flexibility to offer additional services.

Medicaid benefit carve-outs. Under current law, states can choose to exclude, or carve out, a Medicaid benefit delivered through managed care. Many states do not provide behavioral health services under their comprehensive managed care contracts due to a combination of financial constraints, policy restrictions, historical precedent, managed care experience and penetration in the state, and stakeholder opposition (MACPAC 2016). Instead, some states contract separately with specialized provider networks or with managed behavioral health organizations to provide these services, which may operate under capitated or FFS arrangements (MACPAC 2016).

Benefit carve-outs occur in integrated care models as well. For example, in the MMP demonstrations, behavioral health benefits are sometimes carved out and instead provided through a Medicaid limited-benefit plan; this separates the financial risk for potentially complex and costly benefits from the MMP. However, it leads to fragmentation for beneficiaries in addressing their physical and behavioral health needs (Soper 2016). For example, when Michigan set up its MMP, it retained the existing carve-out in Medicaid managed care, providing behavioral health services through Medicaid FFS. This created challenges for integrating behavioral health services across Medicare and Medicaid under the demonstration (Walsh 2019).

One consideration for a unified program will be whether to allow such carve-outs. Stakeholders may seek to establish incentives for states to minimize the number of carve-outs rather than prohibiting carve-outs to make the transition easier for states. In the proposal developed by the Dual Eligible Coalition, benefit carve-outs would not be permitted unless an exception was granted by the Secretary. The BPC proposal does not take a position on benefit carve-outs in a fully integrated model, although we understand that it intended to preclude them by establishing a single set of benefits that would include medical, behavioral health, and LTSS (Hayes 2021). The BPC proposal notes the complexities of including behavioral health services

in an integrated model, pointing out that even when those services are included, states may still carve out services for individuals with serious mental illness (BPC 2020).

Delivery system and care coordination

Given that most integrated care models rely on risk-based managed care arrangements, a unified program would most likely rely on a managed care structure, but allow beneficiaries to opt out if they choose not to participate. With managed care, the health plan acts as a central point of coordination between the Medicare and Medicaid programs. Beneficiaries also benefit by having a single point of contact for questions including benefits covered, appeals of a coverage decision, and communications regarding their plan enrollment.

As noted above, allowing beneficiaries to opt out has been key to requiring dually eligible beneficiaries to enroll in managed care, especially in Medicare. Medicare does not typically allow automatic enrollment into managed care because individuals enrolled in Medicare Parts A and B have freedom of choice, which is the right to choose from any participating provider, a right that extends to choosing a Medicare Advantage or Part D plan (Archibald et al. 2019). Automatic enrollment may be seen as infringing on beneficiary rights. For dually eligible beneficiaries, there is an added concern that even when they are given the ability to opt out, they are being treated differently than other Medicare beneficiaries by being required to enroll in managed care which could be viewed as discriminatory (Archibald et al. 2019). Beneficiaries who opt out could be enrolled in FFS for their Medicare and Medicaid benefits.

Presumably, this managed care structure would be designed to provide incentives for improving beneficiary outcomes. For example, at-risk entities providing integrated coverage to dually eligible beneficiaries under a unified program could be accountable for outcomes such as reducing hospitalizations (Miller 2020). Plans could be given some flexibility in how they use the capitated

payment; for example, they might be given greater flexibility than now permitted to address the social needs of their enrollees (Miller 2020).

Both proposals we reviewed would rely on entities that manage care. The Dual Eligible Coalition proposal would deliver care through at-risk capitated managed care plans or, at the request of the state, an at-risk, value-based alternative fully integrated delivery system approved by the Secretary (Dual Eligible Coalition 2021). It would also allow PACE to continue operating, at the option of the state. The BPC proposal would allow states to choose from three models, two of which are managed care arrangements: FIDE SNPs modified to include lessons learned from the MMPs; PACE; and a flexible option that would build off Washington State's managed FFS model (BPC 2020, MACPAC 2020a).

It is important to note that even though managed care is the dominant delivery system for most Medicaid beneficiaries and has grown substantially in Medicare, most dually eligible beneficiaries are not enrolled in managed care. In 2018, 37 percent of full- and partial-benefit dually eligible beneficiaries were enrolled in Medicare managed care (CMS 2020b). Some states do not contract with D-SNPs and in many cases, FIDE SNPs are not present in the state. In 2020, 42 states contracted with D-SNPs but only 11 states had FIDE SNPs (MACPAC 2020a). Although D-SNPs can be aligned with MLTSS plans, meaning beneficiaries can be enrolled for their Medicare and Medicaid services through the same entity, in most states, D-SNPs and MLTSS plans do not operate in the same areas; in 2020, only three states had D-SNPs with companion MLTSS programs operating in the same area (MACPAC 2020a).

