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The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies

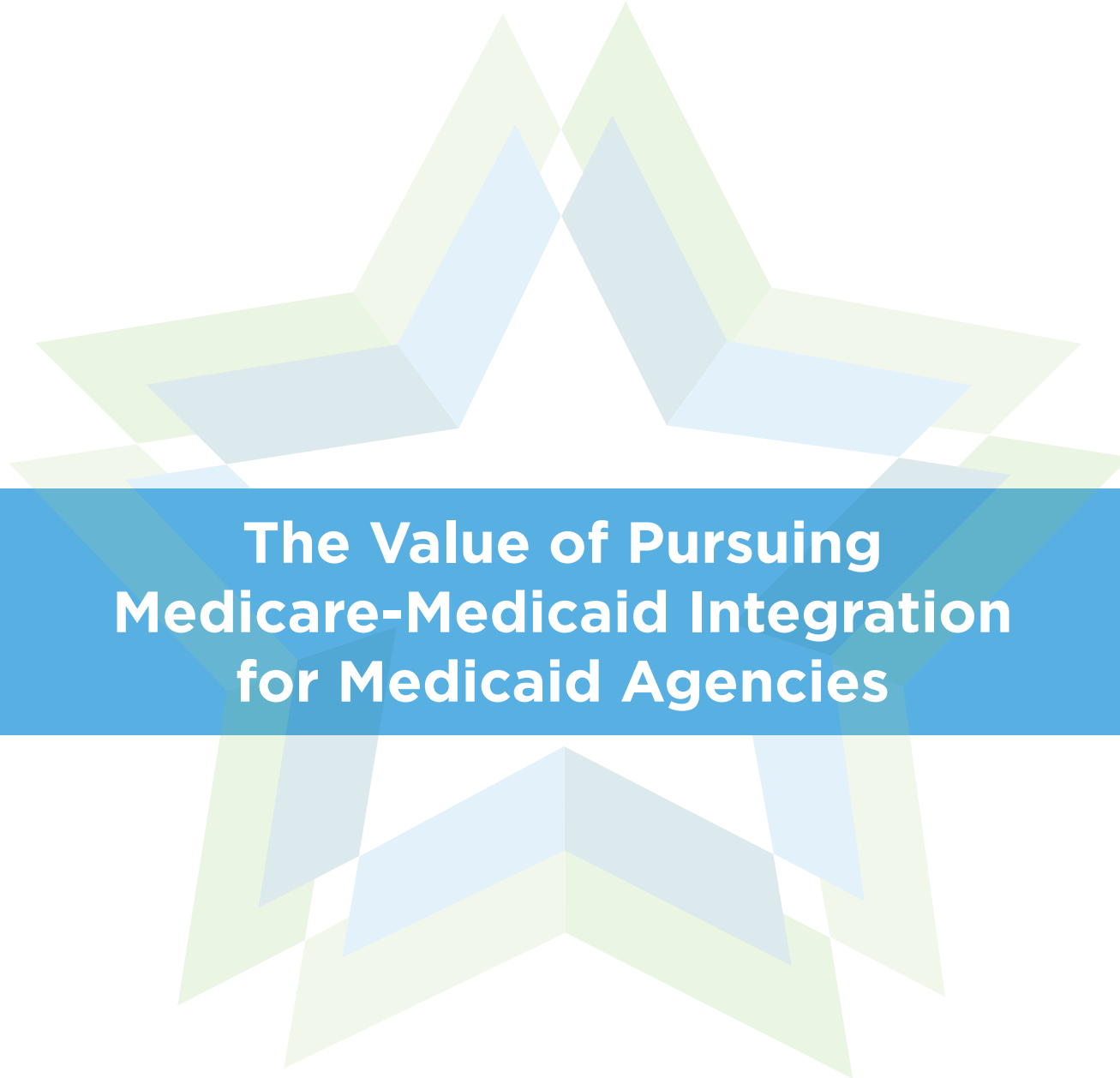
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The Value of Pursuing Medicare-Medicaid Integration for Medicaid Agencies

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The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key managed long-term services and supports (MLTSS) policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

The **Center for Health Care Strategies** (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to advance innovative and cost-effective models for organizing, financing, and delivering health care services, especially those with complex, high-cost needs.

