Chapter 2:

Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration

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Key Points

- Dually eligible beneficiaries, the 12.2 million people eligible for both Medicaid and Medicare in 2022, often experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrating their Medicaid and Medicare coverage has the potential to improve their care, eliminate incentives for cost shifting between the two programs, and reduce spending that may arise from duplication of services or poor care coordination. About 21 percent of dually eligible beneficiaries were enrolled in integrated products in 2022.
- In MACPAC's June 2022 report to Congress, the Commission recommended that all states be required to develop a strategy to integrate care, with federal support. Building on our recommendation, in this chapter, MACPAC explores the different delivery mechanisms that states use to provide Medicaid coverage to dually eligible beneficiaries and opportunities for integration. Our review includes Medicaid fee for service, Medicare Advantage dual eligible special needs plans (D-SNPs), and the Medicare-Medicaid plans (MMPs) under the Financial Alignment Initiative demonstration.
- In 2022, the Centers for Medicare & Medicaid Services (CMS) made regulatory changes that will sunset the MMPs, a long-standing capitated demonstration model that was seen as an example of full integration but had a limited reach. CMS is encouraging states to transition their MMP enrollees to integrated D-SNPs, a transition the Commission is continuing to monitor. This change effectively makes D-SNPs the primary vehicle for states to integrate care, which may expand enrollment in these products.
- States that choose to contract with D-SNPs can leverage contracting tools to increase integration for beneficiaries. CMS has already incorporated certain MMP elements into the regulations governing D-SNPs, and states transitioning away from MMPs may use their three-way contracts as models for their new contracts with D-SNPs.
- Whatever the delivery mechanism states are using to provide coverage to dually eligible beneficiaries, including Medicaid managed care or fee for service, states have access to different system design options to increase integration. MACPAC recognizes that fully integrated coverage is available only to a limited number of dually eligible beneficiaries and that state circumstances vary widely. Identifying options for states across delivery mechanisms is an ongoing area of focus.

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For individuals enrolled in both Medicaid and Medicare, known as "dually eligible beneficiaries," integrating the coverage they receive has the potential to improve the experience for beneficiaries and reduce federal and state spending. Dually eligible beneficiaries often experience fragmented care and poor health outcomes due to inadequate coordination of services and misaligned financial incentives between the two programs (MACPAC 2020a, 2020b). This lack of coordination and the population's overall higher health needs contribute to disproportionate federal and state spending. Although dually eligible beneficiaries made up 19 percent and 14 percent of all Medicare and Medicaid enrollees, respectively, they accounted for 34 percent of total Medicare spending and 30 percent of total Medicaid spending in calendar year (CY) 2020 (MACPAC and MedPAC 2023). Many dually eligible individuals also experience functional limitations along with challenging health-related social needs. They are more likely to have disabilities than non-dual Medicare beneficiaries. They are also more likely than non-dual Medicare beneficiaries to be Black (21 percent compared to 9 percent, respectively) or Hispanic (17 percent compared to 6 percent, respectively), and therefore, the fragmented care that dually eligible individuals receive may have compounding effects on health equity across race and ethnicity (MACPAC and MedPAC 2023).

The Commission's long-term vision is that all dually eligible beneficiaries should have access to integrated care. Our prior 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. States are at different stages of integrating coverage for dually eligible beneficiaries, and the availability of integrated models as well as the level of integration offered in those models varies. Some states have achieved high levels of integration, while others offer few or no integrated coverage options. To provide an impetus for action, in June 2022, the Commission recommended that all states develop an integrated care strategy—including integration approach, eligibility and benefits covered, enrollment strategy, beneficiary protections, data analytics, and quality measurement—that would be structured to promote health equity. To support states in developing their strategies and raising the bar on integrated care, the Commission also recommended that Congress provide additional federal funding to states to assist them in their efforts to integrate Medicaid and Medicare coverage for dually eligible beneficiaries (MACPAC 2022a) (Box 2-1).

BOX 2-1. Recommendation, June 2022

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 (MACPAC 2022a).

Building on the Commission's recommendation, we have set out to take an expansive view of the different delivery mechanisms states use to provide Medicaid coverage to dually eligible beneficiaries and opportunities for integration across the two programs. We have organized our review of delivery mechanisms into three categories: Medicaid fee for service (FFS), Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), and Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative (FAI).

Our review of the varied delivery mechanisms comes at a time of change in the Medicaid-Medicare integration landscape. Access to D-SNPs has been growing since they were permanently authorized in the Bipartisan Budget Act of 2018 (P.L. 115-123). In 2023, 94 percent of Medicare beneficiaries reside in areas with access to D-SNPs, compared to 89 percent in 2019 (MedPAC 2023). State participation in the MMP model under the FAI demonstration has been relatively low, and three states have exited the demonstration to pursue other models.[1] California is the most recent state to leave the demonstration. In response, the Centers for Medicare & Medicaid Services (CMS) incorporated several features of the MMPs into the regulations governing D-SNPs, such as the requirement for an enrollee advisory committee for which the state solicits input from beneficiaries on their experience, and announced it will sunset the MMPs at the end of 2023. For states that opted for a final two-year extension, CMS required that MMP enrollees are transitioned to integrated D-SNPs by the end of 2025 (CMS 2022a).[2] This change effectively makes D-SNPs, and the state contracts under which they operate, the primary vehicle available to states for integrating Medicaid and Medicare. As the eight remaining MMP states begin the transition to D-SNPs, they may provide an example for other states of how to establish an integrated program for dually eligible beneficiaries.

Consistent with MACPAC's prior work calling for states to develop integrated care strategies, which we began in June 2022, this chapter begins by describing the mechanisms available for integrating Medicaid and Medicare for dually eligible beneficiaries. States may cover Medicaid benefits for their dually eligible population through Medicaid FFS or managed care, and the tools for maximizing integration in these mechanisms differ. The chapter details the changing landscape of integrated program design, as illustrated by the sunset of the MMP model, a substantial change that may expand enrollment in D-SNPs. In the discussion of the changing landscape, we also describe MACPAC's framework for monitoring the MMP transition and how D-SNPs are the primary vehicle for integration moving forward. This discussion is informed by insights from beneficiaries about their experience receiving coverage through these models. Finally, the chapter concludes with next steps in our ongoing work to advance integrated care for dually eligible beneficiaries, building on our June 2022 recommendation to require states to develop a strategy.

Background

In 2020, 12.2 million individuals were dually eligible for Medicaid and Medicare (MACPAC and MedPAC 2023). Most were full-benefit dually eligible beneficiaries (72 percent), who received coverage of Medicaid and Medicare services. Partial-benefit dually eligible beneficiaries—who did not receive Medicaid-covered services but rather Medicaid benefits to assist in paying Medicare premiums, and in some cases, Medicare cost sharing—made up the other 28 percent (MACPAC and MedPAC 2023). Medicaid and Medicare offer dually eligible beneficiaries different benefits. Medicare generally serves as the primary payer for services that overlap with those offered by Medicaid, providing coverage for services such as inpatient hospital care and physician services, while Medicaid covers long-term services and supports (LTSS) and other services that Medicare does not, such as certain behavioral health services.

Even as the dually eligible population has grown, the number of beneficiaries enrolled in integrated care products remains relatively small. In 2022, about 21 percent of full-benefit dually eligible beneficiaries, or about 1.75 million individuals, were enrolled in integrated products under managed care arrangements (CMS 2023a). Although partial-benefit dually eligible beneficiaries may also be enrolled in integrated care products, efforts tend to focus on full-benefit dually eligible beneficiaries because they have Medicaid services to coordinate with Medicare coverage (MACPAC 2022a).

Integrated care for dually eligible beneficiaries can address misaligned incentives between Medicaid and Medicare. When different entities bear risk for Medicaid and Medicare services, there is an opportunity to shift costs from one program to the other. For example, a state Medicaid agency may be disinclined to pay for additional services in a nursing facility that could prevent hospital readmissions because the financial risks of subsequent hospitalizations would be borne by Medicare. On the other hand, Medicare may seek to limit its spending by discharging patients from the hospital more quickly, which could lead to beneficiaries requiring a greater level of LTSS, a benefit covered by Medicaid.

Integrated care typically occurs in a managed care environment through either MMPs under the FAI or through D-SNPs (Box 2-2).[3] With some exceptions—such as for Medicaid benefits that the state has carved out—MMPs cover all Medicaid and Medicare benefits under a single entity through a three-way contract between CMS, the state, and the health plan.[4] This three-way contract allows for integrated state and federal oversight, including integrated medical loss ratios that reflect both Medicaid and Medicare payments and spending. All MMPs offer fully integrated coverage, and as a result, appeals and grievances, member materials, and customer service are integrated (CMS 2023b).

BOX 2-2. Integrated Models on a Continuum

Low level of integration

- **Coordination-only dual eligible special needs plans (CO D-SNPs).** These plans are required to meet only minimal levels of integration and coordination defined by the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) and the Bipartisan Budget Act of 2018 (P.L. 115-123). CO D-SNPs cover all Medicare services, while Medicaid services—specifically, behavioral health and long-term services and supports (LTSS)—are typically covered by the state Medicaid program. Federal regulations require only low levels of integration for CO D-SNPs, but each state may set requirements in its state Medicaid agency contract with a D-SNP that raises the bar to moderate levels of integration.

Moderate level of integration

- **Managed fee for service.** Available in one state for dually eligible beneficiaries under the Financial Alignment Initiative demonstration, this model is centered on health homes, which provide comprehensive care coordination services to a high-cost, high-risk subpopulation of dually eligible beneficiaries. The state is eligible to share in savings to Medicare that may result from improvements in quality due to better care coordination.
- **Highly integrated dual eligible special needs plan (HIDE SNP).** These plans must cover behavioral health or LTSS through an aligned Medicaid managed care plan operating under the same parent organization as the D-SNP, but they may cover both. Starting in 2025, a HIDE SNP's aligned Medicaid managed care plan must cover the entire service area of the D-SNP (CMS 2022a).

High level of integration

- **Medicare-Medicaid plan.** Under the Financial Alignment Initiative, Medicare-Medicaid plans enter into three-way contracts with CMS and the state to provide all Medicaid and Medicare services, excluding any the state carved out.
- **Fully integrated dual eligible special needs plan (FIDE SNP).** D-SNPs are designated as FIDE SNPs if they cover LTSS, in addition to other Medicaid benefits. Starting in 2025, FIDE SNPs must cover behavioral health, home health, durable medical equipment, and Medicare cost sharing; operate with exclusively aligned enrollment; and contract to provide Medicaid services covering the entire service area of the D-SNP (CMS 2022a).

D-SNPs are MA plans that limit enrollment to dually eligible beneficiaries. These plans vary widely in the level of integrated care and member experiences they provide as well as the degree to which they coordinate or provide Medicaid services, pursuant to certain federal and state requirements. Plans might coordinate only Medicaid services that are covered by the state Medicaid agency, while the most integrated D-SNPs cover nearly all Medicaid and Medicare services within one health plan. Three different designations of D-SNPs are defined in federal regulation and range from low to high levels of integration, but there may be notable variation even between plans within a single designation (MACPAC 2021a).