Given the current situation, the shift to a wholly managed care model for dually eligible beneficiaries could not be immediate and would likely require a lengthy staged transition. Policymakers would need to think about the time it would take to get these models up and running. For example, states that have long histories with managed care for the dually eligible population, such as Arizona,

which implemented MLTSS in 1989, may have an easier time than states such as North Carolina, which will launch statewide managed care in July 2021 for most Medicaid beneficiaries, excluding populations with complex care needs such as those who are dually eligible (ADvancing States 2021; NC DHHS 2020, 2017). This change is occurring after a lengthy period of debate between the governor and the state legislature (ADvancing States 2021, NC DHHS 2020). Policymakers could look to the expansion of coverage of the new adult group under the ACA, enacted in 2010 but not implemented until 2014, as a model for a timeline that would allow states to conduct outreach to newly eligible beneficiaries and set up the infrastructure for the new program before it begins operation. Similarly, the FAI was announced in 2011 when CMS requested letters of intent from states interested in participating, but enrollment in the first demonstration did not begin until 2013 (MACPAC 2018a).

Provider participation. Educating providers on the benefits of integrated care to improve their understanding of a unified program and encourage them to participate will be key to developing a provider network and enrolling eligible beneficiaries. As noted earlier in this chapter, maintaining an existing provider, even after enrolling in an integrated model, is of primary importance to many beneficiaries.

Providers able to participate in MMPs were not limited by states or CMS and included many different types. For example, in California's demonstration, existing health plans developed new products for the demonstration and established provider networks specifically for them. Those networks included primary care providers, federally qualified health centers (FQHCs), hospitals, and LTSS providers (Hollister et al. 2018). However, some eligible beneficiaries who had previously been enrolled in FFS had to switch providers to join the MMP (Graham et al. 2016). This led some beneficiaries to opt out. Beneficiary focus groups in California concluded that keeping an existing provider was a priority and many opted out of the MMP specifically to retain existing relationships

with providers (McBride et al. 2017, Graham et al. 2016). In addition, in the MMPs, some providers did not have prior experience with managed care or had a bad experience with managed care requirements (e.g., prior authorization rules resulting in delayed payments) (BPC 2020). They opposed managed care arrangements and refused to participate, encouraging their patients to opt out (BPC 2020, MedPAC 2016).

Primary care providers are important to integrating care for the dually eligible population because of their role in coordinating care but their availability is limited in some parts of the country. One study found that counties with the highest density of dually eligible individuals and the fewest primary care clinicians of any type were concentrated in southeastern states (Xu et al. 2021).

Policymakers will need to consider how to address network adequacy requirements for rural areas. Plans serving rural areas may struggle to meet these because the number of providers and the types of providers are limited. It may be especially difficult for plans to contract with specialists. This may make it difficult for plans to meet network adequacy requirements.

As currently crafted, the proposals we reviewed do not focus on this issue. The BPC proposal notes that network adequacy has been a major challenge of integrated care efforts but that states in the FAI developed provider education toolkits that helped promote provider participation (BPC 2020).

Care coordination requirements. A program established exclusively for dually eligible beneficiaries presumably would require participating plans to establish a model of care that explains how care would be coordinated to meet the needs of that population, as is now the case for D-SNPs (CMS 2016). Models of care typically include a plan for care coordination and care management for the beneficiary, including identifying a care management team and an interdisciplinary care team. The beneficiary is part of the interdisciplinary care team that meets

regularly. The team typically conducts a health risk assessment, develops an individualized care plan reflecting the beneficiary's needs and goals, and coordinates Medicare and Medicaid benefits for the individual. The model of care also serves as a quality improvement tool in that it identifies measurable goals for the beneficiary against which progress can be assessed (CMS 2016). Under current law, CMS requires Medicare Advantage special needs plans, including D-SNPs, to establish a model of care plan and submit it for approval to CMS (42 CFR 422.101). It can include clinical and non-clinical elements, such as behavioral health services, transportation, or meal programs. Neither of the proposals we reviewed included requirements specific to models of care.

One consideration in developing a model of care is enrollment of partial-benefit dually eligible beneficiaries who are not entitled to the same benefits as the full-benefit population. Stakeholders have raised concerns about whether enrolling partial- and full-benefit dually eligible beneficiaries in the same plan dilutes the integration possible under that plan because individuals eligible for partial benefits only do not have Medicaid benefits to integrate with Medicare. As noted earlier, policymakers would have to consider whether partial-benefit dually eligible beneficiaries should be in separate plans from the full-benefit population and if not, how they would be accommodated in a plan that offers benefits to which they are not entitled.

