Chapter 5:

Raising the Bar: Requiring State Integrated Care Strategies

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Recommendation

5.1 Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components—integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, quality measurement—and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

Key Points

- The 12.2 million individuals dually eligible for Medicaid and Medicare often experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrating care has the potential to improve care for beneficiaries, eliminate incentives for cost shifting, and reduce spending that may arise from duplication of services or poor care coordination. However, enrollment in integrated models was just over 1 million in 2020.
- States are at different stages of integrating care for their dually eligible populations, and the availability of integrated models and the level of integration offered in those models varies. Some states have achieved high levels of integration, while others offer only minimal or no integrated coverage options.
- State officials point to a number of barriers to integration. These include competing priorities, lack of Medicare expertise, limited staff capacity to manage integrated care initiatives relative to other responsibilities, and limited experience with enrolling dually eligible beneficiaries in Medicaid managed care.
- While the Commission appreciates these dynamics, it continues to press for action to increase enrollment in integrated models, expand the availability of these models, and achieve higher levels of integration. To provide the impetus for action for all states, we recommend that all states be required to develop a strategy to integrate care for dually eligible beneficiaries. We also discuss the key components to be included in such a strategy.
- Given the level of effort and specialized expertise needed to integrate care, we also recommend that Congress provide additional federal funding to support states in developing their strategies.

CHAPTER 5: Raising the Bar: Requiring State Integrated Care Strategies

Integrating Medicaid and Medicare coverage for individuals enrolled in both programs, known as dually eligible beneficiaries, has the potential to improve care and reduce federal and state spending. As noted in the Commission's prior work, dually eligible beneficiaries often experience fragmented care and poor health outcomes due to poor coordination of services between the two programs (MACPAC 2020a and 2020b). Moreover, dually eligible beneficiaries account for about one-third of total costs to the federal government and the states in each program, although they represent just 14 percent of Medicaid beneficiaries and 19 percent of Medicare beneficiaries (MACPAC and MedPAC 2022).

Of the 12.2 million individuals who were dually eligible in 2019, 71 percent were eligible for full Medicaid benefits, and the remainder were eligible only for Medicaid assistance with Medicare premiums and sometimes cost sharing (MACPAC and MedPAC 2022). These groups are known as full-benefit and partial-benefit dually eligible beneficiaries, respectively.

Integrated care efforts tend to focus on full-benefit dually eligible beneficiaries because they have Medicaid benefits to integrate with Medicare (MACPAC and MedPAC 2022). However, just over 1 million full-benefit dually eligible beneficiaries were enrolled in integrated care in 2020 (CMS 2020a).[1]

The Commission's long-term vision is for all dually eligible beneficiaries to be enrolled in an integrated model. To that end, the Commission's work has focused on three key goals: increasing enrollment in integrated products, making integrated products more widely available, and promoting greater integration in existing products.

In our June 2020 and 2021 reports to Congress, we focused on enhancing state capacity to integrate care by recommending additional federal assistance. We also analyzed ways that states could advance integration through contracts with Medicare Advantage (MA) dual eligible special needs plans (D-SNPs) by highlighting existing strategies available to states and describing how state Medicaid program characteristics and local markets may affect state choices.

Over the past year, we consulted with experts on how to further advance integration. In September 2021, we convened a roundtable discussion with states to hear directly about the status of their integration efforts. We focused on states in the early stages of integration to better understand the challenges they face. We also talked with health plans and beneficiary advocates to obtain their perspective on how to raise the bar on integrating care for dually eligible beneficiaries. We heard that integration strategies should focus on ensuring that beneficiary needs are met and that states need more guidance and financial support to stand up integrated models.

Raising the bar on integration will not be successful with a one-size-fits-all approach. States are at different stages of integrating Medicaid and Medicare coverage for dually eligible beneficiaries (Appendix 5A). Some offer fully integrated coverage, while others do not yet have integrated options available. In our conversations with state officials, we heard about some of the different factors—limited state resources, competing priorities for state leadership, and limited experience with enrolling dually eligible beneficiaries in Medicaid managed care—that may make it difficult for states to take steps toward integration. For example, experience enrolling people who are likely to become dually eligible (e.g., older adults and individuals with disabilities) into Medicaid managed care is necessary for states to take advantage of certain strategies, such as default enrollment into D-SNPs.[2]

In the Commission's view, federal policy must both recognize this variation across states but also provide an impetus for further action. In this chapter, we propose an incremental approach that starts by requiring all states to develop a strategy to integrate care for dually eligible beneficiaries. While states will take different paths and make progress at different rates, fully integrated coverage in all states for this population should be the eventual goal. The Commission views a federal requirement that states develop a clear, detailed integrated care strategy as an important step in raising expectations. This step may be particularly useful in spurring action among states that to date have not made progress toward integration. Given the level of effort and specialized expertise needed to integrate care for this population, we also recommend additional federal funding to support states in developing their strategies.

In this chapter, the Commission recommends the following:

- Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components—integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, quality measurement—and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

Finally, we present the rationale for this recommendation and its expected effects on federal spending and on stakeholders, including states, beneficiaries, health plans, and providers.

It is important to note that in addition to support for development of a strategy to integrate care, states will likely need additional resources to set up and operate integrated models. This was the focus of our June 2020 recommendation, which we once again call to the attention of Congress.

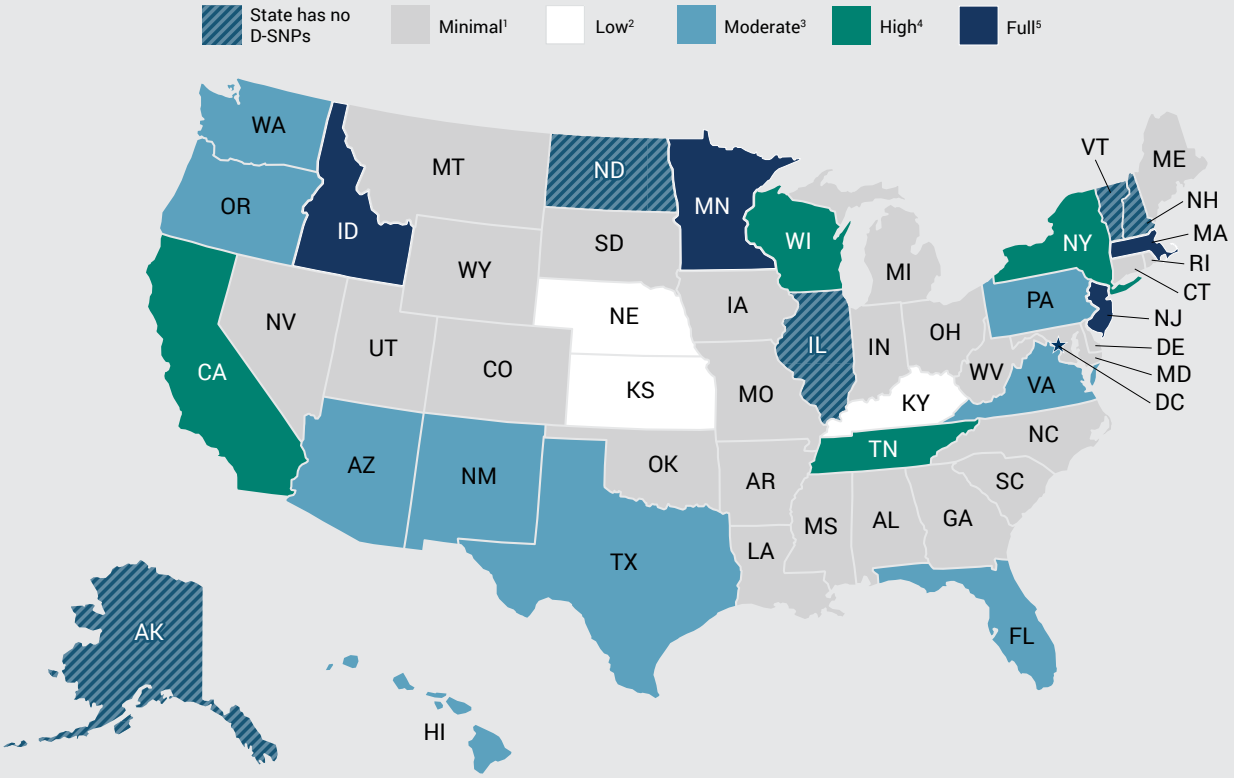
Continuum of Integration

States can adopt a number of models to integrate care that exist on a continuum of integration, with some models offering limited integration and others offering fully integrated coverage (Appendix 5A). Use of these models varies widely across states, including the level of integration offered via D-SNPs (Figure 5-1).