Although use of managed care by dually eligible beneficiaries is growing, most still receive coverage of their Medicaid services through FFS.[5] About half of states do not enroll their dually eligible population in Medicaid managed care, and a number of states that enroll dually eligible beneficiaries in Medicaid managed care do so on a voluntary basis. In CY 2020, 40 percent of dually eligible beneficiaries were enrolled exclusively in Medicaid FFS, and 19 percent were enrolled in Medicaid FFS with a limited-benefit Medicaid managed care plan (MACPAC and MedPAC 2023).

Integration in States Covering Dually Eligible Beneficiaries under Medicaid FFS

States that cover dually eligible beneficiaries under FFS are working to identify pathways forward to better integrate Medicaid and Medicare coverage. In June 2021, the Commission detailed how states, including those covering dually eligible beneficiaries under FFS for their Medicaid benefits, might maximize integration through their state Medicaid agency contracts (SMACs) with D-SNPs (MACPAC 2021a). For example, states can require in the SMAC that D-SNPs limit enrollment to full-benefit dually eligible beneficiaries, as is the case with the MMPs. This strategy allows uniformity for plan enrollees, including a single set of benefits and rules around care coordination. However, it may disrupt coverage for partial-benefit dually eligible beneficiaries who would have to disenroll from the D-SNP. Several states use this strategy, including Indiana and Washington (Bean and Emans 2022).

In the following sections, we describe several methods that states that primarily serve dually eligible beneficiaries under FFS are using to better align Medicaid and Medicare coverage in their respective delivery systems.

Contracting directly with D-SNPs to cover Medicaid benefits. States that deliver Medicaid services for dually eligible beneficiaries through FFS, or states in which there is no overlap between the parent organizations of D-SNPs and Medicaid managed care plans, can achieve higher levels of integration by contracting directly with D-SNPs for coverage of some or all Medicaid benefits. Alabama, Florida, and Idaho are examples of states that have used this strategy.

States leveraging this approach enter into agreements with D-SNPs and capitate payments for the plan to cover some or all Medicaid benefits, enabling the state to use a set of strategies that is typically available only to states with Medicaid managed care for dually eligible beneficiaries. In doing so, states organically implement exclusively aligned enrollment, which means that the state's contracts with D-SNPs allow the plans to enroll only full-benefit dually eligible individuals who choose to receive some or all of their Medicaid benefits from the D-SNP or the D-SNP's affiliated Medicaid managed care plan. For example, Idaho has contracted directly with D-SNPs since 2007, at which time it covered dually eligible beneficiaries under FFS. It has since instituted mandatory Medicaid managed care for dually eligible beneficiaries that opt out of integrated coverage. Idaho maximized its authority under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) and is providing fully integrated care to its full-benefit dually eligible population through a fully integrated dual eligible special needs plan (FIDE SNP), which is explained in greater detail later in this chapter (Spencer et al. 2018). These FIDE SNPs essentially contract with the state as Medicaid managed care organizations and must meet the federal requirements for Medicaid managed care.

Both Idaho and the District of Columbia, which also contracts directly with D-SNPs, use this approach to provide Medicaid services to dually eligible

beneficiaries through a voluntary managed care arrangement. However, a state may contract directly with D-SNPs to provide other Medicaid benefits while still covering Medicaid services for dually eligible beneficiaries under FFS. For example, Alabama only capitates Medicare cost sharing to its D-SNPs to managed care organizations, which can simplify provider billing.

Managed FFS. Managed FFS is currently available for dually eligible individuals in one state through its model under the FAI. In its demonstration, Washington contracted with health homes to provide comprehensive care coordination services to a high-cost, high-risk subpopulation of dually eligible beneficiaries. Health homes primarily provide care coordination and referrals to community and social supports. These health homes receive monthly Medicaid payments for care coordination services. Through its memorandum of understanding with CMS, Washington is eligible to share in savings to Medicare that may result from improvements in quality due to better care coordination (CMS 2012).

Primary care case management. Primary care case management (PCCM) is an approach to administering Medicaid benefits in which beneficiaries are assigned to a primary care provider (PCP) who receives a monthly management fee, in addition to payment through FFS for care provided, to coordinate and monitor beneficiary care and provide referrals. PCCM has historically been used for Medicaid populations with complex health care needs and is more common in states with substantial rural populations that pose operational challenges for managed care plans; for example, Alabama specifically targets dually eligible beneficiaries with its PCCM program (Rizer 2022). Although PCCMs provide low levels of integration and coordination, these programs, along with other value-based payment models, could serve as a basis for building greater levels of integration, such as by requiring PCCMs to partner with D-SNPs (Rizer 2022).

Insights from state panel

In September 2022, MACPAC asked three state Medicaid officials to join a panel to discuss their efforts to integrate care for dually eligible beneficiaries in a FFS delivery system. Representatives from the District of Columbia, Maine, and Washington spoke with the Commission about the challenges they face, such as limited resources for integrated care efforts and a lack of expertise in Medicare program rules among state staff. Although the District of Columbia and Washington have Medicaid managed care programs for some Medicaid beneficiaries, in all three cases, most dually eligible beneficiaries receive their Medicaid coverage through FFS.

Information provided by panelists represents state perspectives from a point in time and are not an exhaustive list of state approaches to integrating care in FFS. Both states on the panel and the District of Columbia are operating in different political and geographic contexts that affect the approaches they can take to integration.

The District of Columbia excludes dually eligible beneficiaries from mandatory Medicaid managed care, but it offers voluntary enrollment in its Dual Choice D-SNP program. Previously, the District of Columbia paid for Medicaid services through FFS, while the D-SNP covered only Medicare benefits. As of February 2022, the District of Columbia began providing a capitation payment to D-SNPs serving full-benefit dually eligible individuals to coordinate and cover Medicaid services, excluding behavioral health services, thereby establishing highly integrated dual eligible special needs plans (HIDE SNPs) (DCDHCF 2022).

Maine does not have a Medicaid managed care program for any of its beneficiaries. The state features several accountable care organizations (ACOs), many of which partner with the state's Medicaid agency under its Accountable Communities program, which aims to reduce costs and improve care for Medicaid beneficiaries (MEDHHS 2022). Currently, Maine does not offer integrated care models for dually eligible beneficiaries above the level of a coordination-only D-SNP (CO D-SNP), although it has several alternate payment model initiatives aimed at better coordinating care more broadly for all patients at the provider level.[6] Maine has previously told the Commission that it would involve its ACOs in any future integrated care strategy.

Washington enrolls certain dually eligible beneficiaries in Medicaid health homes as part of its managed FFS model under the FAI demonstration. Evaluations of the demonstration have identified Medicare program savings, but Medicaid effects were not measured because of a lack of data. 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. The state is seeking CMS certification of the program to allow it to continue permanently (WAHCA 2022). Washington is the only remaining state to integrate care in a FFS environment under the FAI and may provide an example for other states.

Our panelists highlighted three main areas in which federal support facilitated integration in their state's FFS delivery system, or further flexibility could assist them to develop integrated care models. The discussion included financing, state capacity, consumer choice, and transitioning Medicaid coverage to managed care.

Financing. As the state on the panel with the most developed integrated model, Washington noted the importance of up-front investments in its success. In 2011, Washington received $1 million in funding through CMS's State Demonstrations to Integrate Care for Dual-Eligible Individuals program (CMS 2010). With that funding, along with technical support provided by CMS in designing its integrated model, Washington used the money to hire dedicated staff. Then, in 2013, as part of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), Washington received an enhanced 90/10 federal Medicaid match for eight quarters for its health home model, which serves as the basis of the state's managed FFS demonstration. By 2016, the state received its first shared savings payment from CMS followed by another in 2017, which the state said allowed the program to break even without the health home enhanced match and provided Medicaid agency staff with a business case to secure continued funding from the state legislature. By 2018, Washington said shared savings were producing a surplus that could be reinvested into the program.[7]

State capacity. State capacity was a pressing concern for all panelists. State officials noted the need for dedicated staff to do the work of establishing an integrated program, in addition to developing Medicare expertise among state staff that primarily have experience with the Medicaid program. For the District of Columbia, its Medicaid staff acquired Medicare expertise through close collaboration with the insurer that offers its D-SNPs as the agency sought to leverage its SMAC to improve care for dually eligible beneficiaries.

States that previously participated in a MACPAC roundtable on state efforts to integrate care said they valued the technical assistance they received from CMS and expressed interest in technical assistance in the form of peer-to-peer learning, in which one state can learn from another similarly situated state, in addition to federal financial support (MACPAC 2021a). At MACPAC's September 2022 panel, Maine told us that it has engaged in peer-to-peer learning with another panelist, Washington, about its health home model and managed FFS program. Additionally, Maine said that it is in the process of hiring a consultant to assist with developing a strategy for pursuing integrated care, in line with the Commission's recommendation in its June 2022 report to Congress (MACPAC 2022a).

Consumer choice. All three panelists voiced the importance of developing integrated models that allow for the greatest level of consumer choice. For the District of Columbia, a decision to move much of its Medicaid population to managed care was balanced by making that enrollment voluntary for dually eligible beneficiaries and only offered as part of an integrated care program.[8] Meanwhile, Washington state said it emphasized the need for consumer choice beginning with the program's initial development. Washington's health home model is founded on community care organizations, which coordinate care for beneficiaries among a range of partners, including federally qualified health centers, behavioral health agencies, and Area Agencies on Aging. As the state moves to make its managed FFS program permanent, Washington said it intends to leverage its SMACs to require that D-SNPs provide access to health home care coordination, allowing D-SNP enrollees a choice of which delivery system they prefer to use for their care.

Transition to managed care. Of the three panelists, only the District of Columbia is working to transition its dually eligible population from FFS to Medicaid managed care for coverage of Medicaid benefits.[9] Washington has experienced success with its managed FFS model, while Maine noted the difficulties

it would face creating a managed care program given its older, rural population.[10]

In 2019, the District of Columbia announced plans to move its entire Medicaid program, including dually eligible beneficiaries, into managed care. It has begun this transition in incremental steps, starting with its non-dually eligible populations. As part of the process, the District of Columbia is working to integrate community-based behavioral health, which had previously been carved out, into its managed care contracts. The District of Columbia noted that its incremental, staggered move to managed care may be a positive for providers who have been slowly adjusting to the new delivery system.

Integrating Care through Managed Care Arrangements

Dually eligible beneficiaries in managed care are primarily enrolled in two types of integrated models: D-SNPs or MMPs. D-SNPs are more widely available and enroll more people than MMPs. However, MMPs generally provide a higher level of integration because eligible individuals enroll in a single plan that is responsible for all aspects of their coverage. The MMP receives a blended payment that combines Medicaid and Medicare Part A, Part B, and Part D.[11, 12] In the following sections, we discuss these two models.