Administration

Under current law, the Medicare program is administered by CMS, and Medicaid programs are administered by the states within broad federal guidelines and under oversight provided by CMS. In thinking about the design of a unified program, there are trade-offs between using a federal versus a state-driven approach. This design decision also has implications for federal and state spending.

Federal oversight. Under current law, CMS is the sole entity responsible for overseeing the Medicare program, while oversight responsibility

for Medicaid is shared with states. Both proposals would largely maintain Medicaid's split between federal oversight and state program administration. The BPC proposal would allow states to administer their chosen fully integrated program with oversight from the Secretary through MMCO. In states that do not choose to set up their own program, a federal fallback model would be implemented. Under that model, the Secretary would contract with and oversee Medicare Advantage plans serving the dually eligible beneficiaries in those states (BPC 2020).

The Dual Eligible Coalition proposal would have states administer the unified program, with robust federal standards governing program aspects such as beneficiary protections and access to care. Under this proposal, states would choose whether or not to participate and, as such, this model would not be available for dually eligible beneficiaries in non-participating states (Dual Eligible Coalition 2021).

Both proposals would consolidate federal oversight responsibilities under MMCO, the office within CMS specifically established to focus on this population. Under current law, Medicare Advantage plans, including D-SNPs, are overseen by the Medicare division of CMS. It is our understanding that under the two proposals we reviewed, that responsibility would shift to MMCO for integrated products such as D-SNPs, PACE, and MMPs. Under both proposals, MMCO would continue to be an office within CMS. Our understanding is that regular Medicare Advantage plans that are not integrated products would continue to be overseen by the Center for Medicare.

MMCO may be the best-positioned unit within CMS to provide oversight and develop federal parameters given its expertise and experience with integrated care for the dually eligible population. At the same time, policymakers would need to decide whether MMCO should have full regulatory authority over all programs affecting the dually eligible population, such as PACE, that may interact with the unified program. This is the approach taken by BPC, because under current law, MMCO does not have such authority (BPC 2020). Under the BPC proposal,

MMCO would implement the federal fallback program in states that do not establish their own integrated care program. It would be financed jointly by states and the federal government. States that establish their own programs would administer those with federal oversight. This approach consolidates regulatory authority for all programs affecting dually eligible beneficiaries under a single unit within CMS (BPC 2020).

The Dual Eligible Coalition proposal also provides authority to MMCO to oversee the new Social Security Act title that establishes the unified program but leaves day-to-day administration to states (Dual Eligible Coalition 2021). This approach is similar to how Medicaid functions today. Under the Dual Eligible Coalition proposal, MMCO would be responsible for administering the federal responsibilities for this new title (Dual Eligible Coalition 2021).

State option to participate. State flexibility has been a long-standing feature of the Medicaid program. The program itself is optional for states, and policymakers will have to consider whether to give states the option to participate in a fully integrated program. Another consideration is state capacity to implement an integrated approach. For example, some states have limited experience with managed care or a sparsely distributed population that might make it difficult for them to establish a fully integrated program for dually eligible beneficiaries even if they were interested. Policymakers could follow the example established under the ACA, where states had the option to set up their own health insurance exchange using federal parameters or to use the exchange established by the federal government. Most states opted for the federally run model, although 13 states established their own exchanges (CMS 2020f).

States may have limited capacity to implement a new program, particularly as they struggle with multiple competing priorities and demands. Because of varying levels of capacity among states, some states may be more prepared than others to establish unified programs. In addition,

integrated options such as D-SNPs aligned with MLTSS plans are not available to beneficiaries in all states. Although D-SNPs operate in 42 states, they are not available in all counties, particularly in rural areas, and not all of them offer high levels of integration (MACPAC 2020a). Similarly, while most states use comprehensive managed care plans to provide Medicaid services, some, such as Montana and South Dakota, have no or almost no comprehensive managed care presence (MACPAC 2020d). States face resource constraints and competing priorities that make it difficult to develop essential Medicare expertise and limit their ability to finance the up-front costs of establishing integrated care models. In June 2020, MACPAC recommended that Congress provide additional federal funding for states to enhance their Medicare expertise and help them finance these start-up costs (MACPAC 2020b).

Financing

Medicare and Medicaid are financed differently. Medicare benefits are paid from trust funds established by the federal government and financed by payroll taxes, paid by beneficiaries during their working years, and other sources of funding such as general revenues. Medicaid is jointly financed by the federal government and the states.

Managing separate funding streams from Medicare and Medicaid and the different payment rates and rules related to coverage in each program have created challenges for providers and plans participating in integrated care models (CBO 2013). In the MMPs, one of the most highly integrated options available to states, participating plans receive multiple payments (one payment from the state for the Medicaid component of the rate, one payment from CMS for the Medicare Part A and B components, and another payment from CMS for the Medicare Part D component) but rate setting is coordinated between CMS and the states (CMS 2019a). Another fully integrated option, PACE, has something closer to integrated funding because plans have broad authority to combine capitation payments from Medicaid and Medicare (CMS 2011).