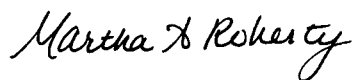
Acknowledgements

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Both the ADvancing States' Board of Directors and the MLTSS Institute Advisory Council identified integrated care as a top priority for research and analysis in 2019. While the underlying research that supports the conclusions in the brief are drawn primarily from capitated integrated care programs, the value of integration accrues to states regardless of the delivery system they choose. We hope that our state members find this analysis compelling and stand ready to assist them as they embark on efforts to drive integrated care for dually eligible beneficiaries.

We are grateful to the state Medicaid officials from Arizona, Connecticut, Maine, Massachusetts, Minnesota, Ohio, Pennsylvania, Virginia, Tennessee and Washington who shared their perspective to inform this issue brief. We also appreciate the insights of the Centene Corporation, Community Catalyst, Long Term Quality Alliance, and the SNP Alliance who shaped our work.

Sincerely,



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Executive Summary

ADvancing States members have identified several barriers to adoption of integrated care strategies; likewise, the Center for Health Care Strategies (CHCS) has frequently heard of challenges states face in moving integrated care options forward. To that end, ADvancing States partnered with CHCS to produce a series of short briefs to inform adoption of state strategies that better align Medicare and Medicaid for dually eligible beneficiaries. This first brief in the series highlights the value of integrated care for state Medicaid agencies from published research and anecdotal information from state leaders who have launched these programs. We selected this topic first since making the case for state investment in the infrastructure necessary to manage integrated care programs is a critical first step for any state contemplating undertaking this effort.

There are new opportunities for states to explore integrated care models for dually eligible beneficiaries, a diverse but high-need, high-cost population. Promising findings for states considering new integrated care models include:

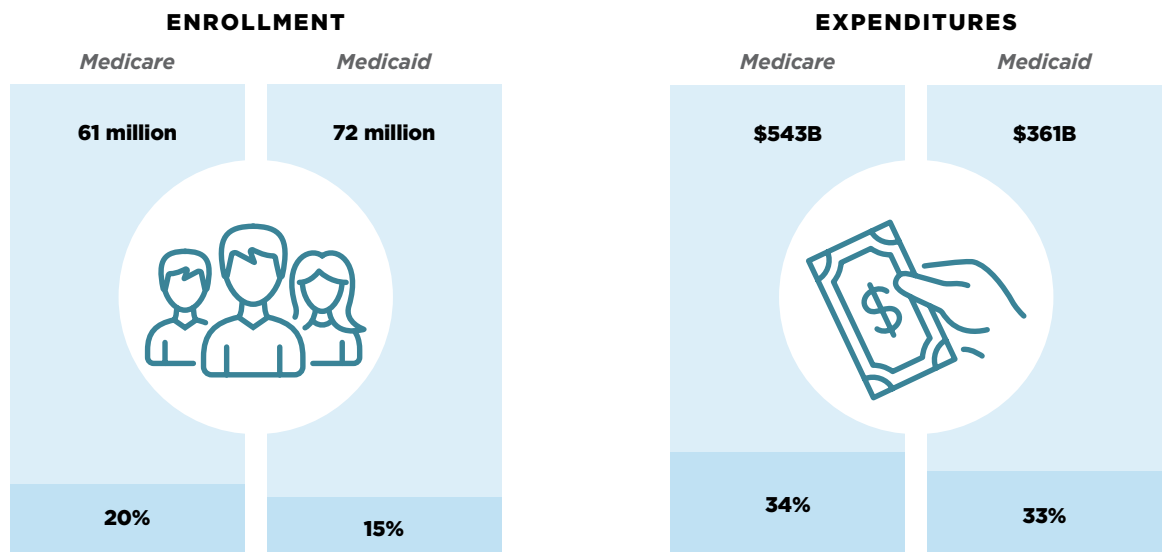
- **Improved beneficiary experience, health outcomes and quality of life** due to closer coordination across different providers, systems, payers, and social supports;
- **Increased program efficiencies** due to aligned financial incentives to provide person-centered care in the right setting at the right time; and
- **Improved Medicaid program administration and management** due to better access to Medicare data and increased capacity to better manage this high-need, high-cost population.

There is a growing body of data supporting the value of integrated care programs for Medicaid agencies. Although savings that result from integration still accrue to Medicare first, there are new opportunities to capture Medicaid savings as well. As states address the growing aging population and subsequent increased demand for LTSS in coming years, identifying and translating this emerging evidence is an essential tool in making the case for state investments in integrated care.