D-SNPs

D-SNPs are a type of MA plan that limits enrollment to dually eligible beneficiaries. To operate, D-SNPs must contract with CMS to provide Medicare benefits as an MA plan; in addition, they must sign contracts with Medicaid agencies in the states in which they operate to at least coordinate Medicaid benefits for their members. States are not required to contract with D-SNPs though, and D-SNPs may not operate in states without a contract. SMACs, as required under MIPPA and sometimes referred to as "MIPPA contracts," define how D-SNPs will coordinate Medicaid and Medicare benefits.

Relative to other integrated models, D-SNPs serve the greatest number of dually eligible beneficiaries and are the most widely available. As of March 2023, D-SNPs were available in 45 states and the District of Columbia with enrollment of nearly 4.9 million beneficiaries, or about 40 percent of all dually eligible beneficiaries nationwide (CMS 2023c) (Figure 2-1). As defined in regulation, D-SNPs can offer three levels of integration between Medicaid and Medicare. In the following sections, we list these types from lowest to highest level of integration. See Table 2A-1 for more information on which plan types are available in which states.

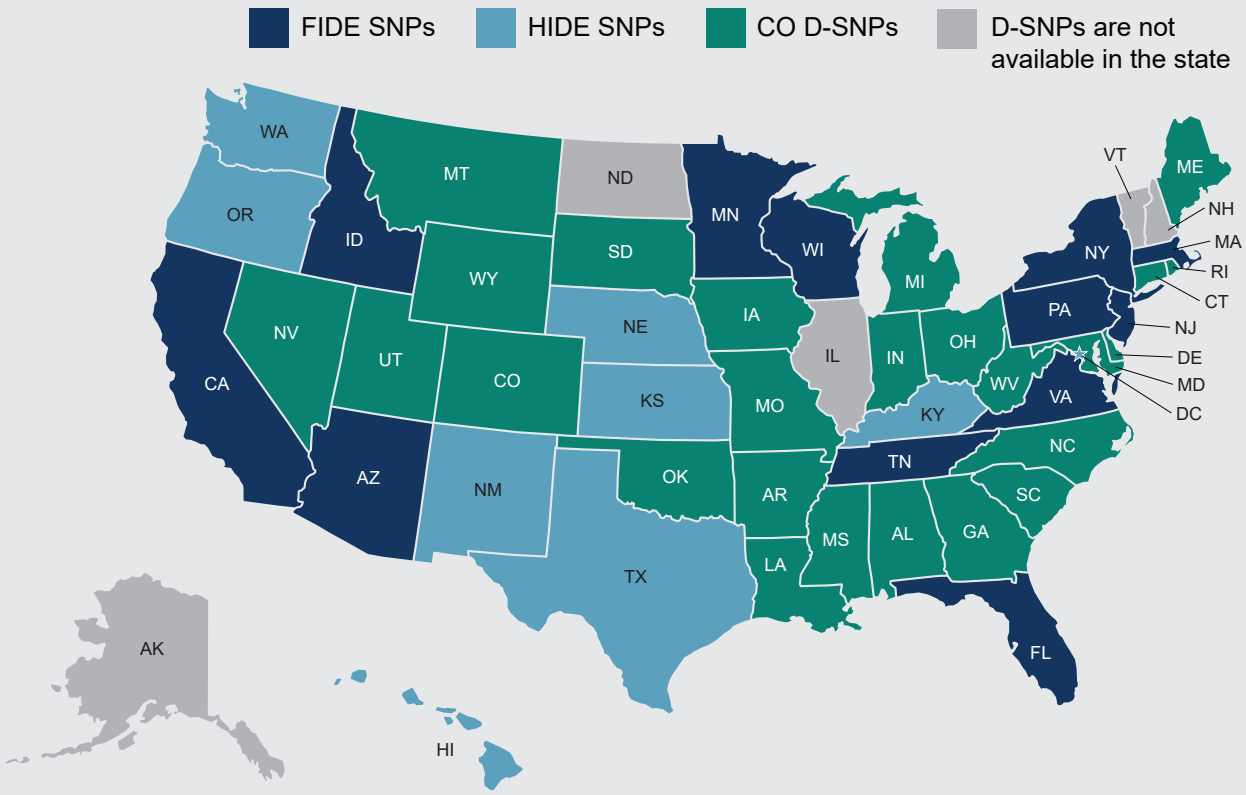
CO D-SNPs. CO D-SNPs are the most common type of D-SNP. They are available in 38 states and the District of Columbia and enroll more than 2.8 million beneficiaries, or about 57 percent of dually eligible beneficiaries in D-SNP products (CMS 2023c). These plans are required to provide only minimal levels of integration, coordinating Medicaid benefits as required under MIPPA and subsequent legislation. CO D-SNPs cover all Medicare services, while Medicaid services are typically covered by the state Medicaid program. However, some states may capitate CO D-SNPs to provide some Medicaid benefits without qualifying as a more integrated type of D-SNP. For example, a state may require a CO D-SNP to cover Medicare cost sharing, or the state may require coverage of a broad array of Medicaid behavioral health services and LTSS but have carve outs that preclude qualifying as one of the following plan types.

HIDE SNPs. Beginning in 2021, D-SNPs can be designated as HIDE SNPs if they have a contract with the state Medicaid agency to cover LTSS, behavioral health services, or both. HIDE SNPs provide moderate to high levels of integration for beneficiaries. HIDE SNPs are available in 15 states and the District of Columbia, enrolling more than 1.7 million beneficiaries, or about 35 percent of all dually eligible beneficiaries enrolled in D-SNP products (CMS 2023c).[13]

FIDE SNPs. D-SNPs can be designated as FIDE SNPs if they cover LTSS, in addition to other Medicaid benefits, unless the state carves behavioral health services out of the capitation rate (CMS 2023c, MACPAC 2020a).[14] FIDE SNPs provide the highest level of integration in a D-SNP. Enrolling about 403,000 beneficiaries in 12 states, or about 8 percent of dually eligible beneficiaries in D-SNP products, these plans must cover all Medicaid and Medicare benefits (CMS 2023c).

In 2019, CMS published regulations that defined new requirements for certain subsets of D-SNPs that qualify as applicable integrated plans (AIPs) to establish an integrated appeals and grievances process (42 CFR 422.629). D-SNPs that use exclusively aligned enrollment, which the state can require in its SMAC, are considered AIPs. 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

FIGURE 2-1. Most Integrated Dual Eligible Special Needs Plan Available by State, 2023



Notes: FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. CO D-SNP is coordination-only dual eligible special needs plan. This figure shows the most integrated type of D-SNP available in the state or the District of Columbia as of February 2023. States may have more than one type of D-SNP available, and plans are not always available statewide. HIDE SNPs were first available starting in 2021.

In 2017, Illinois chose not to continue contracts with D-SNPs to focus on Medicare-Medicaid plans as a platform for integrating care (MedPAC 2019). Washington does not have comprehensive Medicaid managed care for dually eligible beneficiaries, but it does have HIDE SNPs formed by aligning D-SNPs with organizations that cover behavioral health services.

Source: CMS 2023c.

an affiliated Medicaid managed care plan under the same parent organization. In 2022, CMS updated the AIP regulations to apply the designation more broadly to include all subsets of D-SNPs meeting the criteria, not just HIDE SNPs and FIDE SNPs (CMS 2022a). Also in that rule, CMS required FIDE SNP and HIDE SNP service areas to align with their companion Medicaid plans, and it tightened the definition of a FIDE SNP to facilitate greater integration (CMS 2022a).[15]

FAI demonstrations

The FAI demonstration is authorized under Section 1115A of the Social Security Act to test models to increase financial alignment between Medicaid and Medicare and integrate primary, acute, behavioral health, and LTSS for beneficiaries eligible for both programs (CMS 2023a). State participation in the FAI is optional. States can choose a capitated model or a managed FFS model or propose an alternative model. Currently, eight states are participating in the capitated model. These states hold three-way contracts with CMS and MMPs. One state, Washington, operates a managed FFS model, and Minnesota operates an alternative model. The earliest demonstrations began in July 2013, and CMS worked with states to provide opportunities to extend demonstrations beyond their initial three-year window. All states with current demonstrations requested and received approval for multiple extensions, typically for periods of two years at a time. Because most participating states selected the capitated model, our focus is on those demonstrations in which coverage is provided through MMPs.

The capitated model demonstrations under the FAI introduced several innovations aimed at improving care coordination for those dually eligible as well as integrating and aligning administrative processes. These demonstrations are operated under three-way contracts through which the MMPs provide coverage to dually eligible beneficiaries. These contracts allow for passive enrollment of beneficiaries and the opportunity for states to share in Medicare savings. Notably, these three-way contracts require integrated member materials, dedicated funding for an ombudsman program, reporting of specific quality outcome measures, and coverage of additional member benefits beyond the benefits traditionally covered by Medicaid and Medicare (e.g., $0 copays for prescription drugs or fitness benefits).

Enrollment in MMPs has been lower than expected, in part due to high opt-out rates and disenrollment (Grabowski et al. 2017). As of March 2023, about 309,000 dually eligible beneficiaries were enrolled (Table 2-1).[16] According to the most recent publicly available data, participation rates in the MMPs ranged from 8.4 percent of eligible beneficiaries in New York to 61.7 percent in Ohio (Griffin et al. 2022, Snow et al. 2022). Some states have experienced operational challenges that have slowed or paused implementation of passive enrollment, a tool that is associated with higher rates of enrollment (Holladay et al. 2022, MACPAC 2019). Recent evaluations of the demonstrations under the FAI, based in part on interviews with state and health plan staff, have also pointed to increasing competition from MA in the marketplace as a cause for static or declining enrollment (Griffin et al. 2022, Khatutsky et al. 2021).

TABLE 2-1. Monthly Enrollment in Medicare-Medicaid Plans under the Financial Alignment Initiative Demonstration by State, March 2023

State	MMP enrollment
Total	**309,045**
Illinois	88,821
Massachusetts	39,089
Michigan	42,214
New York	1,716
Ohio	76,319
Rhode Island	13,618
South Carolina	12,471
Texas	34,045

Notes: MMP is Medicare-Medicaid Plan. MMP enrollment is current as of March 2023. Data for New York include only the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities demonstration.

Source: ICRC 2023.

Changing Integrated Care Landscape

States are charting a course toward integrated care amid an evolving landscape. In 2022, after a series of regulatory updates to D-SNP requirements, CMS announced it would end the capitated demonstrations under the FAI at the end of CY 2023, with the possibility of an extension through 2025 contingent on states transitioning their MMP enrollees to integrated D-SNPs (CMS 2022a).[17] In its final rule, CMS cited the opportunity to implement integrated care on a broader scale through D-SNPs as a reason for winding down the capitated model demonstrations as well as the potential for stability and reduced state administrative burden by transitioning from time-limited demonstration models to permanent structures. The rule also made a series of regulatory changes that shrank the gap between integrated D-SNPs and MMPs by incorporating features of the MMPs into the regulations governing D-SNPs, reinforcing CMS's decision to end the capitated model demonstrations. Other changes in MA policy that allowed benefit flexibilities in D-SNPs for coverage of benefits related to social determinants of health—such as transportation, which previously did not exist outside of the capitated model demonstrations—also played a role (CMS 2022a, MACPAC 2022b).