Fully integrated models are not available in all states (Appendix 5A).[3] We define fully integrated care as an approach that is intended to align the delivery, payment, and administration of Medicaid and Medicare services (MACPAC 2020b). Ideally, this would involve a single entity covering all Medicaid and Medicare benefits for full-benefit dually eligible beneficiaries (Box 5-1).

D-SNPs are a type of MA plan that limits enrollment to dually eligible beneficiaries. Most D-SNPs offer minimal levels of integration and are referred to as coordination-only D-SNPs because they only coordinate Medicaid services rather than covering them. D-SNPs serve more beneficiaries than other integrated models, with 3.8 million enrollees as of February 2022 (CMS 2022a).[4] They are present in 45 states and the District of Columbia (CMS 2022b). State contracts with D-SNPs must meet minimum requirements for coordination of Medicaid benefits (42 CFR 422.107(c) and (d)). Although the regulations include some minimal coordination between the D-SNP and the state, they do not result in fully integrated coverage (MedPAC 2019).

FIGURE 5-1. Dual Eligible Special Needs Plan Integration Levels by State



Notes: D-SNP is dual eligible special needs plan. Exclusively aligned enrollment occurs when D-SNP enrollment is limited to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan under the same parent company. This map depicts only the level of integration available in the state based on the presence of D-SNPs, including highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs), as described in the following notes. It does not reflect the presence of other integrated models, such as Medicare-Medicaid Plans established under the Financial Alignment Initiative and available in 9 states or Programs of All-Inclusive Care for the Elderly that are available in 30 states (NPA 2022). California has one FIDE SNP that operates with exclusively aligned enrollment, but the FIDE SNP is not available statewide. The other D-SNPs in California are minimally integrated coordination-only D-SNPs. The District of Columbia has one HIDE SNP in 2022 that is capitated to cover all Medicaid benefits but does not restrict enrollment to full-benefit dually eligible individuals. In 2023, the HIDE SNP operating in the District of Columbia will use separate plan benefit packages to serve full- and partial-benefit dually eligible individuals and will have exclusively aligned enrollment for full-benefit dually eligible individuals.

[1] A state with a minimal level of integration is a state that has coordination-only D-SNPs but no HIDE SNPs or FIDE SNPs.

[2] A state with a low level of integration is a state that has at least some HIDE SNPs but has not yet taken active steps to use those D-SNPs to design an integrated care initiative. HIDE SNP status has been achieved because D-SNP parent companies offer Medicaid managed care plans in overlapping service areas.

[3] A state with a moderate level of integration is a state that has HIDE SNPs or FIDE SNPs or both and has worked with the D-SNPs in the state to increase integration through strategies such as selective contracting, in which states contract only with D-SNPs that meet certain state requirements. D-SNPs in the state do not operate with exclusively aligned enrollment.

[4] A state with a high level of integration is a state that has some FIDE SNPs that operate with exclusively aligned enrollment but also has non-integrated or less-integrated D-SNPs.

[5] A state with full integration means all D-SNPs in the state are either FIDE SNPs or HIDE SNPs that operate with exclusively aligned enrollment.

Sources: Mathematica analysis, 2021, for MACPAC. CMS 2022b.

BOX 5-1. Key Features of a Fully Integrated Program

Coverage of all Medicaid and Medicare benefits. A fully integrated program should cover all Medicaid and Medicare benefits for full-benefit dually eligible beneficiaries under one entity with one set of member materials.

Care coordination. Care coordinators and care teams should establish individualized care plans to meet the unique needs of dually eligible beneficiaries enrolled in fully integrated care.

Beneficiary protections and input. A fully integrated model should offer protections to beneficiaries, such as through an ombudsman, and also establish a mechanism for beneficiary input. The Medicare-Medicaid Plans under the Financial Alignment Initiative incorporated both of these elements.

Financial alignment. In a fully integrated model, a single entity should receive a single payment to cover both Medicaid and Medicare services.

Highly integrated dual eligible special needs plans (HIDE SNPs) and fully integrated dual eligible special needs plans (FIDE SNPs) provide higher levels of integration because they are required to cover some Medicaid benefits. They are present in 20 states and the District of Columbia (Appendix 5A). HIDE SNPs offer more coordination with Medicaid than coordination-only D-SNPs because they are required to cover long-term services and supports (LTSS) or behavioral health or both. HIDE SNPs are present in 16 states and the District of Columbia.

FIDE SNPs offer fully integrated coverage and are typically responsible for all Medicaid and Medicare benefits. They are required to cover LTSS; they may also cover behavioral health unless the benefit is carved out by the state. FIDE SNPs may operate with exclusively aligned enrollment, which occurs when enrollment is limited to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the FIDE SNP. FIDE SNPs are present in 12 states.

Other models that offer fully integrated coverage include Medicare-Medicaid Plans (MMPs) and managed fee for service (FFS) under the Financial Alignment Initiative (FAI) as well as the Program of All-Inclusive Care for the Elderly (PACE). MMPs operate under a three-way contract with the Centers for Medicare & Medicaid Services (CMS), the state, and the plan to provide all Medicaid and Medicare benefits. Under the FAI, nine states are operating capitated model demonstrations in which MMPs cover all Medicare and Medicaid benefits, except Medicaid benefits that the state has carved out, with enrollment of over 400,000 dually eligible beneficiaries (ICRC 2022).[5]

Under managed FFS, the state contracts with an organization to manage all Medicaid and Medicare services on an FFS basis. One state, Washington, operates a managed FFS demonstration under the FAI, which covers all Medicaid and Medicare benefits and enrolls about 11,000 dually eligible beneficiaries (Box 5-2) (WA HCA 2022).

In PACE, a provider organization contracts with CMS and the state to provide all Medicaid and Medicare benefits for individuals age 55 and older who qualify for a nursing facility level of care but reside in the community. Almost all PACE beneficiaries—90 percent—are dually eligible for Medicaid and Medicare (NPA 2022). PACE is available in 30 states with about 60,000 enrollees (NPA 2022).

BOX 5-2. Example of an Integration Approach for States with Medicaid Fee for Service

Given that many states enroll dually eligible individuals in Medicaid fee for service (FFS) (21 states and the District of Columbia as of 2018), it is important to consider integration approaches that do not rely on a Medicaid managed care infrastructure (Appendix 5A). Use of such models could enable more states to further advance integration and reach additional beneficiaries. In 2019, most dually eligible individuals were enrolled in either Medicaid FFS (42 percent) or Medicaid FFS with a limited-benefit Medicaid managed care plan (20 percent) (MACPAC and MedPAC 2022).

A managed FFS model could be used to promote better coordination of Medicaid and Medicare benefits, similar to the model used in Washington. Under this model, a designated entity contracts with the state to coordinate all Medicaid and Medicare services on an FFS basis. Washington operates a managed FFS model through the Financial Alignment Initiative demonstration and uses Medicaid health homes for care coordination. Medicaid health homes coordinate physical and behavioral health and long-term services and supports for Medicaid beneficiaries with chronic illnesses and can be created through a state plan amendment (CMS 2021a). Washington contracts with the health homes lead entities, who in turn contract with a network of providers to deliver mandated core health home services, including comprehensive care management and care coordination, to dually eligible beneficiaries in the demonstration (Archibald et al. 2019). Under the demonstration authority, the state is eligible to receive a portion of the Medicare savings that are generated through this model by preventing avoidable hospitalizations or other high-cost services.

