State Efforts to Integrate Care for Dually Eligible Beneficiaries: 2020 Update
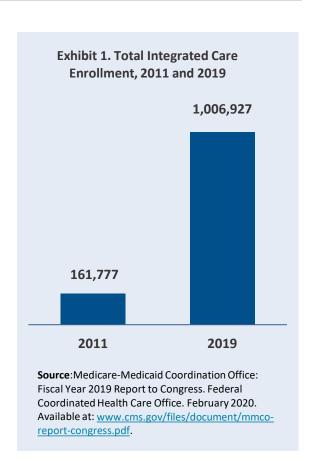
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IN BRIEF

More than one-third of states operate Medicare-Medicaid integrated care models based on demonstrations under the federal Financial Alignment Initiative (FAI) or through Dual Eligible Special Needs Plans (D-SNPs) that are aligned with Medicaid managed care plans. New federal opportunities are prompting states to develop or enhance integrated care programs for their dually eligible beneficiaries. With support from The SCAN Foundation, the Center for Health Care Strategies examined the progress of early-adopter states with established Medicare-Medicaid integrated care models to identify key factors influencing state progress in this area. This brief presents an overview of the opportunities to advance integrated care and reviews the success factors that may affect state efforts going forward.

I n the last decade, many states have made dramatic gains developing integrated care models for their dually eligible populations. As of January 2020, 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. This is a considerable increase from only three states that had integrated models a decade ago. Although enrollment in integrated care models has increased nearly five-fold during this time period (see **Exhibit 1**),[1] fewer than 10 percent of the 12 million Americans who are dually eligible for Medicare and Medicaid are currently enrolled in an integrated program. To serve more dually eligible individuals, more states will need to develop integrated care programs and existing programs will need to increase in scope.

This brief examines opportunities for states to create or enhance integrated care programs. It also shares insights from states that were early implementers of integrated programs ("early adopters") on the factors that drove their investment

Exhibit 1. Total Integrated Care Enrollment, 2011 and 2019

1,006,927

161,777

2011   2019

Source:Medicare-Medicaid Coordination Office: Fiscal Year 2019 Report to Congress. Federal Coordinated Health Care Office. February 2020. Available at: www.cms.gov/files/document/mmco-report-congress.pdf.

in these programs and led to successful program implementation. Understanding these factors is critical for policymakers and other key stakeholders responding to new requirements for and options to advance integrated models of care.

Current Opportunities to Integrate Medicare and Medicaid

Twenty-two states have a fully or partly integrated care model serving individuals dually eligible for Medicare and Medicaid. The majority of these efforts were sparked by the creation of the Medicare-Medicaid Coordination Office within the Centers for Medicare & Medicaid Services (CMS) in 2010. Following is a brief description of currently available integrated care models. *(See Exhibit 2, page 3, for a summary of states providing integration models.)*

FAI Demonstrations

Through state partnerships with CMS, these demonstrations test approaches to aligning Medicare and Medicaid financing and integrating primary and acute care, behavioral health services, and long-term services and supports (LTSS) using either: (1) a capitated model in which Medicare-Medicaid Plans coordinate the full range of health care services; or (2) a managed fee-for-service model. In both models, states may share in savings. Originally announced in 2011, 12 states implemented a demonstration, and 10 states (nine with a capitated model; one with a managed fee-for-service model) continue to operate demonstrations that enroll more than 400,000 individuals.[2,3]
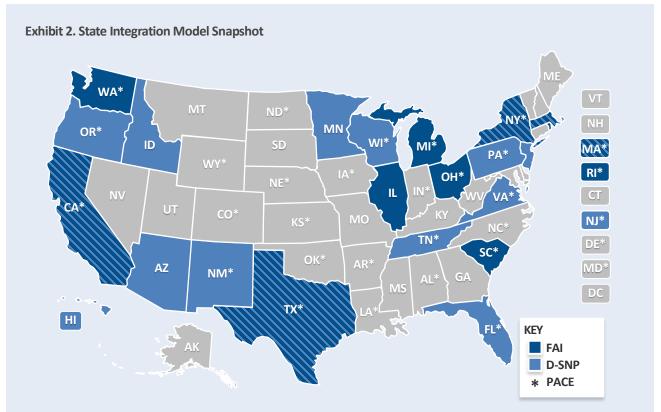
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Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs)