MACPAC has developed a framework for monitoring the transition from MMPs to integrated D-SNPs in the years ahead to identify operational concerns that could lead to disruptions for beneficiaries or states. Although these transitions may incorporate some elements of the FAI demonstrations into D-SNPs, such as the requirement for an enrollee advisory committee, not all aspects of these demonstrations will necessarily transfer to D-SNP models.

CMS sunsets the MMP model

For states intending to transition their MMPs to D-SNPs by the end of 2025, CMS required them to submit preliminary transition plans by October 1, 2022, that addressed key elements of the transition. These elements included how states will maximize integration throughout the transition, how the ombudsman program required under the demonstrations would be sustained in the states' new D-SNP models without continued federal funding, how states would engage stakeholders for feedback on transition plans, and the identification of policy and operational steps needed to achieve these goals (CMS 2022a). Although the current proposed timelines in state transition plans are non-binding, most demonstration states said they view those dates as high-level benchmarks to meet.

States are early in the process of converting their capitated model demonstrations to D-SNP models and receiving guidance from CMS, so specific detail in the transition plans is unavailable. To date, they reflect the early stages of planning around operational changes. Intended to kick off discussions with stakeholder groups, the transition plans represent letters of intent as opposed to final policy decisions.

Not all elements of the demonstrations are transferable to the D-SNPs under current statutory authority. For example, states may lose the ability to share in savings generated by the demonstration with the federal government and the ability to passively enroll beneficiaries. Although the three-way contract under the capitated model established a shared savings mechanism, a comparable mechanism is not currently available for D-SNPs. Similarly, passive enrollment is not possible outside of the three-way contract. Several states noted the importance of the opportunity for shared savings to the sustainability of their programs, as states must spend resources to implement an integrated program but see the savings from those programs accrue to Medicare in the form of decreased hospital and emergency department use. Other elements of the demonstrations may be possible under the D-SNP model, but there are concerns that comparable levels of integration may be difficult to attain. For example, Massachusetts noted the loss of passive enrollment and how that might impact its ability to enroll and retain eligible beneficiaries, even with the use of default enrollment. Overall, Massachusetts said states need clearer guidance from CMS on which pieces of their demonstration—not preserved in the final rule—may still be possible under other authorities.[18]

Framework for monitoring transition away from MMPs

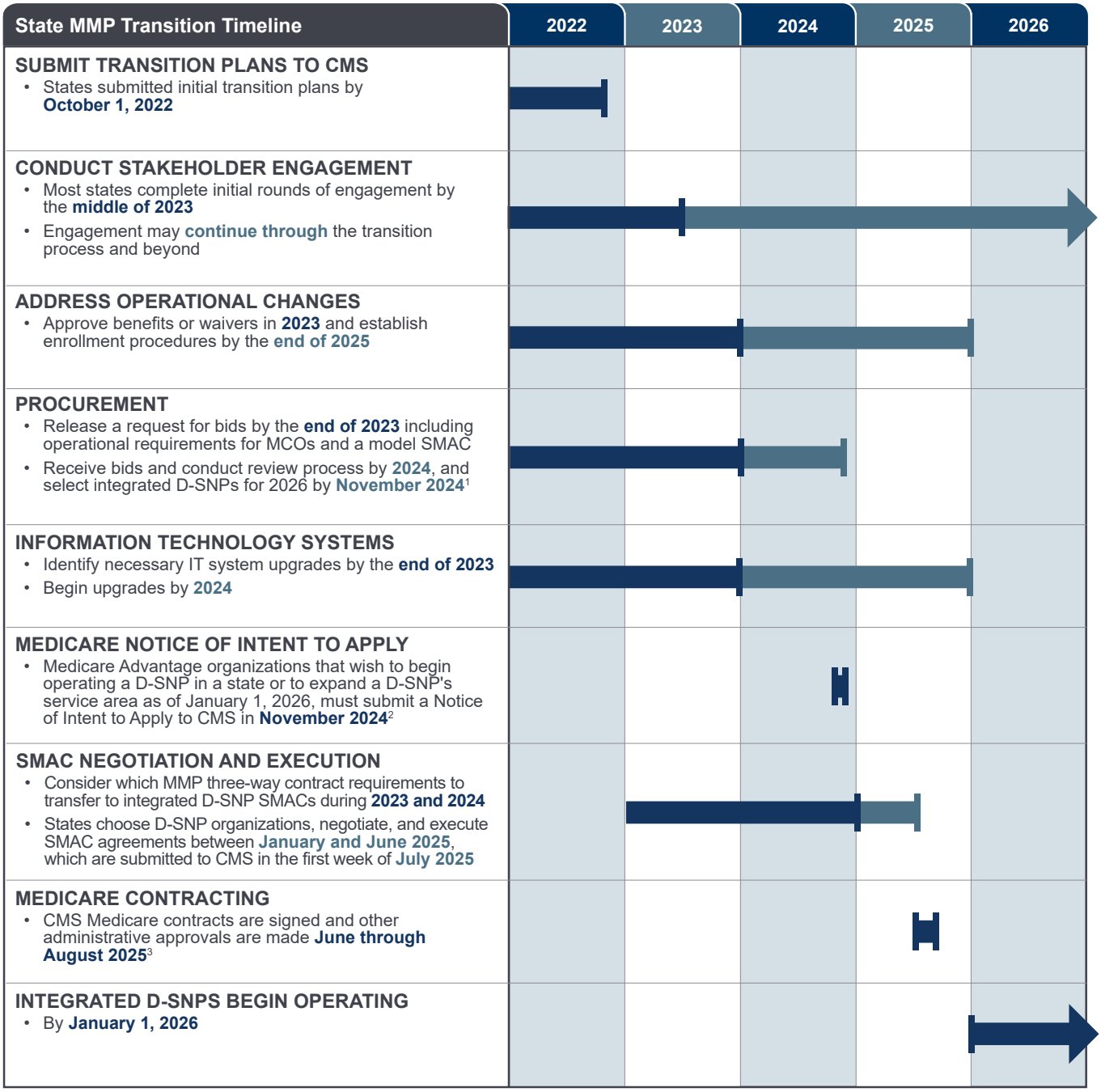
To better understand how states are approaching the transition process and their operational concerns, MACPAC interviewed five of the eight states with capitated FAI demonstrations about the status of their plans to transition to D-SNPs.[19] Through our interviews, we identified a framework with four primary areas for monitoring state progress as states transition their MMPs: stakeholder engagement, Medicaid managed care procurement, information technology system changes, and enrollment processes.

Most states expressed confidence in their ability to successfully transition their demonstrations into integrated D-SNP products by the end of 2025. All current demonstration states have requested the extension through 2025 to have sufficient time to prepare (Figure 2-2). To ease the transition process, some states we spoke with indicated they plan to focus on existing MMP enrollees, but they may roll out changes to include D-SNPs covering the dually eligible population that did not participate in the FAI demonstration. For example, South Carolina said it will transition its MMP enrollees to HIDE SNPs initially, since many of the state's current MMP enrollees are not LTSS users, but it will look to move toward requiring FIDE SNP designation for plans serving its broader dually eligible population in the future as the state transitions LTSS coverage into Medicaid managed care.

CMS has also asked for a commitment from states to continue ombudsman programs that provide person-centered assistance to dually eligible beneficiaries, a requirement under the FAI demonstration. However, as the demonstrations sunset, states will no longer receive federal funding for ombudsman programs. States told us they plan to continue the programs, although some indicated that the source of state-only dollars to fund the programs was still to be determined. For some states, such as Rhode Island and Ohio, ombudsman services for dually eligible beneficiaries will transition to existing long-term care ombudsman offices.

As states flesh out their plans, both federal and state officials are discussing how to assess their progress in implementing the transition. MACPAC will continue to monitor the transition process through ongoing conversations with states using our framework.

FIGURE 2-2. State Transition Timeline from Medicare-Medicaid Plans to Dual Eligible Special Needs Plans



Notes: MMP is Medicare-Medicaid plan. CMS is the Centers for Medicare & Medicaid Services. MCO is managed care organization. SMAC is state Medicaid agency contract. D-SNP is dual eligible special needs plan. IT is information technology.

[1] Some states may not need to undergo procurement. However, D-SNPs still need to file a Medicare Notice of Intent to Apply to CMS in November to ensure access to the Health Plan Management System. SMACs may be provisional and finalized before upload to the Health Plan Management System during the Medicare contracting phase.

[2] Only organizations that intend to offer a new product or expand their service area need to submit a Medicare Notice of Intent to Apply.

[3] Based on the calendar year 2022 deadline for Medicare Advantage plan bids (CMS 2022b).

Source: MACPAC review of state transition plans and interviews with state officials, 2023.

Procurement. As part of the transition, most states will need to undergo a Medicaid managed care procurement, the process through which states competitively award contracts to managed care organizations to provide coverage to Medicaid beneficiaries.[20] Nearly all interviewees acknowledged procurement strategy as a near-term decision, given the potentially lengthy runway needed to complete the process. Medicaid managed care procurement requirements vary by state and may not align with the timeline that CMS established for the transition or the MA bid and enrollment cycle. For states in which the demonstration transition timeline and Medicaid procurement do coincide, opportunities may exist to create alignment among Medicaid and Medicare offerings, such as requiring parent organizations bidding for Medicaid managed care contracts to offer an affiliated D-SNP. The Medicaid procurement process typically takes 18 to 24 months from development of the request for proposals to awarding and implementing contracts.[21] As states plan their procurement timelines, they must take into account that MA organizations intending to offer new D-SNPs or to expand D-SNP service areas in 2026 must submit a Medicare Notice of Intent to Apply in November 2024.

Several states said they are in early discussions about their procurement needs, which may require other state action to proceed. Meanwhile, Michigan said that it initially planned to transition its demonstration to a FIDE SNP model. However, state law requires the state to carve out specialty behavioral health services from its capitated Medicaid managed care contracts to be administered by counties, which prevents the use of a FIDE SNP. In November 2022, an amendment to exempt dually eligible beneficiaries from this statutory requirement failed to pass the state legislature. Therefore, Michigan has revised its plan to target a HIDE SNP model instead. For some states, not all of their existing Medicaid managed care plans offer companion D-SNP products in the same service area. In its transition plan, Rhode Island set November 2023 as a tentative start date for its procurement process, and although it currently has no FIDE SNPs, it said potential Medicaid managed care bidders will be expected to take the steps necessary to qualify as a FIDE SNP.

The states we spoke with expressed confidence that they would be able to complete these changes within the two-year demonstration extension period. However, state familiarity with the procurement process may vary depending on the maturity of its Medicaid managed care program or experience with D-SNP contracting. Experts we spoke with suggested this would be a key area for monitoring progress and any potential challenges in the transition.