Introduction

People who are dually eligible for Medicare and Medicaid must navigate two uncoordinated systems of care with different incentives, benefits, provider networks, and enrollment processes. This can be very challenging for a population with diverse, but significant medical, behavioral health, functional, and social needs.¹ Approximately 60 percent of dually eligible beneficiaries have multiple chronic conditions, more than 40 percent have at least one mental health diagnosis, and nearly half of individuals eligible for both programs use long-term services and supports (LTSS).²

Dual Eligible Characteristics³



Integrating the financing and delivery systems for Medicare and Medicaid enrollees offers the potential to improve beneficiary care experience, increase health outcomes, and reduce costs. As of October 2019, more than one-third of states operate Medicare-Medicaid integrated care models that have substantial enrollment in demonstrations under the Financial Alignment Initiative (FAI) or Dual Eligible Special Needs Plans (D-SNPs) that are aligned with Medicaid managed care plans, an increase from three states in 2009.

Exhibit 1: The Need for Integrated Care

The Challenge



There are 12 million dually eligible beneficiaries in the United States. More than 90 percent receive fragmented care.



Dually eligible beneficiaries have complex needs, including high rates of multiple chronic conditions and use of behavioral health and LTSS services.



Their care accounts for a disproportionate amount of both Medicare and Medicaid costs, primarily driven by LTSS utilization on the Medicaid side.

The Outcomes



Streamlined, coordinated and improved care experience for individuals accustomed to navigating two fragmented delivery systems



Higher utilization of preventive and community-based care



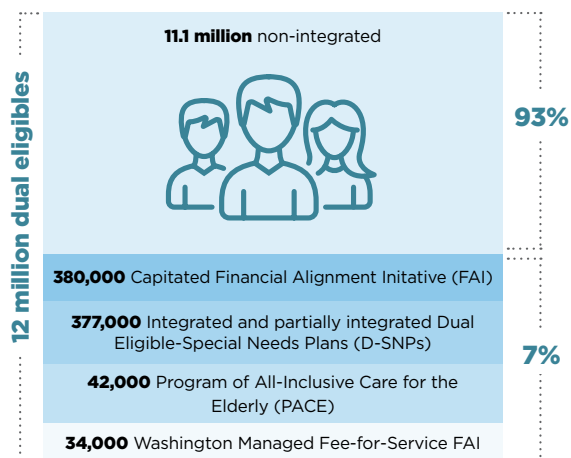
Reduced state and systems costs from increased program efficiencies and aligned incentives

Current Landscape of Integrated Care Models

As of 2018, more than 800,000 dually eligible individuals are enrolled in an integrated care model.⁴ States may choose among models that can be operated by a health plan or provider system. Models may differ in their care management approach and the level of administrative and financial alignment achieved, but have the same overarching goals of integrating primary, acute, and behavioral health services with LTSS. There are also new opportunities available for states to launch integrated models, as described in Exhibit 2.

Integration Status of Dual Eligibles

As of September 2018



Enrollment data estimated from July-September 2018. The Integrated Care Resource Center reported nearly 380,000 enrollees in the capitated FAI and about 42,000 enrolled in PACE in July 2018. About 34,000 were enrolled in Washington's MFFS demonstration for evaluation purposes (with about 20,000 enrolled in a health home) in September. The remainder were enrolled in an integrated or partly integrated D-SNP.