Barriers to Integration

Because states differ in their health care markets and reliance on managed care and have varying priorities, they are at different places on the continuum of integration. Some states have been offering integrated coverage for decades and have achieved high levels of integration, while others offer only minimal or no integrated coverage options. To shed light on state integration efforts and the factors affecting state decisions, MACPAC convened a roundtable in September 2021. States selected to participate in the roundtable had already demonstrated an interest in integrating care but had minimal to moderate levels of integration. Attendees included state staff from six states with minimal levels of integration (Delaware, Louisiana, Maine, Mississippi, Missouri, and North Carolina), one state with a low level of integration (Kansas), and one state with a moderate level of integration (Washington).

At the roundtable, states identified several barriers to integration and how federal policy might address those barriers. These include lack of capacity to focus on integrated care initiatives relative to their other responsibilities. In addition, states noted that many lack experience enrolling the dually eligible population into Medicaid managed care, the delivery system on which most integrated care models are built.

Lack of state capacity

Most roundtable participants agreed that lack of state capacity to take on integrated care is a major challenge, and federal support is needed to help overcome this barrier. They identified several specific constraints, including competing priorities for state leadership, lack of Medicare expertise, and limited staff capacity to manage integrated care initiatives.

Competing priorities. State officials talked about how competing responsibilities and limited bandwidth to focus on integrated care inhibits progress. Standing up an integrated care model is a resource-intensive project that can be affected by other agency priorities, which change frequently. For example, in the time it takes to develop an integrated care strategy, new and unforeseen events such as the COVID-19 pandemic may cause agency priorities to shift and delay efforts to move forward on integrated care. Securing leadership support may be difficult given that integrated care does not necessarily lead to timely or direct reductions in spending, and evaluations of other Medicaid outcomes have had mixed results. Given these competing priorities, leadership commitment to integrated care is crucial to progress.

Lack of Medicare expertise. In addition, states told us that most state Medicaid agency staff have no experience with Medicare requirements. Staff must have expertise to work with D-SNPs, particularly knowledge of Medicare policies, including benefits covered, eligibility requirements, and application requirements. In addition, state leadership may not be familiar with MA or the coverage offered under a D-SNP, making it difficult to advance integrated models that are built on D-SNPs or to establish state contracts with D-SNPs.

Limited staff capacity to manage integrated care initiatives. We heard from roundtable participants that states typically do not have staff who are exclusively dedicated to work on integrating care for dually eligible beneficiaries. In many states, the staff tasked with overseeing D-SNP contracts juggle a range of other responsibilities, from administering multiple home- and community-based services (HCBS) waivers to responding to the COVID-19 pandemic.

States that have achieved higher levels of integration noted the importance of dedicated staff to identify opportunities for integration, serve as project managers, develop internal buy-in among Medicaid and sister agency staff, and move programs forward. One state official described having a core group of staff from different state agencies who were invested in raising the bar on integration and contributed by drafting decision papers and working on contracts with D-SNPs. States also noted that having someone dedicated to learning about the Medicare program was necessary to make progress on integrated care. Another state noted that staff leads can also help by bringing integrated care considerations, such as data exchange capabilities with Medicare, into agencywide decisions about information technology.

Lack of experience with Medicaid managed care

Many states do not have experience with Medicaid managed care for the dually eligible population, either because the state has managed care but does not enroll the dually eligible population or does not have managed care at all. States told us that opposition to managed care from providers and beneficiary advocates can make it difficult to design an integrated care model that relies on Medicaid managed care. For example, one state official said that the nursing facility industry was opposed to changes in the long-standing approach of providing LTSS through FFS because a switch to managed care could result in disruptions to care for beneficiaries.

States and the federal government may need to explore new and innovative ways to achieve some of the goals of integration, such as care coordination, through FFS models. Exploring opportunities to integrate care outside of managed care could enable some states to reach beneficiaries who have expressed a preference for coverage through FFS or who are statutorily exempt from mandatory Medicaid managed care enrollment, such as American Indian and Alaska Native individuals.[6]

Why an Integrated Care Strategy is Needed

Given the varied approaches to integrating care, every state should be able to devise a strategy to provide integrated coverage that is compatible with its population, delivery system, and geography. Developing a strategy, with support from the federal government, is a feasible first step for all states to raise the bar on integrated care. States could design the transition to enrollment in integrated coverage to occur gradually, for example, by phasing it in geographically, but the goal of the strategy should be for the majority of full-benefit dually eligible beneficiaries to be enrolled in an integrated model. Stakeholders we spoke with expressed support for requiring states to develop a strategy, particularly if it does not include rigid goals for a particular level of integrated care by a certain date. Stakeholders viewed this approach as giving states a place to start, particularly states that may be uncertain as to how to proceed.

The federal government's role would be to guide the high-level design of state strategies by requiring certain elements that are informed by a decade of FAI demonstrations and to create an expectation that states should move toward integration, even if their paths forward may differ. We envision that states would have two years to develop their strategy and would be required to review and update the strategy periodically. These updates could coincide with attaining certain milestones, such as executing a contract with a D-SNP, to be determined by the Secretary of the U.S. Department of Health and Human Services (the Secretary).

Given the lack of Medicare expertise among many state staff, technical assistance and financial support from the federal government would be necessary for most states. In the Commission's view, providing states with additional resources to finance the development of an integrated care strategy would advance integrated care efforts and set states up for success. Similarly, federal resources were made available for states interested in the FAI in 2011, when CMS granted 15 states up to $1 million each to develop new care models for dually eligible beneficiaries (CMS 2011). States used those funds to develop proposals to participate in the demonstration as well as to hire dedicated staff, engage external contractors, and support data analytics. New resources could help states overcome existing capacity limits, as noted previously, as they develop their strategies.

The process of developing the strategy should include provisions for stakeholder engagement and public transparency. States should consult with key stakeholders, including beneficiaries, providers, and health plans. They should also be required to submit the integrated care strategy for public comment as is now required for the Medicaid managed care quality strategy (42 CFR 438.340).[7] CMS should clearly articulate in rulemaking which stakeholders should be involved in developing and reviewing the strategy. For example, for the managed care quality strategy, states must obtain input from their medical care advisory committee (42 CFR 431.12). States are also required to obtain input from beneficiaries and consult with tribes. The strategy should also be made available on the state Medicaid agency's website.

The integrated care strategy should also be structured to promote health equity for dually eligible beneficiaries and ensure the approach to integration addresses the needs of diverse subpopulations of beneficiaries. Compared with Medicare beneficiaries who are not dually eligible, dually eligible beneficiaries have worse health outcomes. For example, they are more likely to report being in poor health (13 percent compared with 4 percent) or to be institutionalized (13 percent compared with 3 percent) (MACPAC and MedPAC 2022). In addition, dually eligible beneficiaries are more than two times more likely to be hospitalized for complications from COVID-19 (CMS 2021b). They may also have more limited access to primary care physicians; one-third of U.S. counties with the highest density of dually eligible beneficiaries are designated as health professional

shortage areas by the Health Resources and Services Administration (Xu et al. 2021).

Integrating care can also serve as a catalyst to address disparities through improved care coordination and identification of unmet need or barriers to accessing appropriate services. Dually eligible beneficiaries are more likely to be disabled than non-dual Medicare beneficiaries (MACPAC and MedPAC 2022). They are also more likely than non-dual Medicare beneficiaries to be Black (21 percent and 9 percent, respectively) or Hispanic (17 percent and 6 percent, respectively) (MACPAC and MedPAC 2022).[8]

Components of an Integrated Care Strategy

In the following sections, we list the high-level components that should be required for a strategy to integrate care for dually eligible beneficiaries and provide examples of different ways states could tailor their strategies for each. Some of these components align with those included in a recent final rule that CMS published on May 9, 2022 (CMS 2022c). For example, the strategy would include a mechanism for beneficiary input, such as the enrollee advisory committee that CMS has required that all D-SNPs establish (CMS 2022c).