Federal and state officials did suggest that the substance of demonstration states' three-way contracts with MMPs could be largely lifted to form the states' new contracts with integrated D-SNPs, a potential advantage for states less familiar with D-SNP contracting. This would enable states to ensure they incorporate requirements they established for their MMPs, such as single ID cards or specific care coordination strategies.

Stakeholder engagement. States are sharing their transition plans with stakeholder groups to gather feedback that will help to refine the transition plans and determine how D-SNPs will operate in each state. States differed in how developed their stakeholder outreach strategies were at the time of our interviews at the end of 2022. Massachusetts planned to regularly consult its One Care Implementation Council, a unique consumer-led working committee that provides feedback to the state on issues like access and quality, as the state develops and implements its transition plan. Other states, such as Ohio and Michigan, were in the beginning stages of creating a robust stakeholder engagement strategy. Meanwhile, South Carolina, which does not currently enroll its dually eligible population in Medicaid managed care outside the demonstration, said it would build a communication strategy for those beneficiaries and the state's providers to correct misperceptions about managed care.

Several states said they planned to publicly post their transition documents and have since done so. Most states said they anticipate their initial round of stakeholder outreach to continue through the middle of 2023, but also noted that they plan to engage with stakeholders throughout the transition.

Enrollment processes and related systems improvements. We heard from several stakeholders that enrollment is a potential area of concern as states take on responsibilities for enrolling beneficiaries that were previously handled by an enrollment broker under the MMP demonstration.

A number of states plan to use default enrollment. Under default enrollment, states and CMS can approve D-SNPs to automatically enroll a Medicaid managed care member becoming eligible for Medicare into the Medicaid managed care organization's affiliated D-SNP if the beneficiary will remain enrolled in the Medicaid managed care organization after becoming eligible for Medicare (MACPAC 2021a). This contracting strategy can ensure a smooth transition from Medicaid-only coverage to integrated coverage for those becoming dually eligible. People who are default enrolled have the option to opt out and choose other Medicare coverage. We heard from states that using default enrollment may require information technology system upgrades to facilitate data sharing between states and plans on member eligibility. Additionally, many states relied on a third-party enrollment broker to manage enrollment into the MMPs. For states that lack experience enrolling dually eligible beneficiaries into coverage, enrollment could become more difficult than under the demonstrations.

The transition to integrated D-SNPs may require some states to take on a greater role in processing enrollments than they have in the past and necessitate improvements to facilitate data sharing with health plans. For example, states may need to share prospective Medicare eligibility information with D-SNPs if they are allowing default enrollment, in which Medicaid managed care plan enrollees who are becoming eligible for Medicare would be automatically enrolled into the managed care plan's affiliated D-SNP. States may also need to learn how to better leverage Medicare data they already exchange with CMS, such as the Medicare Modernization Act file, for purposes of default enrollment.[22] These changes may be needed as several states said they anticipate using default enrollment. Additionally, as states move to implement exclusively aligned enrollment outside the FAI demonstrations, the process may require states to revise their current Medicaid enrollment policies and periods.

Leveraging SMACs

As the integrated care landscape changes after the sunset of the MMPs, former MMP states in particular may be looking for opportunities to leverage their SMACs in an effort to maintain the levels of integration achieved in the MMPs. States' ability to use strategies to promote integration depends on several factors. These include the availability of D-SNPs, whether D-SNPs are operated by the same parent company or legal entity as those operating Medicaid plans in the service area, state priorities, administrative capacity, and existing state statute and policy.

States that enroll dually eligible beneficiaries in Medicaid FFS can leverage their SMACs to require that D-SNPs use specific or enhanced coordination methods, such as requiring that D-SNPs train their care coordinators to be familiar with Medicaid benefits to help beneficiaries access these services. States can also require D-SNPs report data for oversight of operations and quality of care, which can help the state obtain a comprehensive picture of which Medicaid and Medicare services enrollees are using and identify areas for improvement. Contract language can also ensure the state receives enrollee communication materials designed by the D-SNP for review before use, which could ensure consistency in Medicaid benefit descriptions across D-SNPs in the state. This requirement could also make enrolling easier for beneficiaries who may find the number of coverage options available to them confusing, especially the diversity of Medicare plans. Finally, states can partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to full-benefit dually eligible beneficiaries, preventing duplication (Table 2-2). Certain levers for maximizing integration through an SMAC are available only to states that enroll dually eligible beneficiaries in Medicaid managed care (MACPAC 2021a).

TABLE 2-2. Strategies for State Contracts with Dual Eligible Special Needs Plans, 2021

Strategy
All states can use these strategies:
Limit D-SNP enrollment to full-benefit dually eligible beneficiaries
Contract directly with D-SNPs to cover Medicaid benefits[1]
Require D-SNPs to use specific or enhanced care coordination methods
Require D-SNPs to send data or reports to the state for oversight purposes
Require state review of D-SNP materials related to delivery of Medicaid benefits
Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits
Only states with Medicaid managed care can use these strategies:
Selectively contract with D-SNPs or Medicaid managed care plans that offer affiliated plans
Require complete service area alignment
Require D-SNPs to operate with exclusively aligned enrollment
Allow or require D-SNPs to use default enrollment
Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization
Incorporate Medicaid quality improvement priorities into the D-SNP contract
Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing

Notes: D-SNP is dual eligible special needs plan. These strategies are available to states under authority established in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275).

[1] Some states may have statutes that could complicate use of this strategy. For example, Mississippi state law requires action from the state legislature to expand Medicaid managed care contracts.

Source: Mathematica, 2021, analysis for MACPAC of MIPPA strategies for contract years 2020 and 2021 and interviews with stakeholders.

States that carve out behavioral health or LTSS from Medicaid managed care face difficulties achieving a high level of integration. When a benefit is carved out, the plan is not responsible for providing the benefit and does not receive payment for it. States carve out benefits for a number of reasons, including plans' inability to provide access to specialized providers, state statutory requirements, or use of county-based models (Inkelas 2005). An evaluation of Michigan's demonstration under the FAI noted that integrating previously carved-out benefits can create substantial operational challenges for states, highlighting Michigan's difficulties with communication between the MMPs and the prepaid inpatient health plans that cover behavioral health services in the state around health assessments (Holladay et al. 2019). Other states voiced concerns that leveraging their SMAC authority too heavily could reduce the number of D-SNPs willing to enter the market. By definition, selective contracting makes fewer contracts available, which results in fewer D-SNPs available in the state and potentially lower D-SNP enrollment. For example, if a state offers three Medicaid managed care plan contracts, only three aligned D-SNPs would be available. Finally, MA penetration, and therefore D-SNP availability, is often limited in rural areas relative to metropolitan areas due to difficulties achieving financial viability with the small number of covered individuals and building an adequate provider network, which means that D-SNP contracting may have limited efficacy in integrating care in states with large rural populations (MedPAC 2022, MACPAC 2021a).

About half of states do not enroll dually eligible beneficiaries in Medicaid managed care, making integrating care through a managed care arrangement a challenge for many states (MACPAC 2021a). However, there are opportunities to coordinate Medicaid and Medicare coverage for dually eligible beneficiaries in a FFS environment. The Commission views the development of an integrated care strategy as a valuable tool for all states, even those states providing Medicaid coverage to dually eligible beneficiaries through FFS, and MACPAC continues to monitor state efforts in this area.

Beneficiary Experiences in Integrated Care

Although the Commission has examined the range of integrated models available and heard from states about their efforts to integrate coverage for their dually eligible populations, we had not solicited input from beneficiaries enrolled in these models. To better understand the experience of receiving coverage through integrated care and how beneficiary protections might improve that experience, MACPAC contracted with NORC at the University of Chicago (NORC) to conduct focus groups with full-benefit dually eligible beneficiaries. We selected participants representing the continuum of integration from minimal levels of integration in most CO D-SNPs to high levels of integration in MMPs under the FAI demonstration. The focus groups occurred virtually from November 2022 through January 2023 in five states: Nebraska, New York, South Carolina, Texas, and Washington. We recruited participants from a diverse set of states located in different geographic regions and with different political leanings. We also considered population size, rurality, and the type of integrated models present in the state.

We recruited beneficiaries enrolled in different types of D-SNPs as well as FAI enrollees. We spoke to beneficiaries enrolled in each of the available D-SNP types: CO D-SNPs, HIDE SNPs, and FIDE SNPs. We talked to MMP enrollees in New York, South Carolina, and Texas and to managed FFS enrollees in Washington. We chose New York so we could hear from enrollees in the state's Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) program. New York's FIDA-IDD program is unique among integrated care models in that it integrates coverage for people who are dually eligible with intellectual disabilities or developmental disabilities (ID/DD), a population typically left out of integrated care efforts to date.

NORC conducted 10 focus groups with 40 participants, including one Spanish-speaking group with 5 participants. Due to challenges in recruitment, NORC also conducted 15 one-on-one interviews with participants who could not attend the focus groups. We also spoke with eight individuals who were caregivers of dually eligible beneficiaries, most of whom were family members. In total, we heard from 55 beneficiaries and caregivers. Overall, 34 focus group participants were enrolled in HIDE SNPs, FIDE SNPs, MMPs, or managed FFS. Twenty-one participants were enrolled in CO D-SNPs. To obtain a diverse set of perspectives, our focus group participants represented a range of different races and ethnicities, ages, and geographic locations.

Limitations

Our summary should not be taken as representative of all dually eligible beneficiaries or of all integrated programs. There is substantial variation across states and across programs in terms of the level of integration offered, the types of benefits available, and the performance of the health plans providing the services. For example, fully integrated programs, such as MMPs under the FAI demonstration or FIDE SNPs, are not widespread. We sought enrollees in those models as well as individuals in lower levels of integration so that we could reflect beneficiaries' varied experiences, but we did not attempt to capture a representative sample of any one type of model. Additionally, dually eligible beneficiaries are a diverse group with wide variation in their health care needs. Most are age 65 or older, but many are also younger and have disabilities. What these distinct groups are looking for from their health plans will affect their perceptions of that coverage, and we did not attempt to control for those differences in how we characterized their experiences. This chapter reports on the experiences of the dually eligible beneficiaries to provide context for the Commission's work to advance integration of Medicaid and Medicare coverage.

Recruiting dually eligible beneficiaries to talk to us about their experiences was challenging. Full-benefit dually eligible beneficiaries enrolled in integrated programs are a relatively small population, made up of about 1.7 million individuals in 2022, relative to Medicaid enrollees who total more than 87 million people in fiscal year 2021 on an ever-enrolled basis (CMS 2023a, MACPAC 2022c). We limited our recruitment to five states, which further limited our available pool of participants. Dually eligible enrollees in those states made up about 7 percent of all dually eligible beneficiaries. We applied selection criteria reflecting full-benefit dually eligible beneficiaries, living in one of the states we selected, enrolled in an integrated plan offering minimal to full levels of integration, with internet or phone access to participate, and not living in an institution. For the Spanish-speaking group, we added the additional language criteria.