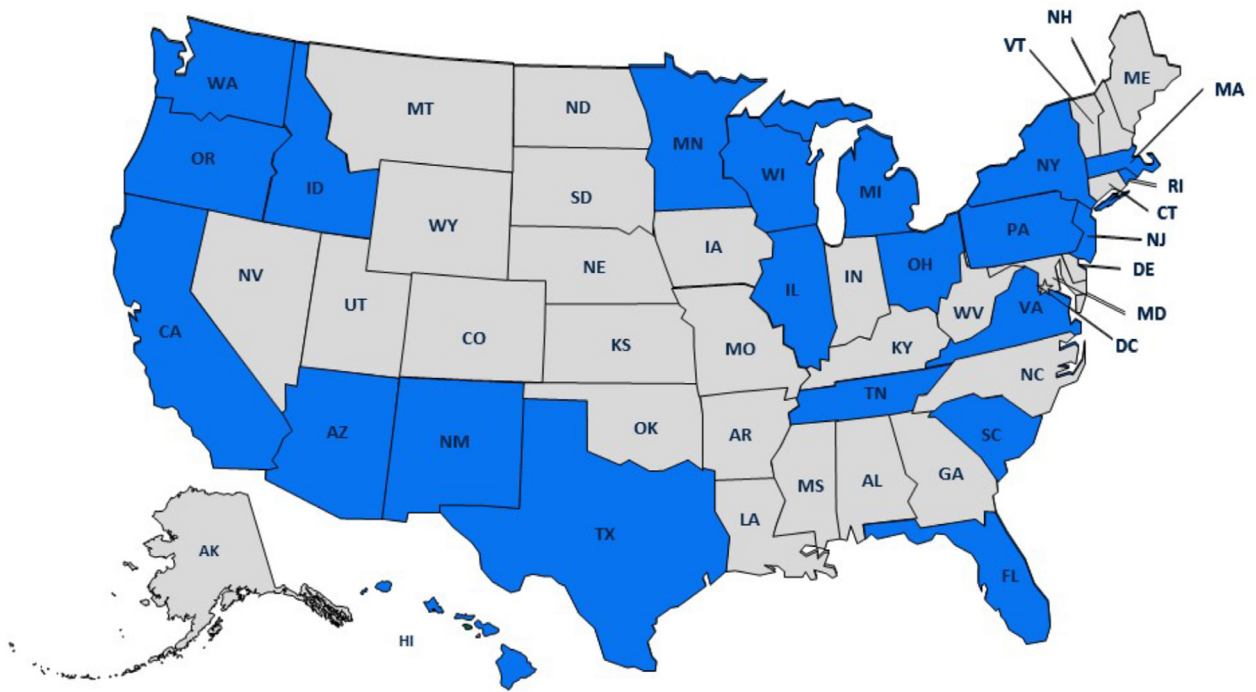
Exhibit 2: Current Integrated Care Models and New Opportunities for States

Current Models	New Opportunities
<p>Financial Alignment Initiative (FAI) demonstrations. Through state partnerships with the Centers for Medicare & Medicaid Services (CMS), these models test capitated and managed fee-for-service (MFFS) designs to align Medicare and Medicaid financing and integrate primary and acute care, behavioral health services, and LTSS.</p>	<p>In an April 24, 2019 State Medicaid Director Letter, CMS opened the FAI demonstrations to new states, and provided states with opportunities to develop new models, including increased flexibility for states outside of current demonstration parameters.⁵ These new models can build off elements from the FAI demonstrations or other types of delivery systems or payment reforms including alternative payment methodologies, value-based purchasing, or episode-based bundled payments. These models may include proposals for states to share in program savings with the federal government.</p>

Exhibit 2: Current Integrated Care Models and New Opportunities for States *(continued)*

<i>Current Models</i>	<i>New Opportunities</i>
<p>Dual Eligible Special Needs Plans (D-SNPs). A D-SNP is a type of Medicare Advantage health plan that only enrolls dually eligible beneficiaries and is required to contract with the state Medicaid agency in addition to CMS. Although not all states require close coordination with Medicaid, many states have developed fully or partly integrated D-SNP programs with often strong linkages to companion Medicaid managed long-term services and supports (MLTSS) plans that require or encourage individuals to enroll into the same plan for both sets of services, and/or promote administrative alignment and benefit integration with Medicaid. Integrated D-SNP models include Fully Integrated D-SNPs (FIDE-SNPs), highly aligned plans that coordinate and are at risk for coverage of Medicaid LTSS benefits, and have procedures for administrative alignment of Medicare and Medicaid processes and materials.</p>	<p>An April 5, 2019 final rule established more rigorous minimum integration standards that must be included in state Medicaid contracts with D-SNPs in 2021.⁶ With increased state focus on meeting these requirements and more than 20 percent of dually eligible beneficiaries currently enrolled in these plans nationwide, there is significant opportunity for states to develop new integrated programs through D-SNPs.⁷ State contracts with D-SNPs for 2021 will need to either:</p> <ul style="list-style-type: none"> • Provide Medicaid LTSS and/or Medicaid behavioral health benefits either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or • Specify a process to share information with the state, or the state’s designee (such as a Medicaid managed care organization), on hospital and skilled nursing facility admissions of high-risk individuals who are enrolled in the D-SNP. For states with D-SNPs and fee-for-service Medicaid arrangements, this requirement provides a mechanism to better coordinate care outside of a Medicaid MLTSS program.
<p>Programs of All-inclusive Care for the Elderly (PACE). The first model that integrated Medicare and Medicaid services at the provider level, PACE is an adult day center-based model first created in 1990. It provides comprehensive medical and social services to frail, community-dwelling individuals age 55 and older, most of whom are Medicare-Medicaid enrollees.</p>	<p>On May 28, 2019, CMS finalized a rule to strengthen PACE patient protections, improve care coordination and expand certain operational flexibilities for PACE organizations.⁸ Most significantly, the final rule removes a former not-for-profit restriction, allowing for-profit entities to be PACE organizations for the first time.</p>

Exhibit 3: Map of Integrated Care Programs, November 2019



This map indicates states with Medicare-Medicaid integrated care models including:

- Demonstrations under the Financial Alignment Initiative demonstrations;
- Fully Integrated D-SNPs (FIDE-SNPs);
- D-SNPs with companion Medicaid managed care plans that allow beneficiaries to enroll in aligned plans; and/or
- D-SNPs which coordinate or align some behavioral health or LTSS Medicaid benefits.