Much of the following discussion centers around managed care but is also applicable to FFS; if not, we have noted that.

Integration approach

The integrated care strategy should specify the approach a state is considering and whether it will leverage a managed care or FFS delivery system. Given their current environment, states may choose different approaches to further advance integration. For example, states that enroll dually eligible beneficiaries in Medicaid managed care may choose to focus on leveraging their contracts with D-SNPs, eventually moving to HIDE SNPs and FIDE SNPs to further advance integration. Others might be more interested in pursuing integration through managed FFS, Medicaid health homes, accountable care organizations, or other shared savings models. For example, Washington uses Medicaid health homes as the vehicle for integration with Medicare FFS (Box 5-2).

The integrated care strategy should include provisions to ensure care coordination for dually eligible beneficiaries, regardless of delivery system. Care coordination typically involves a person or team that helps a beneficiary manage care transitions, access and coordinate Medicaid and Medicare benefits, and address social needs. An integrated program should involve care coordinators and an interdisciplinary care team to establish person-centered care plans to meet the unique needs of dually eligible individuals, such as those who are part of the MMPs. In the Commission's view, comprehensive care coordination is an essential component of an integrated model.

CMS should provide technical assistance to states, including templates or examples of potential approaches to integration, such as leveraging D-SNPs or FFS approaches, to support their decision making in developing an integrated care strategy (Rizer et al. 2020).

Eligibility and benefits covered

The integrated care strategy should specify who will be eligible to enroll in integrated models, with a goal of expanding eligibility to more dually eligible beneficiaries in the state over time. The strategy should focus on full-benefit dually eligible beneficiaries because this group stands to benefit the most from integrated coverage. However, it should also consider the needs of partial-benefit dually eligible beneficiaries and seek to avoid disruptions in their coverage. For example, partial-benefit dually eligible beneficiaries may benefit from the additional supplemental benefits offered by D-SNPs that are not available in other MA plans.[9] CMS's recent final rule focused on changes

affecting full-benefit dually eligible beneficiaries enrolled in D-SNPs but also made provisions for partial-benefit dually eligible beneficiaries, allowing them to stay enrolled in D-SNPs with certain modifications, such as separate plan benefit packages (CMS 2022c).

The integrated care strategy should specify the subpopulations of dually eligible beneficiaries who will be eligible to enroll and how coverage will be tailored to their different needs and circumstances. Dually eligible beneficiaries are a diverse group, including individuals who qualified for Medicare based on their age and may be relatively healthy and others who are younger and qualified for Medicare because of a disability. These groups may look for different types of benefits from their coverage, based on their different circumstances and characteristics.

The strategy should also consider how to improve integration for groups that have been mostly excluded from integrated models that rely on managed care. For example, relatively few states provide coverage through managed care to people with intellectual or developmental disabilities (Barth et al. 2020). Individuals with intellectual or developmental disabilities rely on a broad array of services, often from birth to end of life. States have been hesitant to transition to managed care because of the potential to disrupt care for this high-cost, high-need population. This has been of particular concern for LTSS users. In other cases, individuals who are statutorily exempt from mandatory enrollment in Medicaid managed care, such as American Indian or Alaska Native individuals, are often left out of integrated options in states that rely on managed care. To the extent that states pursue an integrated approach through managed care, such as an integrated D-SNP model, the state should also consider how to improve integration for these groups outside of managed care.

The integrated care strategy should specify which Medicaid benefits will be covered and which, if any, will be carved out. Many states provide Medicaid coverage through managed care, but certain Medicaid benefits may be carved out of comprehensive managed care and provided through FFS or limited benefit plans. These carve outs tend to carry over into integrated care arrangements as well. Carve outs may affect the level of integration that can be achieved by contracting with a D-SNP, as all Medicaid benefits may not be covered. The strategy should move toward full integration of all Medicaid benefits to the extent practicable while allowing for a narrow set of benefit carve outs when needed, recognizing the operational challenges for states in integrating previously carved-out benefits (Holladay et al. 2019). For example, under current law, CMS allows limited Medicaid LTSS and behavioral health services carve outs in HIDE SNPs and FIDE SNPs (CMS 2020b).

If the integration approach involves D-SNPs, the integrated care strategy should also detail the state's expectation for the provision of non-medical MA supplemental benefits for dually eligible beneficiaries. For example, D-SNPs may offer services such as adult day care services, transportation for non-medical needs, pest control, and indoor air quality equipment and service (CMS 2019). States can require D-SNPs to offer these services to complement Medicaid benefits and reduce duplication across the programs (MACPAC 2021a).

Enrollment strategy

The integrated care strategy should describe the state's approach to enrollment.[10] For states with Medicaid managed care, automated enrollment processes, such as passive enrollment in the MMPs and default enrollment in D-SNPs, can increase enrollment and retention in integrated programs.[11] For example, in the FAI, passive enrollment led to higher enrollment in MMPs (MACPAC 2019). However, some stakeholders have raised concerns over how the passive enrollment process may limit the ability of dually

eligible individuals to review accessible materials, understand their options, and make an informed choice (Brill et al. 2021).

States can use other enrollment strategies to further advance integration and promote retention. For example, states can require exclusively aligned enrollment, limiting enrollment in a D-SNP to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan under the same parent company. Under this strategy, one organization is responsible for both Medicaid and Medicare benefits for all its members, maximizing the potential for integration.

Stakeholders have also suggested improvements to the enrollment process, such as improving information provided to dually eligible beneficiaries about their integrated care options and allowing beneficiaries to maintain access to existing providers when enrolling in integrated care for a certain period of time (Brill et al. 2021).[12]

Further, the strategy should describe how the state will conduct outreach to eligible beneficiaries. In the past, low enrollment in integrated care has been associated with a lack of understanding of the benefits of integrated care and a desire to maintain existing providers. At our roundtable, state staff noted that outreach with beneficiaries, providers, and other key stakeholders to help them understand the value of integration is key to bolstering enrollment and obtaining buy-in from beneficiaries.

Outreach strategies should also consider how to provide outreach to a diverse group of dually eligible beneficiaries in a culturally competent manner. For example, states should describe how they will conduct outreach to dually eligible beneficiaries with limited English proficiency.

States may also wish to include a strategy to work with entities such as the state health insurance assistance programs (SHIPs) to ensure they are appropriately trained to advise clients about integrated care options. SHIPs are present in every state, receive federal funding to provide one-on-one assistance to Medicare beneficiaries, and are a resource for dually eligible beneficiaries during the enrollment process.[13]

Finally, states should also describe how they will conduct outreach to providers to improve participation in integrated care. For example, many beneficiaries opted out of the FAI, in some cases with encouragement from providers, to stay with an existing provider who was not participating. Eliciting input from providers enabled one state that participated in our roundtable to better understand provider preferences and incorporate them into the integrated care initiative.

Beneficiary protections and input

The integrated care strategy should contain key beneficiary protections, such as those offered through an ombudsman, a unified appeals and grievance process when possible, care coordination, and an advisory mechanism for beneficiaries to provide input into the design and ongoing operation of the integrated care program.

States, plans, and beneficiary advocates we interviewed viewed an ombudsman program as a critical element of an integrated care strategy. An ombudsman program gives beneficiaries a dedicated point of contact to learn about their coverage and to get help with problems that may arise, such as filing appeals related to coverage denials. For example, states could look to the FAI that required an ombudsman for each demonstration. In the FAI, states could leverage an existing ombudsman program, such as a long-term care ombudsman (the approach taken in Virginia), or contract with a non-profit organization (the approach taken in California) (Archibald et al. 2021).