Although we experienced limitations in conducting this work, we see value in hearing from individuals about their experiences and how they perceive the care they are receiving. Their perspective is one the Commission set out to highlight through these focus groups.

Themes from beneficiary focus groups

Several themes emerged from the focus groups with dually eligible beneficiaries about their experiences in integrated coverage.

Enrollment experiences. Participants commonly cited the ability to keep their existing PCPs, specialists, or health systems, in addition to cost, as the most important factors in choosing a plan. Participants described taking various approaches to choosing their plans and receiving assistance from different sources. Many participants described getting help from family or friends and conducting their own research on the internet to choose a plan, with several using the Medicare Plan Finder tool. Some participants detailed their experiences using enrollment brokers, such as a broker employed by a health plan, but were not always specific about the type of broker they used. Those who used brokers described positive interactions. For example, a few participants noted they would reach out to their brokers if they had issues with their plans. Finally, several enrollees in New York's FIDA-IDD program described hearing about the plan at its inception through information sessions targeted to the ID/DD community.

Access to providers. Generally, study participants did not report issues accessing primary or specialty care providers. Most of what we heard about access was focused on Medicare-covered services such as primary care, urgent care, and specialty care. Most participants reported having and liking their PCPs. Some participants used telehealth when they had a more urgent primary care need. Many participants also relied on urgent care—for example, when they needed a same-day appointment and their PCPs did not have any openings or on the weekend when their PCP offices were closed.

Most focus group participants reported seeing specialists, noting that they did not have difficulty finding specialists who were taking new patients and accepted their plans; however, they did describe long wait times for an initial appointment. Once established, participants largely described regular appointments and sufficient access. In cases in which PCPs made referrals, participants described shorter wait times. A few participants, however, described calling their plans and getting recommendations for providers who were no longer accepting their insurance, indicating outdated or inaccurate provider directories. Participants living in rural areas also reported challenges accessing providers due to a lack of local specialists and transportation barriers (e.g., having to drive long distances), which is consistent with larger national trends of limited access to specialists and transportation barriers in rural areas.

Dually eligible beneficiaries in our focus groups reported challenges accessing mental health providers, consistent with trends across the country and across our health care system with access to this type of provider. They reported a general lack of local providers, high turnover among existing providers, and long wait times. Some participants also noted how few of the available providers accepted their coverage, and therefore, they paid out of pocket or turned to other options, like the county health system or telehealth services. This finding also aligns with national trends regarding mental health providers not accepting health insurance, particularly with the increased demand for mental health services after the COVID-19 pandemic.

Care coordination. Overall, about half of focus group participants reported having a care coordinator employed by their health plans with some variation across states. For example, all the focus group participants in the New York FIDA-IDD demonstration and in Washington's managed FFS demonstration reported having care coordinators. In Texas, focus group participants were more mixed, with some reporting that they had care coordinators and others reportedly declining the service.

Participants reported mixed experiences with care coordination and formal care planning. A subset of focus group participants enrolled in New York's FIDA-IDD demonstration and in Washington's managed FFS demonstration reported positive and robust relationships with their care coordinators. In Washington's demonstration, care coordinators are employed by the health homes, which contract with the state. Focus group participants appreciated how they retained the same care coordinator even if they switched plans. Most of the focus group participants in these same two state demonstrations also reported having care plans that they revisited regularly and contained goals related to their health. Some participants in the other states noted frequent turnover of care coordinators and did not feel like they were getting much value out of the service. Most did not report having formal care plans.

Coverage of additional benefits. A few caregivers and participants described receiving Medicaid home- and community-based services (HCBS), as well as rehabilitation services after a hospitalization, and the importance of these services. Caregivers for beneficiaries in New York's FIDA-IDD plan in particular emphasized the plan's coordination of HCBS as a strength of the plan. A caregiver in another state, however, shared that they found the residential services and employment support services for their adult child to be lacking. Several participants also described difficulties with obtaining and retaining home health aides, noting high turnover of these workers.

Most participants had positive feedback about receiving additional benefits from their plan, such as food allowances and an over-the-counter benefit, which provided funds for purchasing certain non-prescription drugs and health-related items, which for some participants had not been available in their prior coverage. In Nebraska and South Carolina, people reported the ability to use these funds to pay utility bills, which they described as helpful. Several participants also described incentives for participating in certain preventive screenings, such as mammograms and annual physicals. Several focus group participants noted that dental services were not covered by their plans.

Participants reported mixed experiences with transportation benefits.[23] Generally, participants with transportation barriers were grateful for this benefit. Several participants who used this benefit noted extended wait times or long travel times. Another recounted how their driver dropped them off at the wrong location. And in one state, participants expressed frustration with this benefit and did not understand if they qualified for it. These findings are largely consistent with what we heard in prior focus groups on Medicaid's non-emergency medical transportation (NEMT) benefit (PerryUndem 2021). Participants in those focus groups said NEMT plays a vital role in facilitating their access to care and was essential to maintaining their health; however, they also reported variation in quality and satisfaction. For example, most participants had experienced at least one late pickup or driver no-show, and some people reported waiting as long as three hours to be picked up for their return trips (PerryUndem 2021).

Experiences resolving issues with health plans. Study participants' experiences resolving issues with their health care coverage largely centered around contacting their plan, with most participants unfamiliar with ombudsman programs. However, dedicated ombudsman programs are largely available only to dually eligible beneficiaries enrolled in an MMP. Since no dedicated ombudsman program is required for D-SNP enrollees, they likely have access only to their state's ombudsman program for LTSS users to the extent they assist with non-nursing facility issues. When faced with an issue with their coverage, most participants said they would call their health plan's customer service line for help. All of the participants in the Spanish-speaking group said their plans offered assistance in Spanish, with one person noting there could be long wait times.

Focus group participants also had limited understanding of the appeals and grievances processes through which beneficiaries can appeal a coverage decision by a health plan or file a grievance

to make a complaint about their coverage. In the MMPs, the appeals and grievance processes were unified across Medicaid and Medicare, meaning that beneficiaries could file an appeal for either a Medicaid- or Medicare-covered benefit through a single process. Outside of a unified process, Medicaid and Medicare have different processes for filing appeals and grievances, which can cause confusion for beneficiaries and gaps in coverage during an appeal. Although most participants were familiar with an appeal, few had used the process. Participants had less understanding of filing a grievance, and few had done so. A few participants described filing complaints with providers or with their health plans, most often due to issues with transportation and dental services. One caregiver for an enrollee in New York's FIDA-IDD program demonstrated the most robust understanding of these processes, detailing how they were currently going through the appeals process.

Some participants reported receiving unexpected medical bills and working with either their providers or their plans to resolve it. In all cases, these bills were sent in error, and participants were not ultimately responsible for paying them. However, focus group participants reported that the experience caused stress and frustration. A few people described having to communicate with their plans and providers multiple times before the issues were resolved or that the plans did not respond until a formal appeal was filed. One person worked with their care manager to figure out how to resolve the unexpected bill.

Overall satisfaction with integrated care. When asked about overall satisfaction with their health care coverage, most focus group participants reported a positive experience. For example, most participants did not report having any unmet needs. Those who did reiterated points they had made earlier in the discussion that reflect national concerns, such as a lack of mental health providers or access to dental coverage. On a scale of one to five, with five being the highest, most participants rated their coverage at a three or higher.

Conclusions. Although the beneficiaries we talked with do not constitute a representative sample of dually eligible beneficiaries enrolled in integrated care, we heard that they are largely satisfied with their coverage and able to access the care they need. We did not hear meaningful differences between the experiences of dually eligible beneficiaries enrolled in different types of integrated coverage, and it was not our intention to assess different plan types relative to each other.

Although the focus groups were intended to obtain feedback from beneficiaries about their overall experiences in integrated programs, we heard from a number of beneficiaries about challenges accessing Medicaid benefits in particular, including behavioral health services, HCBS, and NEMT. The challenges that participants noted align with prior MACPAC work that found access challenges in these areas more broadly, not specific to dually eligible beneficiaries (MACPAC 2021a, 2021b). The feedback from the focus groups underscores the important role that states play in oversight and monitoring of integrated products and ensuring that beneficiaries have access to Medicaid services.

Hearing directly from beneficiaries is important for policymakers to make informed decisions about policies affecting their care. This work may serve as an example of the benefits of stakeholder engagement and feedback on integrated products, particularly as states prepare for the transition away from the FAI demonstration. Although the themes from the focus groups are not generalizable to the entire dually eligible population and cannot be interpreted to indicate that people enrolled in integrated care are more satisfied with this coverage than with other types of coverage, hearing from a small subset of beneficiaries that they are generally satisfied with their coverage may support continued investment in this area. Additionally, this continued investment in integrated care could include individuals with complex care needs, such as people with ID/DD. Elements of integrated care, such as care coordination and person-centered care planning, emerged from the focus groups as particularly beneficial for individuals with disabilities and may advance equity among subpopulations of dually eligible beneficiaries.

Next Steps

The Commission remains focused on identifying options for integrated care across delivery mechanisms, such as the variety of FFS and managed care possibilities identified in this chapter, so that states can

design an integrated care strategy for their dually eligible beneficiaries that meets their needs. The Commission views these integrated care strategies as a path for all states to advance the goals of making integrated care more widely available, increasing enrollment in integrated care, and increasing the level of integration in existing models. States have access to many tools to adopt the approaches that we have described in this chapter. As D-SNPs are now present in almost all states and enrolling millions of dually eligible beneficiaries, the Commission plans to build on our earlier work highlighting strategies states can use to increase integration in their contracts with D-SNPs. We plan to explore ways that states can optimize their contracts with D-SNPs, informed by the beneficiary experience in these models. We also plan to continue monitoring the sunset of the MMP model as state plans to transition to D-SNPs develop over the next several years. In the eight states making the transition from MMPs to D-SNPs, states may have an opportunity to develop a comprehensive strategy for integrating Medicaid and Medicare coverage for dually eligible beneficiaries, consistent with our June 2022 recommendation, so that all dually eligible beneficiaries in the states would ultimately have access to an integrated coverage option.

Endnotes

[1] Three states that originally operated capitated model demonstrations under the FAI have since ended those demonstrations, including Virginia in 2017, New York in 2019, and California in 2022 (CMS 2023a). New York ended its Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities demonstration, which transitioned into its current Integrated Appeals and Grievances Demonstration that began in 2020, and the state maintains a separate demonstration under the FAI targeting its intellectually and developmentally disabled population.

[2] If states opted to end their demonstrations in 2023, there is no requirement to transition MMP enrollees to an integrated D-SNP. However, all current states participating in the MMP model requested the two-year extension.