Note: 31 states operate PACE programs but are not reflected on this map

Although a few additional states are exploring the possibility of establishing an integrated care option, most have yet to act. Establishing an integrated care program requires considerable state resources and investment in staffing and systems, and stakeholder engagement. Also, historically, savings from reduced acute care service use achieved through better care coordination have accrued to Medicare, not state Medicaid programs. To make the case for integration, states need a clear picture of the value that these programs can bring to their Medicaid agencies and the beneficiaries they serve.

Policy Findings on the Value of Integration

Most integrated care programs are relatively new, and it can take years for states and their partners to ramp up programs to the point that they begin to show results. However, evidence is emerging about the impact of integrated care models. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC) recently released an issue brief and data file exploring this research.⁹ Additional data are coming from the formal evaluations of the FAI demonstrations, funded by CMS and conducted by RTI International.¹⁰ Positive early findings demonstrate:

- Decreased inpatient and emergency department utilization;
- Greater use of home and community-based services (HCBS);
- Improved beneficiary satisfaction and care coordination; and
- Reduced or slowed cost growth.

To supplement these data and help build the case for integration, we spoke with officials from several states—Arizona, Connecticut, Maine, Massachusetts, Minnesota, Ohio, Pennsylvania, Tennessee, Virginia, and Washington—that have explored or launched integrated care programs to include their perspectives on the value of these programs. While recognizing the many resources that it takes to launch these programs, state interviewees report positive state outcomes. This brief presents select examples of research on the value of integrated care drawn from published reports and our conversations with state officials across three dimensions: (1) beneficiary experience; (2) program efficiency; and (3) program administration.

“Enrolling in a D-SNP aligned with my CCC Plus health plan made my life so much easier. Now the health plan coordinates all my care and figures out who pays what rather than me.”

—Virginia beneficiary

1. Beneficiary Experience

A key priority for integrated care is to create a seamless, coordinated system that improves beneficiary experience, which is often measured in terms of beneficiary satisfaction with their program or health plan. One state affirmed that the public good of creating an integrated benefit for a complex population far outweighed the relative costs of setting up the program. Another commented that from a consumer

standpoint, it just makes no sense for people to be in separate, unconnected programs that create barriers to coordinated, high-quality care. A beneficiary in Virginia’s integrated D-SNP program, Commonwealth Coordinated Care Plus (CCC Plus) reports that “Enrolling in a D-SNP aligned with my CCC Plus health plan made my life so much easier. Now the health plan coordinates all my care and figures out who pays what rather than me.”

Self-Reported Beneficiary Satisfaction. Data show that, across all integrated care models, beneficiary satisfaction is high and tends to improve as programs mature. For example, results from the CAHPS survey of enrollees in Medicare-Medicaid Plans (MMPs) across all the capitated model FAI demonstrations show that 90 percent of respondents rated their health plan and health care a seven or higher in 2018 on a scale of 0 (lowest) to 10 (highest).^{11, 12} High satisfaction rates may be due in part to less beneficiary confusion, fewer issues with coordinating authorizations across different entities for important services, and avoided delays in care from aligning services under one entity or program.

Evidence is emerging about higher beneficiary satisfaction in integrated care programs compared to those in non-integrated, Medicaid FFS arrangements. A SCAN Foundation evaluation of California’s FAI demonstration, Cal MediConnect, found that 94 percent of beneficiaries were “somewhat or very satisfied” with their benefits, and the majority rated their overall quality of care as “excellent or good.”¹³ Satisfaction with benefits was higher among Cal MediConnect beneficiaries than those who opted out of the program or resided in counties where it was not offered.