Depending on the integration approach, the strategy should consider a unified appeals and grievance process. Appeal and grievance processes are an important beneficiary protection in Medicaid and in Medicare. They give

beneficiaries a formal opportunity to question coverage decisions or express dissatisfaction with a health plan or a provider. Given that the processes vary in each program, creating confusion for beneficiaries and providers, these should be integrated into a single process when possible. The FAI requires integration of the Medicaid and Medicare appeals and grievance processes at the health plan level, which is the first level of appeal.[14] Certain D-SNPs with exclusively aligned enrollment must also have a unified process, and CMS expanded the number of D-SNPs subject to this requirement in the recent final rule (Stringer and Tourtellotte 2020, CMS 2022c).

Finally, the strategy should establish a meaningful mechanism to obtain input from beneficiaries on their experiences in integrated care. We heard interest from states in ensuring that integrated care models are designed with beneficiary preferences and needs in mind. The strategy should provide opportunities for input and engagement by key subgroups, such as HCBS users, and should represent the diversity of dually eligible beneficiaries. Beneficiaries should provide input on issues of access to care, care coordination, and health equity, among other topics.

Beneficiary input should be collected routinely by health plans. The advisory mechanism could be modeled after the approach in the FAI. Each FAI MMP is required to set up an enrollee advisory committee or recruit MMP enrollees to governing boards to ensure that the plans obtain enrollee input on the program (ATI Advisory 2021, CMS 2022c). Membership is made up of beneficiaries, family members, and other caregivers that reflect the enrolled population (CMS 2022c).

States could also set up beneficiary advisory committees to provide input to the state directly. For example, as part of its FAI demonstration, Massachusetts established the One Care Implementation Council. At least half the membership of the One Care Implementation Council is made up of beneficiaries (CMS 2022c).

Data analytics

The integrated care strategy should describe how the state will exchange data with Medicare and how states will learn how to use Medicare data, such as the Medicare Modernization Act file. The Medicare Modernization Act file enables states to identify dually eligible beneficiaries and Medicaid beneficiaries who will become dually eligible based on an exchange of demographic data between states and CMS.

State processes and infrastructure for successfully exchanging data with Medicare are critical to coordination of Medicaid and Medicare benefits in a D-SNP model. For example, we heard from one state that the state's health information exchange has been one of the most important factors enabling that state to take steps toward integrated care. The health information exchange allows D-SNPs and Medicaid health homes in the state to store and share data regarding hospital admissions, discharges, and transfers for dually eligible beneficiaries.

The data analytics section of the strategy should also identify the data-sharing arrangements states will need to have in place with D-SNPs to use D-SNP contracting strategies, such as default enrollment (42 CFR 422.107).[15] The strategy should consider whether states will use their contracting authority to require D-SNPs to submit data or reports to states for oversight of operations and quality of care. For example, requiring D-SNPs to submit encounter data or data on prescription drugs covered under Medicare Part D can help the state obtain a comprehensive picture of which services enrollees are using and identify areas for improvement, such as the need for added care coordination. Several states told us they meet monthly with their D-SNPs and their Medicaid managed care plans to discuss data issues and foster relationships as well as promote coordination across plan types. State staff said these meetings allow the state and the plan to get on the same page before the D-SNP begins submitting reports to the state, saving time later.

The strategy should also describe how the state will share data with other state agencies in cases in which another agency may administer a Medicaid benefit. For example, in South Dakota, LTSS is administered by the Department of Human Services, while the Medicaid program is part of the Department of Social Services.

Finally, the strategy should describe how the state would collect and use beneficiary demographic data, such as age, gender, disability, social determinants of health, race and ethnicity, or residence in an urban or rural area, that may reflect the disparate needs of different subpopulations. Collection of this data could inform measurements of quality and beneficiary experience in integrated care. Improved collection of demographic data can also help the state better target efforts to improve health equity and identify and address potential disparities. For example, to maximize COVID-19 vaccinations among dually eligible beneficiaries and to address access barriers and vaccine hesitancy, CMS has encouraged plans serving dually eligible beneficiaries to collect data on COVID-19 testing, hospitalization, and outcomes, stratified by gender, race, ethnicity, preferred language, disability status, and other demographics (CMS 2021c).

Quality measurement

The integrated care strategy should include a plan for how states will measure the quality of the care that dually eligible beneficiaries receive in the integrated care program. States could draw on efforts already underway to develop standard quality measures for populations with complex care needs (BPC 2021, Bossley and Imbeah 2020).

Quality measurement could be based on the model of care (MOC) that is statutorily required for every SNP (§ 1859(f)(7) of the Social Security Act). This tool ensures that the plan has identified the needs of its enrollees and is addressing them through its care management practices (CMS 2021d). All SNPs are required to have a MOC approved by the National Committee for Quality Assurance. The MOC provides the basic framework that the SNP will use to meet the needs of its enrollees (CMS 2021d). The Secretary sets the standards for how the MOC is scored by the National Committee for Quality Assurance, including clinical and non-clinical elements. The MOC is scored in four areas: description of the population served, care coordination, provider network, and MOC quality measurement and performance improvement. Each of the four areas contain detailed measurement requirements. For example, the description of the population standard includes specific characteristics of the population, such as age, gender and ethnicity profiles, incidence and prevalence of major diseases, and other barriers that the target population faces (NCQA 2021). The care coordination standard includes a health risk assessment, an individualized care plan, and an interdisciplinary care team (NCQA 2021).

Further, quality measurement should go beyond clinical measures and include LTSS quality measures that address the experience of beneficiaries receiving HCBS. For example, one of the key goals of HCBS is to allow individuals to live independently in the community, see their family and friends, and participate in activities that would be unavailable to them in an institution. LTSS quality measures should consider how to measure these social outcomes as well as whether beneficiaries are receiving the level of care and direct service hours they need. For example, in 2020, CMS released a request for information to solicit feedback on a set of standardized HCBS quality measures (CMS 2020c). These proposed quality measures were intended as a resource for states with managed LTSS plans. Many of the measures proposed by CMS are drawn from questions in nationally accredited beneficiary surveys of LTSS users. These surveys include the National Core Indicators, the National Core Indicators of Aging and Disabilities, and the HCBS Consumer Assessment of Healthcare Providers and Systems. States could consider how to use these surveys to measure quality for LTSS users in integrated care programs.

Commission Recommendation

The Commission recommends that states develop a strategy to integrate care for their dually eligible beneficiaries. The Commission also recommends that states be given federal support to do so.

Recommendation 5.1

Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy as needed, to be determined by the Secretary. The strategy should include the following components—integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement—and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

Rationale

The Commission recommends that all states develop a strategy to integrate care as a framework for raising the bar on integration. Many states need a place to start, and requiring that they develop a strategy is an important step to ensure that the time and resources are dedicated to improving delivery models for this population.[16]

The Commission also recommends additional federal funding to enhance state capacity to integrate care. Such resources could be used to finance the administrative costs of designing a strategy, hire new staff with Medicare expertise, or train existing state staff in Medicare. This recommendation is consistent with the recommendation in our June 2020 report but goes a step further by specifically linking federal funding to the development of an integrated care strategy.

Implications

Federal spending. This recommendation would increase federal spending by the amount of the additional funding provided to states. In the long run, greater adoption of integrated models and increased enrollment could affect spending due to increased coordination and reduced use of duplicative services, although the extent to which strategy development leads to such outcomes may not be quantifiable.

States. States would have to dedicate staff and other resources to develop the strategy. The federal support provided would potentially increase state Medicare expertise, reducing one of the barriers of moving to an integrated care model.

Enrollees. There is no direct effect on beneficiaries, although they may be asked for input as the state works through the process of developing an integrated care strategy. Ultimately, the effect on beneficiaries will depend upon which actions states take. To the extent this recommendation leads to greater availability of integrated care and more enrollment in integrated programs, beneficiaries could experience more coordinated care.

Plans and providers. There is no direct effect on plans and providers, although they may be asked for input on strategy development.

Looking Ahead

We plan to continue our work on integrated care for dually eligible beneficiaries in the coming year. This could include a focus on the beneficiary experience in integrated care. In addition, we will continue to reinforce support for states and will monitor potential changes to integrated coverage as a result of publication of the final rule, including the implications of transitioning MMPs to D-SNPs.