[3] Other delivery mechanisms are designed to provide integrated care to dually eligible beneficiaries who do not fall into the categories described previously. One notable example is the Program of All-Inclusive Care for the Elderly (PACE), which is a Medicare program that was permanently established under the Balanced Budget Act of 1997 (P.L. 105-33). We did not include it in our analysis because it serves relatively few beneficiaries. Low enrollment reflects both the resource intensity of establishing a PACE site and competition with state-operated programs (Gross et al. 2004). PACE programs intend to provide comprehensive medical, pharmaceutical, and psychosocial services—including the full range of Medicaid and Medicare benefits—to frail adults age 55 or older with nursing facility level of care needs who are living in the community. PACE programs receive capitated payments from both CMS and states to provide Medicare and Medicaid benefits, respectively. Under this model, beneficiaries enrolled in PACE may only receive Medicaid and Medicare services from their PACE organization. PACE programs do not cover the Medicare hospice benefit, and PACE participants must disenroll from the program if they elect to receive hospice benefits (42 CFR 460.154(i)). PACE programs are currently available in 32 states and the District of Columbia, but these programs are limited in scale, serving around 63,000 individuals, most of whom are dually eligible beneficiaries (NPA 2023).

[4] For example, South Carolina carved nursing facility services out of its MMP model.

[5] In CY 2020, 41 percent of dually eligible beneficiaries were enrolled in Medicare managed care—including MA, MMPs, and PACE—compared with 35 percent of Medicare beneficiaries who were not dually eligible for Medicaid. Among those in managed care, 51 percent were enrolled in a D-SNP (MACPAC and MedPAC 2023).

[6] Maine noted that it participates in the Primary Care First model under the Centers for Medicare and Medicaid Innovation, in which the state took dually eligible beneficiaries into account in the model's methodology and reimbursement structure. The state additionally requires its CO D-SNPs to fund its nursing facility partners to connect directly to the statewide health information exchange to facilitate care transitions.

[7] During the panel, Washington said it has earned $98.7 million in shared savings to date.

[8] The District of Columbia also has two health homes that coordinate care for certain beneficiaries, and it has worked closely with its D-SNPs to leverage the SMAC for greater oversight of coordination efforts. The District of Columbia's two health homes are My DC Health Home, which serves Medicaid beneficiaries with severe mental illness, and My Health GPS, which serves beneficiaries with multiple chronic conditions (DCDHCF 2023). It also recently launched its first PACE program, which opened in March 2023, that the

District of Columbia said was the culmination of a decade of agency planning (PR Newswire 2023).

[9] Another state we spoke with as part of our interviews on the MMP transition, South Carolina, also announced plans to transition its dually eligible population from FFS to managed care. Like the District of Columbia, South Carolina already serves many of its Medicaid beneficiaries in managed care.

[10] Washington does mandatorily enroll dually eligible beneficiaries into integrated managed care plans known as Behavioral Health Service Only plans that cover Medicaid-covered behavioral health services (WAHCA 2020).

[11] The Bipartisan Budget Act of 2018, which permanently authorized D-SNPs, set further requirements for how D-SNPs operate, such as clarifying responsibility for coordinating benefits and assisting beneficiaries in navigating Medicaid appeals.

[12] SMACs, or MIPPA contracts, must cover eight minimum requirements, including the following: the MA organization's responsibilities to provide or arrange for Medicaid benefits; categories of eligibility for dually eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific subsets; Medicaid benefits covered under the D-SNP; cost-sharing protections covered under the D-SNP; information about Medicaid provider participation and how that information is to be shared; verification process of an enrollee's eligibility for both Medicare and Medicaid; service area covered under the SNP; and the period of the contract (MACPAC 2021a).

[13] This figure does not include the roughly 294,000 dually eligible beneficiaries in Puerto Rico who are enrolled in D-SNPs (CMS 2023c).

[14] D-SNPs are designated as FIDE SNPs when Medicaid services are covered by the same legal entity as the D-SNP providing Medicare benefits. FIDE SNPs must also use aligned care management and specialty care network methods to meet the needs of high-risk enrollees and "coordinate or integrate beneficiary communication materials, enrollment, communications, grievance[s] and appeals, and quality improvement" (42 CFR 422.2). FIDE SNPs are not required to cover behavioral health services, if the state carves them out of the capitation rate, until 2025. Plans may qualify as FIDE SNPs if they cover at least 180 days of nursing facility coverage during the plan year under its LTSS benefit, while other LTSS may be carved out. More details on these models can be found in chapter 1 of MACPAC's June 2020 report to Congress (MACPAC 2020a).

[15] The CMS final rule that sunsets the MMP models also requires that all plans with a FIDE SNP designation use exclusively aligned enrollment by 2025 (CMS 2022a).

[16] This level of enrollment is substantially lower than the year prior, when enrollment sat at nearly 426,000 beneficiaries, due to California's exit from the demonstration (ICRC 2023).

[17] Not all enrollees will be able to be transitioned to an integrated D-SNP at the start of January 2026 because CMS and states cannot automatically transition a beneficiary from a plan owned by one parent organization to a D-SNP owned by another parent organization. For example, if a parent organization that operates an MMP in a state does not offer a D-SNP in 2026, that MMP's enrollees would be returned to FFS Medicare with the option to voluntarily enroll in a different integrated D-SNP.

[18] The state also signaled an appetite for greater integration than either the MMPs or D-SNPs provide. In its transition letter, Massachusetts noted it would carefully consider adopting the option described in the Comprehensive Care for Dual Eligible Individuals Act (S. 4635), which was introduced by Senator Sherrod Brown and then-Senator Robert Portman on July 27, 2022. The legislation would create a new title under the Social Security Act allowing for an optional state-administered plan to provide fully integrated care for full-benefit dually eligible beneficiaries, should that legislation be passed and enacted.

[19] We also spoke with officials in California, which began the process of winding down its MMP demonstration and transitioning members to aligned D-SNPs before rulemaking by CMS. The state moved MMP enrollees into FIDE SNPs operated by the same parent company as that of their MMP at the start of 2023 in all seven of its demonstration counties. CMS told us it has worked closely with the state throughout its transition process and plans to use its experience as a template as it crafts technical assistance materials for the remaining MMP states. California noted that it largely preserved its MMP contract language in its D-SNP contracts. Beginning January 1, 2024, the California Department of Health Care Services will expand its integrated dually eligible beneficiary plans to five additional counties. This D-SNP program is already available in seven counties in the state (CA DHCS 2023).

[20] At least one state, South Carolina, contracts with any willing and qualified plan and does not undergo a competitive procurement process.

[21] Commissioners discussed Medicaid managed care procurement practices across states at the April 2022 Commission meeting (MACPAC 2022d).

[22] 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.

[23] Dually eligible beneficiaries use non-emergency medical transportation with greater frequency than those enrolled only in Medicaid. Of the 3.2 million non-emergency medical transportation users in fiscal year 2018, more than one-third were dually eligible (MACPAC 2021b).

References

Bean, A., and K. Emans. 2022. A new era in supporting state efforts to improve care for dual-eligible individuals. Presentation before the Center for Health Care Strategies, October 11, 2022. San Antonio, TX: Advancing Medicare & Medicaid Integration. https://medicare-medicaid.org/a-new-era-in-supporting-state-efforts-to-improve-care-for-dual-eligible-individuals/.

California Department of Health Care Services (CA DHCS). 2023. DHCS stakeholder update—March 17, 2023. Sacramento, CA: DHCS. https://www.dhcs.ca.gov/Pages/031723StakeholderUpdate.aspx.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023a. *FY 2022 Medicare-Medicaid Coordination Office: report to Congress*. Baltimore, MD: CMS. https://www.cms.gov/files/document/mmco-report-congress.pdf-0.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023b. Financial alignment initiative (FAI). 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. 2023c. *SNP comprehensive report 2023 03*. Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/special/snp-comprehensive-report-2023-03.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022a. 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. 2022b. CY 2023 Medicare Parts C and D annual calendar. Baltimore, MD: CMS. https://www.cms.gov/files/document/cy2023medicarepartscanddannualcalendar.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. *Memorandum of understanding (MOU) between the Centers for Medicare & Medicaid Services (CMS) and the state of Washington regarding a federal-state partnership to test a managed fee-for-service financial alignment model for Medicare-Medicaid enrollees: HealthPath Washington: A Medicare and Medicaid integration project (managed fee-for-service model)*. Baltimore, MD: CMS. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2010. CMS informational bulletin regarding “State demonstrations to integrate care for dual eligible individuals.” December 10, 2010. https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/12-10-2010-Federal-Coordinated-Health-Care-Office.pdf.

District of Columbia Department of Health Care Finance (DCDHCF). 2023. Health homes. Washington, DC: DCDHCF. https://dhcf.dc.gov/page/health-homes.

District of Columbia Department of Health Care Finance (DCDHCF). 2022. District Dual Choice (D-SNPs). Washington, DC: DCDHCF. https://dhcf.dc.gov/page/district-dual-choice-d-snps.

Grabowski, D.C., N.R. Joyce, T.G. McGuire, and R.G. Frank. 2017. Passive enrollment of dual-eligible beneficiaries into Medicare and Medicaid managed care has not met

expectations. *Health Affairs* 36, no. 5: 846–854. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1082.

Griffin, E., D. Tyler, N. Mulmule, et al. 2022. *MyCare Ohio second evaluation report*. Report to Centers for Medicare & Medicaid Services, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/data-and-reports/2022/fai-oh-secondevalrpt.

Gross, D.L., H. Temkin-Greener, S. Kunitz, and D.B. Mukamel. 2004. The growing pains of integrated health care for the elderly: Lessons from the expansion of PACE. *The Milbank Quarterly* 82, no. 2: 257–282. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690172/.

Holladay, S., J. Howard, M. Toth, et al. 2022. *Michigan MI Health Link second evaluation report*. Report to Centers for Medicare & Medicaid Services, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/data-and-reports/2022/fai-mi-secondevalrpt.

Holladay, S., E. Bayer, I. Dave, et al. 2019. Financial Alignment Initiative: *Michigan MI Health Link first evaluation report*. Report to Centers for Medicare & Medicaid Services, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder2/Folder73/Folder1/Folder173/MI_FAI_EvalReport1.pdf?rev=acc359111473488d8055a8efdc0bd0fc.

Inkelas, M. 2005. Incentives in a Medicaid carve-out: Impact on children with special health care needs. *Health Services Research* 40, no. 1: 79–100. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361127.

Integrated Care Resource Center (ICRC). 2023. *Monthly enrollment in Medicare-Medicaid plans by plan and by state, March 2022 to March 2023*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/MMP-Enroll-by-State-Mar-2023.pdf.

Khatutsky, G., D. Tyler, A. Bernacet, et al. 2021. *California Cal MediConnect preliminary second evaluation report*. Report to Centers for Medicare & Medicaid Services, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/data-and-reports/2021/fai-calif-prelim-er2.