Minnesota collects National Core Indicators-Aging and Disabilities™ data to assess how its LTSS programs affect beneficiaries’ quality of life. Early results from the 2016 survey showed higher performance in the domain of service satisfaction for health plans overall in its integrated Minnesota Senior Health Options (MSHO) program compared to those in non-integrated, FFS programs.¹⁴

Exhibit 4: Minnesota Senior Health Options (MSHO) Beneficiary Satisfaction		
<i>Measures of Service Satisfaction</i>	<i>MSHO Health Plans (an integrated care program)</i>	<i>FFS</i>
Paid support staff do things how they want them done	87%	74%
Met service needs and goals	73%	61%
Allowed for them to choose or change who provides their services	77%	53%

Care Coordination. In integrated programs one entity coordinates the full range of medical and behavioral health as well as LTSS needs. Investments in care coordination at the health plan and provider levels—particularly as individuals move from institutional settings to home—can both reduce unnecessary hospitalization and other adverse health events, and keep people at home longer. MMPs and D-SNPs must meet extensive care coordination requirements to assess comprehensive needs and implement a person-centered care plan that offers timely and coordinated services.

Nationally, data on two CAHPS measures indicate strong satisfaction with care coordination activities among Medicare-Medicaid Plans in the FAI demonstrations. In 2017, 90 percent of beneficiary respondents enrolled in a demonstration answered ‘usually’ or ‘always’ to the Care Coordination Composite measure, which assesses individual experiences with coordination of care, such as whether consumers were reminded about getting needed tests/filling prescriptions, and how quickly consumers got their test results. Similarly, 89 percent were ‘somewhat satisfied’ or ‘very satisfied’ with care coordination.¹⁵ Improved care coordination can shift care from hospitals and emergency departments to community-based, outpatient settings. An evaluation showed that compared to Minnesota Senior Care, a Medicaid-only managed care program for dually eligible beneficiaries, MSHO enrollees in health plans integrated with Medicare were almost three times as likely to have had a primary care visit over the past year, which researchers cite as an impact of better coordination.¹⁶

Findings also reinforce that it often takes time to establish new beneficiary-level care coordination processes that are foundational to achieving strong results. A 2018 evaluation by Ohio of its FAI demonstration, MyCare Ohio, showed considerable improvements in these key processes between 2014 (its first year of operation) and 2017:

MyCare Ohio showed improvements in key processes over a three-year period.

- Rate of assessment completion within 90 days increased from 60 to 84 percent;
- Percentage of enrollees with a documented care plan increased from 33 to 77 percent; and
- Percentage of hospital discharges with ambulatory care follow-up visits within 30 days increased from 49 to 79 percent.¹⁷

Quality of Care. Many integrated programs demonstrate improved health outcomes, typically through better management of Medicare-covered primary or acute care services. Medicaid agencies have a great interest in ensuring that dually eligible beneficiaries are as healthy as possible. In particular, better management of chronic conditions can prevent or deter utilization of Medicaid-covered LTSS. The FAI demonstration evaluations have found all or most MMPs in the state examples below performed better than the national Medicare Advantage benchmark on certain HEDIS quality measures, many of which reflect areas that can impact Medicaid utilization of and spending on behavioral health services and LTSS, such as:

- Initiation of alcohol and other drug dependence treatment: CA, IL, MA, MI, OH, TX
- Annual monitoring for patients on persistent medications: IL, OH, TX
- Follow-up after hospitalization for mental illness: MA, OH, TX
- Antidepressant medication management: IL, MA, OH¹⁸

These initial FAI results on HEDIS measures are promising. A December 2016 study from the U.S. Department of Health and Human Services found that Medicare beneficiaries with social risk factors had worse health outcomes on many quality measures, regardless of the providers they saw, and that dual eligible status was the most powerful predictor of poor outcomes.¹⁹ These results indicate significant potential to improve quality of care for an enrollee population that is typically higher need. Several state interviewees reported that, due to an integrated capitated arrangement, health plans have offered additional services that address beneficiaries’ social risk factors that they would be unable to provide in a traditional model.

Integrated care programs can impact other program goals in addition to health outcomes. Tennessee’s Employment and Community First CHOICES program is an MLTSS program for people with intellectual and developmental disabilities that seeks to help people gain as much independence as possible, including the possibility of working. Some members of Employment and Community First CHOICES also participate in an aligned Fully Integrated Dual Eligible (FIDE)-“like” SNP.²⁰ One of its health plans has demonstrated impressive improvements after implementing the more fully integrated D-SNP. Compared to 2018, 2019 shows that ECF CHOICES members who participated in the FIDE-like D-SNP had a:

- 144 percent increase in members who are employed;
- 220 percent increase in behavioral health outpatient visits; and
- 16 percent decrease in emergency department visits.