Endnotes

[1] The Centers for Medicare & Medicaid Services defines enrollment in integrated care as enrollment in fully integrated dual eligible special needs plans and other integrated dual eligible special needs plans whose enrollees are also enrolled in affiliated Medicaid managed care plans that generally cover substantial behavioral health services or long-term services and supports or both. Other models included in the 2020 enrollment figure are Washington's managed fee-for-service program, Medicare-Medicaid Plans, and the Program of All-Inclusive Care for the Elderly (CMS 2020a).

[2] States that enroll dually eligible beneficiaries in Medicaid managed care can allow or require D-SNPs to use default enrollment, a process under which the state identifies Medicaid beneficiaries who are becoming eligible for Medicare and enrolls them into a D-SNP under the same parent company as their current Medicaid managed care plan.

[3] In 2022, MMPs are present in 9 states and FIDE SNPs are available in 12 states. In three states, both MMPs and FIDE SNPs are available. One state, Washington, has a managed FFS model. Programs of All-Inclusive Care for the Elderly (PACE) are available in 30 states (NPA 2022). PACE offers fully integrated coverage but because of its smaller reach relative to other integrated care models, it is not a focus of this chapter.

[4] This total does not include 285,000 dually eligible beneficiaries enrolled in D-SNPs in Puerto Rico (CMS 2022a).

[5] On May 9, 2022, CMS published a final rule in which the agency described a planned approach for converting MMPs to integrated D-SNPs. This approach is informed by comments received on the notice of proposed rulemaking that CMS published on January 12, 2022. MMP demonstrations are scheduled to end between December 31, 2022, and December 31, 2023. In the final rule, CMS offers states interested in converting their MMPs into integrated D-SNPs the opportunity to extend their demonstrations through 2025 under certain conditions and in order to smooth the transition, with a transition plan to be submitted to CMS by October 1, 2022. For states that do not choose to convert MMPs to integrated D-SNPs, CMS plans to work with them on reaching an appropriate MMP conclusion by December 31, 2023. CMS also applies many MMP policies to D-SNPs, such as the requirement that the plan establish an enrollee advisory committee (CMS 2022c).

[6] States may not use a state plan amendment to require American Indian and Alaska Native (AIAN) individuals to enroll in managed care unless the entity is an Indian health entity (i.e., an entity operated by the Indian Health Service, a tribe, or an urban Indian organization) (§ 1932(a)(2)(C) of the Social Security Act). AIAN individuals may choose to enroll in a managed care plan. In some states, AIAN individuals represent a large share of overall Medicaid enrollment. For example, in Alaska and South Dakota, more than 30 percent of Medicaid enrollees are AIAN individuals. For more, see MACPAC's issue brief *Medicaid's Role in Health Care for American Indians and Alaska Natives* (MACPAC 2021b).

[7] States contracting with a managed care organization or a prepaid inpatient health plan are required to develop and adopt a quality strategy with input from beneficiaries and stakeholders (42 CFR 438.340). Minimum requirements for this strategy include "procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the managed care organization and prepaid inpatient health plan contracts, and to individuals with special health care needs" and "procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee."

[8] In 2019, most individuals dually eligible for Medicaid and Medicare benefits were female (59 percent) and white (54 percent) and lived in an urban area (79 percent). Dually eligible beneficiaries were more likely to be white (54 percent) than non-dual Medicaid beneficiaries who were eligible on the basis of a disability (46 percent) but less likely than non-dual Medicare beneficiaries (82 percent) (MACPAC and MedPAC 2022).

[9] Compared with regular MA plans, D-SNPs may allocate more rebate dollars to benefits given that Medicaid already provides assistance with Medicare cost sharing for dually eligible beneficiaries. D-SNPs may also be more likely to offer supplemental benefits targeted to the needs of dually eligible beneficiaries, such as adult day care services, home-based palliative care, in-home support services, caregiver supports, medically approved non-opioid pain management, home and bath safety devices and modifications, transportation, and coverage for over-the-counter medications and items (MACPAC 2021a). D-SNPs may also offer benefits such as

home-delivered meals, pest control services, non-medical transportation, indoor air quality equipment, and structural home modifications (CMS 2019).

[10] Some of these strategies, such as automated enrollment into a managed care plan, are not relevant in FFS.

[11] Under the FAI, states could passively enroll dually eligible beneficiaries into MMPs at the beginning of the calendar year. States can allow or require D-SNPs to use default enrollment, a process under which the state identifies Medicaid beneficiaries who are becoming eligible for Medicare and enrolls them into a D-SNP under the same parent company as their current Medicaid managed care plan.

[12] Based on focus groups with beneficiaries, Brill and coauthors (2021) recommended that states allow beneficiaries to maintain a relationship with existing providers for up to one year to avoid disruptions in care, such as delays in access to medications as a result of a transition to a new pharmacy. While the MMPs allowed a 90-day transition, focus group participants considered this insufficient to avoid disruptions (Brill et al. 2021).

[13] SHIPs are run by volunteer counselors who provide advice to Medicare beneficiaries about their Medicare coverage options. SHIPs receive federal funding administered by the Administration for Community Living.

[14] Most of the time, an appeal is resolved at the health plan level, but if not, beneficiaries can pursue higher levels of appeal, ultimately reaching legal review by a state or federal court.

[15] To implement default enrollment, states would need to put in place systems to share data with D-SNPs about Medicaid beneficiaries becoming eligible for Medicare and about the status of their Medicaid redeterminations upon becoming eligible for Medicare. States would need to do this in a timely manner to allow D-SNPs to notify Medicaid beneficiaries of their upcoming enrollment into a D-SNP within 60 days of becoming eligible for Medicare.

[16] MACPAC's recommendation requests that Congress authorize the Secretary to require that all states develop a strategy. It is unclear if the authority already exists for the Secretary to establish this requirement or whether additional authority would be needed.

References

Archibald, N., D. Perra, A. Tourtellotte, and K. Lim. 2021. *State approaches to developing and operating ombudsman programs for demonstrations under the Financial Alignment Initiative*. Hamilton, NJ: Center for Health Care Strategies. https://www.integratedcareresourcecenter.com/sites/default/files/Ombudsman%20Programs%20brief.pdf.

Archibald, N., K. Moses, and L. Rava. 2019. *Using health homes to integrate care for dually eligible individuals: Washington state's experiences*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/media/Washington-case-study_Final.pdf.

ATI Advisory. 2021. *Enhancing Medicare-Medicaid integration: Bringing elements of the Financial Alignment Initiative into dual-eligible special needs plans*. Washington, DC: ATI Advisory. https://atiadvisory.com/enhancing-medicare-medicaid-integration-bringing-elements-of-the-fai-into-d-snps/.

Barth, S., S. Lewis, and T. Simmons. 2020. *Medicaid services for people with intellectual or developmental disabilities—evolution of addressing service needs and preferences*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-services-for-people-with-intellectual-or-developmental-disabilities-evolution-of-addressing-service-needs-and-preferences/.

Bipartisan Policy Center (BPC). 2021. *Guaranteeing integrated care for dual eligible individuals*. Washington, DC: BPC. https://bipartisanpolicy.org/report/integrated-care/.

Bossley, H., and K. Imbeah. 2020. *Measuring complexity: Moving toward standardized quality measures for the field of complex care*. Camden, NJ: National Center for Complex Health and Social Needs. https://www.nationalcomplex.care/wp-content/uploads/2020/05/Quality-measures-report_final.pdf.