A criticism of the current system is that funds flow to integrated models in separate streams (Archibald and Kruse 2015). When there are savings in one program, these are not shared. Proponents of a unified program argue that a single funding stream would strengthen the ability to integrate care. An integrated funding stream would also avoid conflicting financial incentives that exist today where costs may be shifted among programs (Archibald and Kruse 2015). For example, Medicaid programs would have an incentive to reduce costs such as those incurred from hospital readmissions because the costs of those readmissions would be paid out of an integrated funding stream rather than by Medicare only.

Both the BPC and the Dual Eligible Coalition recommend a more streamlined financing approach. The BPC recommends fully aligned financing with a single entity responsible for Medicare and Medicaid funding in all counties or regions of the state (BPC 2020). The Dual Eligible Coalition proposal envisions a single, integrated funding stream that pays plans from the combined funding from Medicare and both the federal and state share of Medicaid (Frizzera 2020).

Federal and state shares of financing. Both proposals we reviewed would maintain a shared financing system between the states and the federal government but make changes in how those shares are determined initially and over time. Although the details of those arrangements are not fully specified, each proposal sheds some light on how it would work.

Under the BPC proposal, the federal fallback option would be financed based on existing state and federal spending on the dually eligible population. The state share would be calculated using state-specific per capita rates set by the Secretary based on state spending on the date of enactment (BPC 2020).

The Dual Eligible Coalition would establish a baseline by blending Medicare and Medicaid spending for dually eligible beneficiaries derived

from the federal fiscal year two years prior to enactment of the unified program (Dual Eligible Coalition 2021). The federal government and the states would both contribute to funding the program and states would assume full risk for managing it. For the first year of operation, the federal and state shares of costs would be allocated according to base-year percentages that are calculated for each. The federal share of the costs would include all Medicare costs for full-benefit individuals plus federal Medicaid matching payments for that population. The state share of the costs would include all state Medicaid costs for the full-benefit dually eligible population (including LTSS) plus the state's clawback payments to Medicare Part D.¹⁶ Each subsequent year would be based on the prior year's expenditures. Spending thresholds are not specified but would be set to ensure spending is controlled. The mechanism would be designed to increase the state contribution and decrease the federal contribution if total expenditures exceeded the threshold. If total expenditures were to fall below the threshold, the federal contribution would increase and the state contribution would decrease, meaning states would have an incentive to reduce spending. Exceptions to this adjustment would have to be approved by the Secretary (Dual Eligible Coalition 2021).

Shared savings for states. As noted above, a frequent criticism of existing models is that savings in one program are not shared with the other, limiting state incentives to participate in integrated care models. For example, reductions in hospitalizations would generate savings to Medicare, not to Medicaid. To incentivize states to participate, a unified program could include a mechanism by which states could share in any savings the program generates.

The BPC proposal would provide the authority to the Secretary to establish a guaranteed shared savings program for integrated care where Medicare savings would be shared with states and would be guaranteed in that they would be incorporated into the rates so that the total cost of care would reflect decreases in per capita costs (BPC 2020). The BPC

proposal specifies that states should share in at least 33 percent of total savings (BPC 2020).

The Dual Eligible Coalition proposal requires a reinvestment of savings back into the unified program when the decrease in annual expenditures exceeds a predetermined spending threshold (Dual Eligible Coalition 2021). The state would share in these savings based on the share of the state's contribution to the financing of the program. The state would have the authority to use the savings to promote a number of core principles including prevention and wellness to enable beneficiaries to receive individualized health care focused on improving their outcomes, increased integration with social needs that impact health outcomes, and capacity building to enable access to more community-based care (Dual Eligible Coalition 2021).

This discussion assumes that stakeholders will be able to identify any savings generated by integrated care, even though this has been a challenge in existing models such as the MMPs, and that those savings will exceed the administrative costs of the health plans and allow for savings to be shared with states.

Risk mitigation. The BPC proposal notes that health plans entering a new market face uncertainties in a number of areas, including lack of experience with how much the population enrolled will cost and how many services they will use (BPC 2020). The BPC suggests there are ways to mitigate those risks for plans and promote plan participation through risk mitigation strategies (BPC 2020). For example, FAI demonstrations in some states included additional risk mitigation techniques to share risk between plans and the state, including risk corridors (MACPAC 2018a). With a risk corridor, participating states receive a payment from CMS if their losses exceed a certain threshold, and the plans pay CMS and the state if their gains exceed a certain threshold (MACPAC 2018a). These risk mitigation strategies also help states and the federal government mitigate the uncertainty around developing payment rates.