2. Medicaid Program Efficiency

Some early findings on program efficiency support a critical premise for these models: that aligning services in one integrated arrangement, coupled with investments in better care management and coordination, can lead to healthier people who live

Given the aging population and increasing demand for LTSS facing states in the next decade, the opportunity to achieve Medicaid system savings or at least bend the cost curve for LTSS will become increasingly important.

in the community longer and can reduce or delay Medicaid LTSS utilization. As one state noted, aligning incentives, risk, and accountability, particularly through one entity, can have a profound impact on ensuring the right interventions are provided at the right time. It is also important to note that the FAI demonstrations allow states to share in savings with Medicare, either prospectively as savings are built into MMP rates in the capitated model, or retroactively if both quality and financial targets are met in the MFFS model. In an April 2019 State Medicaid Director Letter, CMS indicated

receptivity to working with states on new demonstration models that could include a shared savings component.²¹ This represents a key lever for states to impact spending for this population on Medicaid.

Early Cost Savings Results

Early results are promising, with Washington State’s MFFS demonstration offering the most compelling to date. Through its approach of targeting high-risk individuals with intensive care management, as of November 2018, the state has received more than \$36 million in interim performance payments from CMS for the first three years of its demonstration 2016.²² In September 2019, CMS released a new report that estimates an additional \$55.2 million in Medicare savings from this model in 2017, which will likely result in another performance payment. Capitated model results have been slower to calculate due to lags in availability of Medicaid comparison data. Despite this, preliminary findings from federally funded FAI demonstration evaluations in Illinois and Texas found lower Medicare costs in the first year, while the demonstrations in California, Massachusetts, Michigan, Ohio and South Carolina did not demonstrate any effect on Medicare costs.²³ A state-supported analysis in Ohio found that MyCare Ohio saved the state \$30 million from 2015 to 2017 by shifting LTSS utilization to HCBS.²⁴

Health plans' results are also beginning to demonstrate the savings potential of integrated models, particularly after individuals are enrolled continuously for several months. For example, Commonwealth Care Alliance (CCA), an MMP in Massachusetts' One Care FAI demonstration, reduced its overall per member per month (PMPM) medical expenses in 2017 by five percent for members enrolled for 24 continuous months. CCA reduced inpatient admissions and emergency department utilization by 29 and 13 percent respectively for members continuously enrolled for all of 2016 to 2017 compared to members with just six months of enrollment. CCA decreased inpatient admissions for members with severe disabilities by 27 percent and PMPM expenses for members with serious mental illness by 16 percent. The lower utilization rates did not impact quality; CCA is consistently one of the highest-rated MMPs nationally in the annual CAHPS survey for all MMPs.²⁵

Long-Term Services and Supports Utilization

A disproportionate amount of LTSS spending is driven by institutional care costs. Encouraging appropriate LTSS utilization by dually eligible beneficiaries—focusing on skilled nursing facility (SNF) admissions and long stays in nursing facilities (NF)—is a high priority for states eager to reduce LTSS cost growth.²⁶ Among Medicare beneficiaries who become newly eligible for Medicaid, most who used Medicare-covered SNF and Medicaid-covered NF services in the first month of dual coverage started using these services upon or after initial transition to full-dual status.²⁷ One study found that dually eligible individuals are 12 percent more likely to become long-stay NF residents and use more SNF care compared to Medicare-only patients, underscoring the importance of managing appropriate utilization of both SNF and NF services.²⁸ Following are select results from integrated care programs in decreasing both SNF and NF stays:

- Early FAI demonstration evaluations have found a significant cumulative decline in the probability of long-stay NF facility use in Massachusetts, Ohio and Washington. The evaluations found that most states with available data—Illinois, Ohio, South Carolina and Washington—show a decrease in SNF utilization.
- A 2013 study showed that Massachusetts' Senior Care Options, an integrated D-SNP model, achieved a 12 percent reduction in NF residency months.²⁹
- The Long-Term Quality Alliance found similar statistically significantly lower SNF admissions compared to Medicare FFS patients across three integrated programs: an MMP, an aligned D-SNP and a PACE program.³⁰
- A study on PACE found that participants had a 31 percent lower risk of long-term (greater than 90 days) nursing facility admission compared to HCBS waiver enrollees, even though upon NF admission, PACE participants had greater levels of cognitive impairment.³¹

A PACE study showed 31% lower risk of long-term stay nursing facility admission.