Brill, R., B. Gleason, J. Curbera, et al. 2021. *Listening to dually eligible individuals: Person-centered enrollment strategies for integrated care.* Washington, DC: Community Catalyst. https://www.healthinnovation.org/Person-Centered-Enrollment-Strategies-for-Integrated-Care.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. *SNP comprehensive report 2022 02*. Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldata special-needs/snp-comprehensive-report-2022-02.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022b. *Integration status for contract year 2022 D-SNPs*. Baltimore, MD: CMS. https://www.cms.gov/files/document/smacdsnpintegrationstatusesdatacy2022.xlsx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Medicare program; Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and regulatory revisions in response to the COVID-19 Public Health Emergency; Additional policy and regulatory revisions in response to the COVID-19 Public Health Emergency. Final Rule. *Federal Register* 87, no. 89 (May 9): 27704—27902. https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021a. *Medicaid Health Homes: An overview*. 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. 2021b. *Medicare COVID-19 data snapshot overview*. Baltimore, MD: CMS. https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022c. Medicare program: Contract year 2023 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. Final Rule. *Federal Register* 87, no. 89 (May 9): 27704—27902. https://www.federalregister.gov/documents/2022/01/12/2022-00117/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021d. *Model of care (MOC)*. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Medicare-Medicaid Coordination Office: FY 2020 Report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/files/document/reporttocongressmmco.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Memo from Sharon Donovan 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. 2020c. Request for information: Recommended measure set for Medicaid-funded home and community-based services. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Memo from Kathryn Coleman regarding "Implementing supplemental benefits for chronically ill enrollees." April 24, 2019. Baltimore, MD: CMS. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. *15 states win contracts to develop new ways to coordinate care for people with Medicare and Medicaid.* April 14, 2011, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/fact-sheets/15-states-win-contracts-develop-new-ways-coordinate-care-people-medicare-and-medicaid.

Holladay, S., E. Bayer, I. Dave, et al. 2019. *Financial Alignment Initiative: Michigan MI Health Link first evaluation report*. Waltham, MA: RTI International. https://www.michigan.gov/documents/mdhhs/MI_FAI_EvalReport1_666833_7.pdf.

Integrated Care Resource Center (ICRC). 2022. *Monthly enrollment in Medicare-Medicaid plans by plan and by state, January 2021 to January 2022*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_Jan_2022.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 6: Improving integration for dually eligible beneficiaries: Strategies for state contracts with dual eligible special needs plans. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/improving-integration-for-dually-eligible-beneficiaries-strategies-for-state-contracts-with-dual-eligible-special-needs-plans/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. *Medicaid's role in health care for American Indians and Alaska Natives.* Washington, DC: MACPAC. https://www.macpac.gov/publication/16275/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. 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/publication/chapter-2-integrating-care-for-dually-eligible-beneficiaries-policy-issues-and-options/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. 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). 2019. The complex art of making it simple: Factors affecting enrollment in integrated care demonstrations for dually eligible beneficiaries. Washington, DC: MACPAC. https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/.

Medicaid and CHIP Payment and Access Commission (MACPAC) and Medicare Payment Advisory Commission (MedPAC). 2022. *Data Book: Beneficiaries dually eligible for Medicare and Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare Payment Advisory Commission (MedPAC). 2019. Chapter 12: Promoting integration in dual-eligible special needs plans. In *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/.

National Committee for Quality Assurance (NCQA). 2021. *Model of care scoring guidelines for contract year 2023*. Washington, DC: NCQA. https://snpmoc.ncqa.org/resources-for-snps/scoring-guidelines/.

National PACE Association (NPA). 2022. *PACE by the numbers*. Alexandria, VA: NPA. https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends-0.

Rizer, A., A. Abdnor, and A. Mir. 2020. *HCBS—just one piece of the puzzle*. Washington, DC: ATI Advisory. https://atiadvisory.com/hcbs-just-one-piece-of-the-puzzle/.

Stringer, R., and A. Tourtellotte. 2020. *Integrated appeal and grievance process for integrated D-SNPs with "exclusively aligned" enrollment*. Washington, DC: Integrated Care Resource Center. https://www.integratedcareresourcecenter.com/sites/default/files/Appeal_and_Grievance_Fact_Sheet_0.pdf.

Washington Health Care Authority (WA HCA). 2022. *Washington State's fee-for-service dual eligible demonstration quarterly report*. Olympia, WA: WA HCA. https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf.

Xu, W., S. Retchin, and P. Buerhaus. 2021. Dual-eligible beneficiaries and inadequate access to primary care providers. *The American Journal of Managed Care* 27, no. 5: 212–216. https://www.ajmc.com/view/dual-eligible-beneficiaries-and-inadequate-access-to-primary-care-providers.

Commission Vote on Recommendation

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on March 4, 2022.

Raising the Bar: Requiring State Integrated Care Strategies

5.1 Congress should authorize the Secretary of the U.S. Department of Health and Human Services to require that all states develop a strategy to integrate Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries within two years with a plan to review and update the strategy, to be specified by the Secretary. The strategy should include the following components – integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, quality measurement – and be structured to promote health equity. To support states in developing the strategy, Congress should provide additional federal funding to states to assist with these efforts toward integrating Medicaid and Medicare coverage for full-benefit dually eligible beneficiaries.

5.1 Voting Results	#	Commissioner
Yes	16	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Scanlon, Herrera Scott, Weno

APPENDIX 5A: State Use of Integrated Models

States use multiple models to serve dually eligible beneficiaries (Table 5A-1). Examples of fully integrated models include a Medicare-Medicaid Plan under the Financial Alignment Initiative, a managed fee-for-service model under the Financial Alignment Initiative, a Medicare Advantage fully integrated dual eligible special needs plan (FIDE SNP), and a Program of All-Inclusive Care for the Elderly.[1]

Most dual eligible special needs plans (D-SNPs) offer minimal levels of integration and are referred to as coordination-only D-SNPs because they are only required to coordinate Medicaid services, not cover them. Highly integrated dual eligible special needs plans (HIDE SNPs) must cover behavioral health services or long-term services and supports.

TABLE 5A-1. Landscape of Integrated Care for Dually Eligible Beneficiaries by State, January 2022

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries?[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
Alabama	–	Yes	Yes	–	–	–
Alaska	–	–	–	–	–	–
Arizona	–	–	–	Yes	Yes	Yes
Arkansas[2]	–	Yes	Yes	–	–	Yes
California[3]	Yes	Yes	Yes	–	Yes	Yes
Colorado[3]	–	Yes	Yes	–	–	Yes
Connecticut	–	–	Yes	–	–	–
Delaware	–	Yes	Yes	–	–	Yes
District of Columbia	–	–	–	Yes	–	No
Florida	–	Yes	Yes	Yes	Yes	Yes
Georgia	–	–	Yes	–	–	No
Hawaii	–	–	–	Yes	–	Yes
Idaho	–	–	–	–	Yes	Yes
Illinois	Yes	–	–	–	–	Yes
Indiana	–	Yes	Yes	–	–	No
Iowa	–	Yes	Yes	–	–	Yes
Kansas	–	Yes	–	Yes	–	Yes
Kentucky	–	–	Yes	Yes	–	Yes
Louisiana[4]	–	Yes	Yes	–	–	–
Maine	–	–	Yes	–	–	–

TABLE 5A-1. (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries?[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
Maryland	–	Yes	Yes	–	–	No
Massachusetts[5]	Yes	Yes	–	–	Yes	Yes
Michigan	Yes	Yes	Yes	–	–	Yes
Minnesota[6]	–	–	–	Yes	Yes	Yes
Mississippi	–	–	Yes	–	–	No
Missouri	–	–	Yes	–	–	No
Montana	–	–	Yes	–	–	–
Nebraska	–	Yes	Yes	Yes	–	Yes
Nevada	–	–	Yes	–	–	No
New Hampshire	–	–	–	–	–	Yes
New Jersey	–	Yes	–	–	Yes	Yes
New Mexico	–	Yes	–	Yes	–	Yes
New York[3]	Yes	Yes	Yes	Yes	Yes	Yes
North Carolina[7]	–	Yes	Yes	–	–	–
North Dakota	–	Yes	–	–	–	No
Ohio	Yes	Yes	Yes	–	–	Yes
Oklahoma	–	Yes	Yes	–	–	–
Oregon[9]	–	Yes	Yes	Yes	–	Yes
Pennsylvania	–	Yes	Yes	Yes	Yes	Yes
Rhode Island[8]	Yes	Yes	Yes	–	–	–
South Carolina	Yes	Yes	Yes	–	–	No
South Dakota	–	–	Yes	–	–	–
Tennessee	–	Yes	Yes	Yes	Yes	Yes
Texas[3]	Yes	Yes	Yes	Yes	–	Yes
Utah[3]	–	–	Yes	–	–	Yes
Vermont	–	–	–	–	–	Yes
Virginia	–	Yes	Yes	Yes	Yes	Yes
Washington[4]	–	Yes	Yes	Yes	–	No