Establishing spending levels. Depending on how a unified program is financed, decisions would need to be made about how funding amounts for states would be determined, particularly if states are managing the program and assuming the risk. Medicare and Medicaid are open-ended entitlement programs that do not operate with a fixed amount of funding but draw down federal and state dollars to pay for services. Policymakers would need to decide how this open-ended funding approach would work in a unified program. For example, decisions include the choice of a base year for the purposes of setting initial funding amounts based on Medicaid and Medicare spending for dually eligible beneficiaries in each state, and year-to-year growth rates and adjustments to be made in the case of unforeseen events such as pandemics or economic downturns, which may affect enrollment and spending in the program. For example, in the Dual Eligible Coalition proposal, a funding baseline would be established using the federal fiscal year that is two years prior to implementation of the program; it could be adjusted for changes that occur, based on the Secretary's discretion (Dual Eligible Coalition 2021).

The Future of Coverage for Dually Eligible Beneficiaries

In the Commission's view, a unified program designed specifically for the dually eligible population has the potential to address the fragmentation and poor outcomes that result from having two uncoordinated programs. The complexity of designing such a program, however, requires careful consideration of available options and their attendant trade-offs. Moreover, the wide availability of managed care options envisioned by both the BPC and the Dual Eligible Coalition are not yet a reality, and they acknowledge this in their proposals. States and the federal government would also need a substantial amount of time to stand up a new structure of coverage for the dually eligible population. In the meantime, the Commission will continue work aimed at improving the integration of care for dually eligible beneficiaries.

Endnotes

- ¹ The 12.3 million figure represents all dually eligible beneficiaries. 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. Of this total, 71.1 percent are considered full-benefit dually eligible beneficiaries, eligible for full Medicaid benefits. The remaining 28.9 percent are considered partial-benefit dually eligible beneficiaries because they qualify for Medicaid assistance only with their Medicare premiums and sometimes cost sharing. They do not receive Medicaid services such as long-term services and supports (CMS 2020a).
- ² For more information on the dually eligible population, see MACPAC's June 2020 report to Congress, Chapter 1, Integrating Care for Dually Eligible Beneficiaries: Background and Context (MACPAC 2020a).
- ³ For example, the Bipartisan Policy Center published a proposal in July 2020 that would require states to establish a fully integrated system or adopt a federal fallback mechanism (BPC 2020). Another group, the Dual Eligible Coalition, is developing a proposal to establish a new program for dually eligible beneficiaries (Dual Eligible Coalition 2021). We discuss these two proposals in detail later in this chapter.
- ⁴ MMPs were created under the FAI, which was authorized under Section 1115A of the Social Security Act (the Act), as a demonstration program to improve health care delivery to dually eligible beneficiaries and align financial incentives in Medicaid and Medicare (CMS 2020g). Other FAI models include a managed FFS model and an option for states to develop an alternative model.
- ⁵ Medicare Part A covers inpatient hospital and skilled nursing facility care, post-acute home health care, and hospice care. Medicare Part B covers physician services and the services of other practitioners, outpatient hospital care, care in other outpatient settings, home health care not paid for under Part A, other medical services and supplies, and drugs that cannot be self-administered. Part D covers prescription drugs.
- ⁶ For more information on the payment framework in the FAI capitated model, see MACPAC's January 2018 issue brief, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare* (MACPAC 2018a).
- ⁷ 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.
- ⁸ 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 2020d).
- ⁹ 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 2020h).
- ¹⁰ To qualify for coverage of Medicare Part A at age 65, individuals must pay Medicare payroll taxes for at least 40 quarters (10 years). 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).
- ¹¹ 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/>.
- ¹² In calendar year 2013, 42 percent of full-benefit dually eligible beneficiaries enrolled in FFS used Medicaid LTSS (MACPAC and MedPAC 2018).
- ¹³ Passive enrollment generally refers to automatic enrollment into an MMP and can also be used in somewhat limited circumstances to allow beneficiaries to retain access to integrated care, such as when a Medicaid managed care plan's contract is not renewed by the state. Default enrollment, which was previously called seamless conversion, refers to automatic enrollment into a D-SNP. The focus of default enrollment is on a Medicaid beneficiary who is newly eligible for Medicare (ICRC 2018).

¹⁴ See MACPAC staff presentation, Integration of care for dually eligible beneficiaries: New analyses, at <https://www.macpac.gov/publication/integration-of-care-for-dually-eligible-beneficiaries-new-analyses/>.

¹⁵ For more information on integrating appeals processes between the two programs, see MACPAC's January 2018 staff presentation, Integrating Appeals Processes for Dually Eligible Beneficiaries, at <https://www.macpac.gov/publication/integrating-appeals-processes-for-dually-eligible-beneficiaries/>.