Since spending on Medicaid LTSS is projected to grow due to an anticipated 50 percent increase in individuals age 65 and older by 2030, continuing to shift the balance of LTSS to community-based care is critical for states. Many integrated care programs have incentives for health plans and providers to encourage LTSS system rebalancing. Ohio's state-supported evaluation estimated that the MyCare demonstration implementation led to a two percent increase in NF transition rates,

resulting in \$30 million in savings to the state as noted above.³² The most recent federal evaluation of One Care, Massachusetts' FAI demonstration found that by the end of its third year, NF use decreased and HCBS use increased by more than five percent.³³ A recent CMS report highlights states that have made significant rebalancing progress from 2012 to 2016. This includes New Jersey and South Carolina, which increased use of HCBS over institutional care by nearly 12 and eight percentage points respectively.³⁴ New Jersey credits this shift to launching its fully integrated D-SNP and MLTSS program in 2014.³⁵ Between 2014 and 2019, the percent of LTSS recipients in New Jersey receiving care in the home or community increased from 29 percent to 54 percent. Likewise, the greatest increases in HCBS utilization in South Carolina occurred between 2014 and 2016, coinciding with implementation of its FAI demonstration. Another state noted that although it took time to achieve provider buy-in for the state's FAI demonstration, most participating NF and HCBS providers now appreciate the streamlined approach that integrated health plans put in place to improve access to HCBS and acknowledge it as a major improvement over the FFS system. Lastly, enrollees in Minnesota's MSHO program were 13 percent more likely to use HCBS compared to enrollees in Minnesota Senior Care.

3. Program Administration

Although state leaders acknowledge the significant investment in state resources to implement integrated care programs, interviewees reported that building the infrastructure for these models can support improvements in Medicaid program administration and management. One key advantage for states with integrated models is increased access to and capacity to use Medicare data to analyze the full range of service utilization, costs, and gaps in care across Medicare and Medicaid. Better access to and use of Medicare data also expands opportunities to include this high-need, expensive population in other Medicaid payment and delivery reform efforts. Despite the likely benefits to dually eligible beneficiaries, states often exclude these individuals from health homes, accountable care organizations, and other similar efforts due to data limitations.

States that have FAI demonstrations have joint oversight of the programs and regular interactions with various parts of CMS through contract management teams. As a result, several states note improved communication channels with CMS, particularly with the Medicare-Medicaid Coordination Office. States may also establish requirements that increase coordination of Medicaid benefits and programs with Medicare service delivery by way of three-way contracts with CMS and MMPs in FAI demonstrations, or by using D-SNP contracts to require care coordination, information sharing, and administrative alignment across the programs. Robust contract management also provides states with an opportunity to streamline beneficiary, provider and health plan experience, such as requiring health plans to report on uniform quality metrics, use consistent assessment tools and integrated member materials, and use interoperable payment and data systems.

Robust contract management also provides states with an opportunity to streamline beneficiary, provider and health plan experience.

Conclusion

Evidence is emerging on the value of integration. There is a growing body of data supporting the value of integrated care programs for Medicaid agencies. This is focused on better care experience, shifting of Medicaid LTSS utilization to lower-cost, community-based services, and improvements in program administration. Although savings that result from integration still accrue to Medicare first, there are new opportunities to explore shared savings via demonstration models. As states address the growing aging population and subsequent increased demand for LTSS in coming years, identifying and translating this emerging evidence is an essential tool in making the case for state investments in integrated care. Many of the interviewed states are analyzing utilization patterns and health care needs of individuals at risk of becoming dually eligible to identify opportunities for early interventions that deter higher service needs down the road.

There are limitations with the early findings discussed in this brief. These programs serve complex and often hard to engage beneficiaries and, while these early results offer promising insights, it takes time to collect the data needed to draw solid conclusions about program impact. In addition, most current evaluations do not yet include Medicaid data. However, CMS has developed a new Transformed Medicaid Statistical Information System that will provide needed information about Medicaid spending and utilization in these programs. In addition, current research does not delineate differences in outcomes across sub-populations who are dually eligible which could inform important design elements. MACPAC provides a detailed discussion of future research needs in its recent issue brief.³⁶

As many state interviewees noted, the investments needed in staffing, system resources, and stakeholder engagement for these programs are significant factors that dictate program success. One interviewee noted, “These programs are worth it, and you get back what you put in.” As pioneering states begin to generate lessons about the benefits of integrated care for beneficiaries, states, and the federal government, this information, along with new federal opportunities, may catalyze new state activity as well. Early research and anecdotes provide a strong start and, as these programs mature, they will provide more evidence to guide improvements in quality and cost-effectiveness for dually eligible beneficiaries across the nation.

Endnotes

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