Maine Department of Health and Human Services (MEDHHS). 2022. Accountable communities. Augusta, ME: MEDHHS. https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022a. Chapter 5: Raising the bar: Requiring state integrated care strategies. In *Report to Congress on Medicaid and CHIP*. June 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/raising-the-bar-requiring-state-integrated-care-strategies/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022b. Letter from Melanie Bella to Chiquita Brooks-LaSure regarding "CMS-4192-P Medicare program; contract year 2023 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs (March 7, 2022). https://www.macpac.gov/publication/comment-letter-on-proposed-rule-on-dual-eligible-special-needs-plans/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022c. Exhibit 1: Medicaid and CHIP enrollment as a percentage of the U.S. population. In *MACStats: Medicaid and CHIP data book*. December 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-and-chip-enrollment-as-a-percentage-of-the-u-s-population/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022d. Understanding Medicaid managed care procurement practices across states. Washington, DC: MACPAC. https://www.macpac.gov/publication/understanding-medicaid-managed-care-procurement-practices-across-states/.

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. Chapter 5: Mandated report on non-emergency medical transportation. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/publication/mandated-report-on-non-emergency-medical-transportation/.

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). 2019. T*he 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 and Medicare Payment Advisory Commission (MACPAC and MedPAC). 2023. *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

Medicare Payment Advisory Commission (MedPAC). 2023. Chapter 11: The Medicare Advantage program: Status report. In March *2023 Report to the Congress: Medicare payment policy*. March 2023. Washington, DC: MedPAC.https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.

Medicare Payment Advisory Commission (MedPAC). 2022. Chart 9-10: The share of Medicare beneficiaries in MA plans is lower in rural areas, 2022. In *July 2022 Data Book: Health Care Spending and the Medicare Program*. July 2022. Washington, DC: MedPAC. https://www.medpac.gov/document/july-2022-data-book-health-care-spending-and-the-medicare-program/.

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*. June 2019. Washington, DC: MedPAC. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_ch12_medpac_reporttocongress_sec-pdf/.

National Pace Association (NPA). 2023. PACE facts and trends. Washington, DC: NPA. https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends-0.

PerryUndem. 2021. *Understanding the value of the Medicaid non-emergency medical transportation (NEMT) benefit*. Washington, DC: PerryUndem. https://www.macpac.gov/publication/understanding-the-value-of-the-medicaid-non-emergency-medical-transportation-benefit/.

PR Newswire. 2023. Edenbridge PACE at Skyland Town Center, Washington DC's first program of all-inclusive care for the elderly, now open. March 1, 2023, press release. Washington, DC: Edenbridge PACE at Skyland Town Center. https://www.prnewswire.com/news-releases/edenbridge-pace-at-skyland-town-center-washington-dcs-first-program-of-all-inclusive-care-for-the-elderly-now-open-301759667.html.

Rizer, A. 2022. Is Medicare-Medicaid integration possible in a fee-for-service environment? *Health Affairs Forefront*. Washington, DC: Health Affairs. https://www.healthaffairs.org/content/forefront/medicare-medicaid-integration-possible-fee-service-environment.

Snow, K.I., E.C. Gattine, E.J. Griffin, et al. 2022. *New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) preliminary combined first and second evaluation report*. Report to Centers for Medicare & Medicaid Services, contract no. HHSM-500-2014-00037i TO #7. Waltham, MA: RTI International. https://innovation.cms.gov/data-and-reports/2022/fai-ny-fida-idd-prelim-firstsecondevalrpt.

Spencer, A., N. Archibald, and M.H. Soper. 2018. *A new approach to integrating care for dually eligible beneficiaries: Idaho's Medicare Medicaid Coordinated Plan*. Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/a-new-approach-to-integrating-care-for-dually-eligible-beneficiaries-idahos-medicare-medicaid-coordinated-plan/.

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

Washington State Health Care Authority (WAHCA). 2020. Integrated managed care: Behavioral health billing for duals. Olympia, WA: WAHCA. https://www.hca.wa.gov/assets/program/imc-bh-billing-for-dual-eligible-clients.pdf.

APPENDIX 2A. State Use of Integrated Models

States use multiple models to serve dually eligible beneficiaries (Table 2A-1). Examples of integrated models include Medicare-Medicaid plans (MMPs) operating within demonstrations under the Financial Alignment Initiative (FAI), a managed fee-for-service (FFS) model under the FAI, Medicare Advantage dual eligible special needs plans (D-SNPs), or a Program of All-Inclusive Care for the Elderly (PACE).

Most D-SNPs offer minimal levels of integration and are referred to as coordination-only D-SNPs, or CO D-SNPs, because they are required to only coordinate Medicaid services, not cover them. Highly integrated dual eligible special needs plans (HIDE SNPs) must cover Medicaid behavioral health services, long-term services and supports (LTSS), or both. Fully integrated dual eligible special needs plans (FIDE SNPs) offer fully integrated coverage and must cover all Medicaid benefits, with limited exceptions for benefit carve outs through 2024.

States are testing two models under the FAI: (1) a fully integrated model, the MMP model, in which beneficiaries receive coverage of all their Medicaid and Medicare benefits under a single entity through a capitated arrangement; and (2) a FFS model that offers care coordination and a person-centered experience.

PACE offers another option for full integration and is available in 32 states and the District of Columbia (NPA 2023). PACE offers a day center providing comprehensive services to adults age 55 and older who are certified to need a nursing home level of care but can live safely in the community. Enrollees in PACE receive all their Medicare and Medicaid benefits through the PACE organization they are enrolled in.

TABLE 2A-1. Landscape of Integrated Care for Dually Eligible Beneficiaries by State, February 2023

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Total	**8**	**33**	**39**	**16**	**12**	**29**
Alabama	–	Yes	Yes	–	–	–
Alaska	–	–	–	–	–	–
Arizona	–	–	–	Yes	Yes	Yes
Arkansas[2]	–	Yes	Yes	–	–	Yes
California[3]	–	Yes	Yes[4]	–	Yes[4, 5]	Yes
Colorado[3]	–	Yes	Yes	–	–	Yes
Connecticut	–	–	Yes	–	–	–
Delaware	–	Yes	Yes	–	–	Yes
District of Columbia	–	Yes	Yes	Yes[4]	–	No
Florida	–	Yes	Yes	Yes[4]	Yes[4]	Yes
Georgia	–	–	Yes	–	–	No
Hawaii	–	–	–	Yes	–	Yes
Idaho	–	–	Yes	–	Yes[4]	Yes
Illinois	Yes	–	–	–	–	Yes
Indiana	–	Yes	Yes	–	–	No

TABLE 2A-1. (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Iowa	–	Yes	Yes	–	–	Yes
Kansas	–	Yes	–	Yes	–	Yes
Kentucky	–	Yes	Yes	Yes	–	Yes
Louisiana[6]	–	Yes	Yes	–	–	–
Maine	–	–	Yes	–	–	–
Maryland	–	Yes	Yes	–	–	No
Massachusetts[7]	Yes	Yes	–	–	Yes[4]	Yes
Michigan	Yes	Yes	Yes	–	–	Yes
Minnesota[8]	–	–	–	Yes[4]	Yes[4]	Yes
Mississippi	–	–	Yes	–	–	No
Missouri	–	Yes	Yes	–	–	No
Montana	–	–	Yes	–	–	–
Nebraska	–	Yes	Yes	Yes	–	Yes
Nevada	–	–	Yes	–	–	No
New Hampshire	–	–	–	–	–	Yes
New Jersey	–	Yes	–	–	Yes[4]	Yes
New Mexico	–	Yes	–	Yes	–	Yes
New York[3]	Yes	Yes	Yes	Yes[4]	Yes[4]	Yes
North Carolina[9]	–	Yes	Yes	–	–	–
North Dakota	–	Yes	–	–	–	No
Ohio	Yes	Yes	Yes	–	–	Yes
Oklahoma	–	Yes	Yes	–	–	–
Oregon[10]	–	Yes	Yes	Yes	–	Yes
Pennsylvania	–	Yes	Yes	Yes	Yes[5]	Yes
Rhode Island[11]	Yes	Yes	Yes	–	–	–
South Carolina	Yes	Yes	Yes	–	–	No
South Dakota	–	–	Yes	–	–	–
Tennessee	–	Yes	Yes	–	Yes[4]	Yes
Texas[3]	Yes	Yes	Yes	Yes	–	Yes
Utah[3]	–	–	Yes	–	–	Yes
Vermont	–	–	–	–	–	Yes
Virginia	–	Yes	Yes	Yes	Yes[4]	Yes
Washington[6]	–	Yes	Yes	Yes	–	No
West Virginia	–	–	Yes	–	–	No

TABLE 2A-1. (continued)

State	MMP	PACE	D-SNP			Medicaid managed care for dually eligible beneficiaries[1]
			Coordination-only D-SNPs	HIDE SNPs	FIDE SNPs	
Wisconsin[10]	–	Yes	Yes	Yes	Yes[4]	Yes
Wyoming	–	–	Yes	–	–	–

Notes: D-SNP is dual eligible special needs plan. MMP is Medicare-Medicaid plan. PACE is Program of All-Inclusive Care for the Elderly. HIDE SNP is highly integrated dual eligible special needs plan. FIDE SNP is fully integrated dual eligible special needs plan. Forty-five states and the District of Columbia have D-SNPs in 2023. Integrated care programs may not be available statewide. Washington operates a managed fee-for-service (MFFS) model under the Financial Alignment Initiative (FAI). Minnesota operates an alternative model focused on administrative alignment under the FAI. HIDE SNPs also operate in Puerto Rico, which is not included in this table.

– Dash indicates state does not have the factor listed or it is not applicable to the state. For example, states that do not enroll any Medicaid beneficiaries in Medicaid managed care are marked with a dash.

[1] Medicaid managed care for dually eligible beneficiaries is as of 2018.

[2] In 2019, Arkansas implemented the mandatory Provider-Led Arkansas Shared Savings Entity (PASSE) program for certain individuals with developmental disabilities or individuals 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] Designated as applicable integrated plan(s) by the Centers for Medicare & Medicaid Services, a designation that requires an integrated appeals and grievances process (42 CFR 422.629).

[5] Although these states currently contract with D-SNPs that meet the FIDE SNP designation, they will no longer qualify as FIDE SNPs in 2025 when those plans must begin covering behavioral health services.

[6] 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 FAI that provides fully integrated coverage to dually eligible beneficiaries through a managed FFS approach that relies on Medicaid health homes. The MFFS model is not listed in this table.

[7] 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.

[8] 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).

[9] North Carolina implemented a new Medicaid managed care program in 2019. The state is required to transition full-benefit dually eligible beneficiaries to this program by 2026.

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

[11] Rhode Island ended its Medicaid managed care program for dually eligible beneficiaries in September 2018.

Sources: Mathematica analysis, 2021, under contract with MACPAC. CMS 2023. ICRC 2023.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. *SNP comprehensive report 2023 02*. Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/special/snp-comprehensive-report-2023-02.

Integrated Care Resource Center (ICRC). 2023. *Monthly enrollment in Medicare-Medicaid plans by plan and by state, February 2022 to February 2023*. Washington, DC: ICRC. https://www.integratedcareresourcecenter.com/sites/default/files/MMP-Enroll-by-State-February-2023.pdf.

National PACE Association (NPA). 2023. PACE facts and trends. Alexandria, VA: National PACE Association. https://www.npaonline.org/policy-and-advocacy/pace-facts-and-trends-0.