¹⁶ States make a monthly payment to the federal government to help finance the cost of prescription drug coverage for full-benefit dually eligible beneficiaries that is covered under Medicare Part D. Prior to 2006, states covered prescription drug costs for dually eligible beneficiaries and this payment was not necessary.

References

Advancing States. 2021. State Medicaid integration tracker: North Carolina. <http://www.advancingstates.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker/north-carolina>.

Archibald, N., and M. Soper. 2020. COVID-19's effect on dually eligible populations. Center for Health Care Strategies *CHCS Blog*. November 2. <https://www.chcs.org/covid-19s-effect-on-dually-eligible-populations/>.

Archibald, N., M. Soper, L. Smith, et al. 2019. *Integrating care through dual-eligible special needs plans (D-SNPs): Opportunities and challenges*. Washington, DC: Assistant Secretary for Planning and Evaluation (ASPE). <https://aspe.hhs.gov/system/files/pdf/261046/MMI-DSNP.pdf>.

Archibald, N. and A. Kruse. 2015. *Snapshot of integrated care models to serve dually eligible beneficiaries*. Washington, DC: Center for Health Care Strategies, Inc. <https://www.chcs.org/media/INSIDE-Snapshot-of-Integrated-Care-12-14-15-FINAL.pdf>.

Bipartisan Policy Center (BPC). 2020. *A pathway to full integration of care for Medicare-Medicaid beneficiaries*. Washington, DC: BPC. <https://bipartisanpolicy.org/report/a-pathway-to-full-integration-of-care-for-medicaremedicaid-beneficiaries/>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Beneficiary counseling & ombudsman programs. Baltimore, MD: CMS. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/BeneficiaryCounselingandOmbudsmanPrograms>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Data analysis brief: Medicare-Medicaid dual enrollment 2006 through 2019*. Washington, DC: Medicare-Medicaid Coordination Office. <https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. *People dually eligible for Medicare and Medicaid*. March 2020 fact sheet. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Preliminary Medicare COVID-19 data snapshot. Baltimore, MD: CMS. <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020d. Letter from Sharon Donovan to Dual Eligible Special Needs Plans regarding "Additional guidance on CY 2021 Medicare-Medicaid integration requirements for Dual Eligible Special Needs Plans (D-SNPs)." January 17, 2020. <https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020e. PACE. Baltimore, MD: CMS. <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/pace>.

- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020f. State-based exchanges. Baltimore, MD: CMS. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020g. Financial alignment initiative. Baltimore, MD: CMS. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020h. *Medicaid health homes: An overview*. December 2020 fact sheet. Baltimore, MD: CMS. <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019a. *Joint rate-setting process for the Financial Alignment Initiative's Medicare-Medicaid Plans*. Baltimore, MD: CMS. <https://www.cms.gov/files/document/capitatedmodelratesettingprocess03192019.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019b. Original Medicare (Part A and B) eligibility and enrollment. Baltimore, MD: CMS. <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABELigEnrol>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Chapter 16B: Special needs plans. In *Medicare managed care manual*. (Rev.123 8-19-16). Baltimore, MD: CMS. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. CMS and Washington State partner to coordinate care for Medicare-Medicaid enrollees. October 2012 fact sheet. Baltimore, MD: CMS. <https://www.cms.gov/newsroom/fact-sheets/cms-and-washington-state-partner-coordinate-care-medicare-medicaid-enrollees>.
- Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Chapter 13: Payments to PACE organizations. In *PACE manual*. Baltimore, MD: CMS. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c13.pdf>.
- Congressional Budget Office (CBO). 2013. *Dual-eligible beneficiaries of Medicare and Medicaid: Characteristics, health care spending, and evolving policies*. <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf>.
- Department of Health and Human Services, State of North Carolina (NC DHHS). 2020. NC Medicaid launches website for beneficiaries to learn more about Medicaid managed care. November 9, 2020, press release. Raleigh, NC: NC Medicaid Division of Health Benefits. <https://medicaid.ncdhhs.gov/blog/2020/11/09/nc-medicaid-launches-website-beneficiaries-learn-more-about-medicaid-managed-care>.
- Department of Health and Human Services, State of North Carolina (NC DHHS). 2017. *Medicaid managed care: A guide for people with North Carolina Medicaid*. Raleigh, NC: NC DHHS. https://files.nc.gov/ncdhhs/ProgramDesign_BeneficiaryInfoSheet_FINAL_20170808.pdf.
- Department of Health Care Services, State of California (CA DHCS). 2021. Continuity of care information. Sacramento, CA: DHCS. <https://www.dhcs.ca.gov/services/Pages/ContinuityOfCareInfo.aspx>.
- Dual Eligible Coalition. 2021. About the coalition. Washington, DC: Leavitt Partners. <https://info.leavittpartners.com/dual-eligible-coalition>.
- Engelhardt, T., Medicare-Medicaid Coordination Office (CMS). 2021. Email to MACPAC, January 23.
- Feng, Z., A. Vadhais, E. Vreeland, et al. 2019. *Loss of Medicare-Medicaid dual-eligible status: Frequency, contributing factors and implications*. Washington, DC: Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf>.
- Frizzera, C., Leavitt Advisors. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, October 29, 2020, Washington, DC. https://www.macpac.gov/public_meeting/october-2020-macpac-public-meeting/.