TABLE 5A-1. (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries?[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**9**	**30**	**35**	**17**	**12**	**29**
West Virginia	–	–	Yes	–	–	No
Wisconsin[9]	–	Yes	–	Yes	Yes	Yes
Wyoming	–	–	Yes	–	–	–

Notes: D-SNP is dual eligible special needs plan; 45 states and the District of Columbia have D-SNPs. FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. MMP is Medicare-Medicaid Plan. PACE is Program of All-Inclusive Care for the Elderly. Integrated care programs may not be available statewide. Washington operates a managed fee-for-service model under the Financial Alignment Initiative. Minnesota operates an alternative model focused on administrative alignment under the Financial Alignment Initiative.

– Dash indicates state does not have the factor listed or it is not applicable to the state.

[1] Medicaid managed care for dually eligible beneficiaries is as of 2018. States that offer Medicaid managed care but do not enroll dually eligible beneficiaries in Medicaid managed care are marked as "no". States without Medicaid managed care programs are marked with a dash.

[2] In 2019, Arkansas implemented the mandatory Provider-Led Arkansas Shared Savings Entity (PASSE) program for certain individuals with developmental disabilities or who use certain behavioral health services. Medicaid enrollees who qualify because of specific developmental disabilities or use of behavioral health services, including dually eligible beneficiaries who qualify, must enroll in a PASSE plan. The program provides comprehensive coverage for individuals with developmental disabilities.

[3] These states enroll dually eligible beneficiaries into certain Medicaid managed care programs on a mandatory basis and into other managed care programs on a voluntary basis.

[4] Louisiana and Washington operate behavioral health organization models that enroll full-benefit dually eligible beneficiaries, but we included only comprehensive managed care programs in this table. Washington also operates a demonstration under the Financial Alignment Initiative that provides fully integrated coverage to dually eligible beneficiaries through a managed fee-for-service approach that relies on Medicaid health homes.

[5] Dually eligible beneficiaries can receive Medicaid benefits through Senior Care Options FIDE SNPs or One Care Medicare-Medicaid Plans, but the state does not have a separate Medicaid managed care program serving dually eligible beneficiaries.

[6] Minnesota requires dually eligible beneficiaries and individuals eligible through the aged, blind, and disabled pathways who are age 65 and older to enroll in their Minnesota Senior Care Plus program unless those individuals enroll in the state's fully integrated D-SNP programs (Minnesota Senior Health Options and Special Needs Basic Care Plus).

[7] North Carolina implemented a new Medicaid managed care program in 2019, but as of 2022, dually eligible beneficiaries are not yet covered through that program.

[8] Rhode Island ended its Medicaid managed care program in September 2018.

[9] These states enroll dually eligible beneficiaries into a Medicaid managed care program on a voluntary basis.

Source: Mathematica analysis, 2021, under contract with MACPAC. CMS 2022b. NPA 2022.

States can also be characterized by the level of integration in D-SNPs. In Table 5A-2, we designate integration levels as follows:

- Minimal: State has coordination-only D-SNPs but no HIDE SNPs or FIDE SNPs.
- Low: State has some HIDE SNPs but has not yet taken active steps to use them to design an integrated care initiative. HIDE SNP status has been achieved because D-SNP parent companies offer Medicaid managed care plans in overlapping service areas.
- Moderate: State has either HIDE SNPs or FIDE SNPs (or both) and has worked with the D-SNPs in the state to increase integration through strategies such as selective contracting (meaning that the state contracts only with D-SNPs meeting certain state requirements). D-SNPs in the state do not operate with exclusively aligned enrollment.
- High: State has some FIDE SNPs operating with exclusively aligned enrollment but also has non-integrated or less-integrated D-SNPs.
- Full: All D-SNPs in the state are either FIDE or HIDE SNPs that operate with exclusively aligned enrollment.

TABLE 5A-2. Dual Eligible Special Needs Plan Integration Levels by State, January 2022

State	D-SNP integration level				
	Minimal	Low	Moderate	High	Full
Total	**25**	**3**	**9**	**4**	**5**
Alabama	Yes	–	–	–	–
Alaska	–	–	–	–	–
Arizona	–	–	Yes	–	–
Arkansas	Yes	–	–	–	–
California[1]	–	–	–	Yes	–
Colorado	Yes	–	–	–	–
Connecticut	Yes	–	–	–	–
Delaware	Yes	–	–	–	–
District of Columbia[2]	–	–	–	–	Yes
Florida	–	–	Yes	–	–
Georgia	Yes	–	–	–	–
Hawaii	–	–	Yes	–	–
Idaho	–	–	–	–	Yes
Illinois	–	–	–	–	–
Indiana	Yes	–	–	–	–
Iowa	Yes	–	–	–	–

TABLE 5A-2. (continued)

State	D-SNP integration level				
	Minimal	Low	Moderate	High	Full
Total	**25**	**3**	**9**	**4**	**5**
Kansas	–	Yes	–	–	–
Kentucky	–	Yes	–	–	–
Louisiana	Yes	–	–	–	–
Maine	Yes	–	–	–	–
Maryland	Yes	–	–	–	–
Massachusetts	–	–	–	–	Yes
Michigan	Yes	–	–	–	–
Minnesota	–	–	–	–	Yes
Mississippi	Yes	–	–	–	–
Missouri	Yes	–	–	–	–
Montana	Yes	–	–	–	–
Nebraska	–	Yes	–	–	–
Nevada	Yes	–	–	–	–
New Hampshire	–	–	–	–	–
New Jersey	–	–	–	–	Yes
New Mexico	–	–	Yes	–	–
New York	–	–	–	Yes	–
North Carolina	Yes	–	–	–	–
North Dakota	–	–	–	–	–
Ohio	Yes	–	–	–	–
Oklahoma	Yes	–	–	–	–
Oregon	–	–	Yes	–	–
Pennsylvania	–	–	Yes	–	–
Rhode Island	Yes	–	–	–	–
South Carolina	Yes	–	–	–	–
South Dakota	Yes	–	–	–	–
Tennessee	–	–	–	Yes	–
Texas	–	–	Yes	–	–
Utah	Yes	–	–	–	–
Vermont	–	–	–	–	–

TABLE 5A-2. (continued)

State	D-SNP integration level				
	Minimal	Low	Moderate	High	Full
Total	**25**	**3**	**9**	**4**	**5**
Virginia	–	–	Yes	–	–
Washington	–	–	Yes	–	–
West Virginia	Yes	–	–	–	–
Wisconsin	–	–	–	Yes	–
Wyoming	Yes	–	–	–	–

Notes: D-SNP is dual eligible special needs plan. Several states do not have D-SNPs, including Alaska, Illinois, New Hampshire, North Dakota, and Vermont.

[1] California has one fully integrated dual eligible special needs plan (FIDE SNP) that operates with exclusively aligned enrollment, but the FIDE SNP is not available statewide. The other D-SNPs in the state are minimally integrated coordination-only D-SNPs.

[2] The District of Columbia has one highly integrated dual eligible special needs plan (HIDE SNP) in 2022 that is capitated to cover all Medicaid benefits but does not restrict enrollment to full-benefit dually eligible individuals. In 2023, the HIDE SNP operating in the District of Columbia will use separate plan benefit packages to serve full- and partial-benefit dually eligible individuals and will have exclusively aligned enrollment for full-benefit dually eligible individuals.

Sources: Mathematica analysis, 2021, under contract with MACPAC. CMS 2022b.