Grabowski, D.C. 2007. Medicare and Medicaid: Conflicting incentives for long-term care. *Milbank Quarterly* 85, no. 4: 579–610. <https://www.milbank.org/quarterly/articles/medicare-and-medicare-conflicting-incentives-for-long-term-care/>.

Graham, C., E. Kurtovich, M. Liu, et al. 2016. *Evaluation of Cal MediConnect: Key findings from focus groups with beneficiaries*. Long Beach, CA: The SCAN Foundation. https://www.thescanfoundation.org/sites/default/files/cal_medicconnect_key_findings_brief_march_2016.pdf.

Hayes, K., Bipartisan Policy Center (BPC). 2021. E-mail to MACPAC, January 29.

Hollister, B., W. Tseng, M. Pi-Ju Liu, et al. 2018. *Integration of Medicare and Medicaid in California: Provider Perspectives of Cal MediConnect*. Long Beach, CA: The SCAN Foundation. http://www.thescanfoundation.org/sites/default/files/provider_perspectives_final_010818.pdf.

Integrated Care Resource Center (ICRC). 2018. Aligning coverage for dually eligible beneficiaries using default and passive enrollment. Presentation from an ICRC webinar, July 31, 2018. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Default_and_Passive_Enrollment_July-31-18%20FOR%20508%20%28002%29.pdf.

Lewis, S., R. Patterson, and M. Alter. 2018. *Current landscape: Managed long-term services and supports for people with intellectual and developmental disabilities*. Washington, DC: American Network of Community Options and Resources. https://www.ancor.org/sites/default/files/ancor_mltss_report_-_final.pdf.

Lipson, D., E. Lakhmani, A. Tourtellotte, and D. Chelminsky. 2018. *The complex art of making it simple: Factors affecting enrollment in integrated care demonstrations for dually eligible beneficiaries*. Washington, DC: Mathematica. <https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/>.

McBride, K., A. Reynoso, T. Alunan, et al. 2017. *Cal MediConnect enrollment: Why are dual-eligible consumers in Los Angeles County opting out?* Los Angeles, CA: University of California Los Angeles. <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1661>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Chapter 1: Integrating care for dually eligible beneficiaries: Background and context. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. <https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. Chapter 2: Integrating care for dually eligible beneficiaries: Policy issues and options. In *Report to Congress on Medicaid and CHIP*. June 2020. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-2-Integrating-Care-for-Dually-Eligible-Beneficiaries-Policy-Issues-and-Options.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020c. Enrollment process for Medicaid managed care. Washington, DC: MACPAC. <https://www.macpac.gov/subtopic/enrollment-process-for-medicare-managed-care/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020d. Exhibit 29: Percentage of Medicaid enrollees in managed care by state. In *MACStats: Medicaid and CHIP data book*. December 2020. Washington, DC: MACPAC. <https://www.macpac.gov/macstats/>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. *Financial Alignment Initiative for beneficiaries dually eligible for Medicaid and Medicare*. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicare.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. Chapter 3: Managed long-term services and supports: Status of state adoption and areas of program evolution. In *Report to Congress on Medicaid and CHIP*. June 2018. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2018/06/Managed-Long-Term-Services-and-Supports-Status-of-State-Adoption-and-Areas-of-Program-Evolution.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 4: Integration of behavioral and physical health services in Medicaid. In *Report to Congress on Medicaid and CHIP*. March 2016. Washington, DC: MACPAC. <https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. Chapter 4: Medicaid coverage of premiums and cost sharing for low-income beneficiaries. In *Report to Congress on Medicaid and CHIP*. March 2013. Washington, DC: MACPAC. <https://www.macpac.gov/publication/ch-4-medicare-coverage-of-premiums-and-cost-sharing-for-low-income-medicare-beneficiaries/>.

Medicaid and CHIP Payment and Access Commission and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2018. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC and MedPAC. <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicare-3/>.

Medicare Payment Advisory Commission (MedPAC). 2019. Chapter 12: Promoting integration in dual-eligible special needs plans. In *Report to Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC). 2018. Chapter 9: Managed care plans for dual-eligible beneficiaries. In *Report to the Congress: Medicare and the health care delivery system*. June 2018. Washington, DC: MedPAC. http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf.

Medicare Payment Advisory Commission (MedPAC). 2016. Chapter 9: Issues affecting dual eligible beneficiaries: CMS' Financial Alignment Demonstration and the Medicare Savings Programs. In *Report to the Congress: Medicare and the health care delivery system*. June 2016. Washington, DC: MedPAC. <http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf>.

Miller, M., Arnold Ventures. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, October 29, 2020, Washington, DC. https://www.macpac.gov/public_meeting/october-2020-macpac-public-meeting/.

National PACE Association (NPA). 2019. *PACE by the numbers*. Alexandria, VA: NPA. https://www.npaonline.org/sites/default/files/3186_pace_infographic_update_121819_combined_v1.pdf.

Ormond, C., G. Khatutsky, T. Thach, et al. 2019. *Financial Alignment Initiative California Cal MediConnect: First evaluation report*. Report to CMS, contract no. HHSM-500-2014-0037i TO #7. Durham, NC: RTI International. <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.

Prindiville, K., Justice in Aging. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, October 29, 2020, Washington, DC. https://www.macpac.gov/public_meeting/october-2020-macpac-public-meeting/.

Rizer, A. 2020. *Making sense of Medicare-Medicaid integration models*. Washington, DC: ATI Advisory. <https://atiadvisory.com/making-sense-of-medicare-medicare-integration-models/>.

Soper, M. 2016. *Integrating behavioral health into Medicaid managed care: Design and implementation lessons from state innovators*. Washington, DC: Center for Health Care Strategies. https://www.chcs.org/media/BH-Integration-Brief_041316.pdf.

Sorbero, M.E., A. M. Kranz, K. E. Bouskill, et al. 2018. *Addressing social determinants of health needs of dually eligible beneficiaries in Medicare Advantage plans*. Report to ASPE, contract no. HHSP23320059649WCTO38. Santa Monica, CA: RAND Corporation. https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf.

Stringer, R., and A. Tourtellotte. 2020. *Integrated appeal and grievance processes for integrated D-SNPs with "exclusively aligned enrollment."* Washington, DC: Integrated Care Resource Center. <https://www.integratedcareresourcecenter.com/resource/integrated-appeal-and-grievance-processes-integrated-d-snps-%E2%80%99Cexclusively-aligned-enrollment>.

U.S. Government Accountability Office (GAO). 2020.

Medicare and Medicaid: Alignment of managed care plans for dual eligible beneficiaries. Report no. GAO-20-319. Washington, DC: GAO. <https://www.gao.gov/assets/710/705345.pdf>.

Verdier, J. and D. Chelminsky. 2017. *State and health plan strategies to grow enrollment in integrated managed care plans for dually eligible beneficiaries.* Washington, DC: Integrated Care Resource Center.

https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf.

Walsh, E. 2019. *Financial Alignment Initiative Michigan MI Health Link first evaluation report.* Report to CMS, contract no. HHSM-500-2014-00037i TO#7. Waltham, MA: RTI International. <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIEvalReport1.pdf>.

Xu, W., S. Retchin, and P. Buerhaus. 2021. Dual-eligible beneficiaries and inadequate access to primary care providers. *American Journal of Managed Care* 27, no. 5. <https://www.ajmc.com/view/dual-eligible-beneficiaries-and-inadequate-access-to-primary-care-providers>.

APPENDIX 4A: Integrated Care Authorities

Over the past 20 years, Congress has created a number of authorities to encourage integration of Medicaid and Medicare and provide a more seamless experience for beneficiaries (Table 4A-1).

These actions include establishing the Program of All-Inclusive Care for the Elderly; creating and refining dual eligible special needs plans, a type of Medicare Advantage plan; and designating offices within the Centers for Medicare & Medicaid Services to coordinate Medicaid and Medicare and develop innovative payment and delivery models.

TABLE 4A-1. Federal Legislative Milestones to Integrate Care for Dually Eligible Beneficiaries, 1997–2018

Year	Legislative milestone and key provisions
1997	<p>Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)</p> <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	<p>Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173)</p> <ul style="list-style-type: none"> Establishes Medicare Advantage (MA). 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). Allows a D-SNP to target enrollment to a subset of the dually eligible population if the D-SNP has an agreement with the state Medicaid agency. SNPs were initially authorized to operate from 2006 through December 31, 2008, but the authority has been extended repeatedly through subsequent legislation.
2008	<p>Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)</p> <ul style="list-style-type: none"> Requires all D-SNPs to have contracts with the states in which they operate by 2013. MIPPA requires 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	<p>Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended)</p> <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	<p>Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123)</p> <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.