D-SNPs are Medicare Advantage plans that serve only dually eligible beneficiaries. D-SNPs operate in 42 states, the District of Columbia, and Puerto Rico and enroll more than 2.8 million individuals, or 23 percent of the dually eligible population.[4] All D-SNPs must have contracts with the Medicaid agencies in the states in which they operate that include minimum standards for coordination of Medicaid benefits. However, these contract requirements are not robust enough to provide a pathway to an integrated or aligned arrangement. States interested in strengthening benefit coordination and/or alignment between D-SNPs and Medicaid programs — particularly those with Medicaid managed long-term services and supports (MLTSS) programs — can include additional language in these contracts to increase benefit and care coordination as well as enrollment and administrative alignment. Fourteen states currently have fully or partially integrated D-SNP programs with strong linkages to Medicaid managed care organizations.[5] These are highly aligned plans that do not just coordinate, but are at risk for coverage of Medicaid LTSS benefits.

Programs of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare program that provides comprehensive medical and social services to adults age 55 and older who need a nursing facility level of care, but can live safely in community settings. With early program history stretching back to the 1970s, PACE is the first model that integrated Medicare and Medicaid services at the provider-level through an adult-day center-based approach. Nearly 90 percent of PACE participants are dually eligible. As of January 2020, 132 PACE organizations were operating in 31 states with an enrollment of 48,581.[6]

Exhibit 2. State Integration Model Snapshot

Some states operate both FAI demonstrations and integrated D-SNPs. Thus, there are 26 of these integrated care models in place in 22, states as noted on page 2.

Model	States
Fully-integrated model, FAI (10)	California,[7] Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Washington.
Fully-integrated model, D-SNP (10)	Arizona, Idaho, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Tennessee, Virginia, and Wisconsin.
Partly-integrated model, D-SNP (6)	California, Florida, Hawaii, New Mexico, Oregon, and Texas.
PACE (31)	Alabama, Arkansas, California, Colorado, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, and Wyoming.

Federal Policies Supporting Integration

Federal policies are the backdrop for state-level efforts to integrate Medicare and Medicaid. Historically, inadequate program design flexibility and shared savings opportunities have impeded state development of new integrated care programs. The first round of FAI demonstrations, which allowed states to include administrative and financial flexibilities that had been unavailable to them up to that point, attempted to address these barriers. Exhibit 3 highlights key areas where recent federal policy levers have enhanced integration options for states.

Exhibit 3. Federal-Level Factors Supporting Integration

Factor	Description of Enhanced Federal Opportunities
Flexibility	Access to waivers for Medicare program requirements; flexibility in integrating or aligning Medicare and Medicaid administrative processes through D-SNPs, MMPs, and new demonstration opportunities
Permanency	Permanent authorization of Medicare D-SNPs in 2018; extension of and potential path to permanency of FAI demonstrations
Financial Incentives	Ability for states to share savings with Medicare when integration lowers costs through FAI demonstration opportunities
Sustainability	Flexible payment policies and methodologies; new mechanisms to grow or sustain enrollment; the ability to seamlessly enroll new Medicare beneficiaries

New federal policy activities continue to reinforce these factors and are prompting states to develop or enhance integrated care programs for their dually eligible beneficiaries. In April 2019, CMS issued a State Medicaid Director Letter inviting states to submit proposals for new FAI demonstrations. [8] These proposals can build upon the FAI demonstrations or provide greater flexibility for states to suggest new approaches using other types of delivery system or payment reforms.[9] Importantly, these models continue to provide states with a potential mechanism to share in Medicare savings achieved with CMS.

In addition, the Bipartisan Budget Act of 2018 provided permanent operating authority for D-SNPs, which may encourage long-term state and health plan investment in these plans.[10] This legislation also required CMS to develop more rigorous minimum integration standards for all D-SNPs. Beginning January 1, 2021, D-SNPs must either cover Medicaid behavioral health services and/or long-term services and supports or communicate information on certain high-risk members' hospital and skilled nursing facility admissions to the entity coordinating their Medicaid benefits.[11] States with D-SNPs — including those that do not currently have integrated models — are thinking about how to meet these new requirements and work more closely with their D-SNPs. States are examining the feasibility of having D-SNPs cover Medicaid benefits and exploring new opportunities to better integrate Medicare and Medicaid benefits and administrative processes. Beyond the Bipartisan Budget Act's provisions, other new federal

policies encourage aligned enrollment (e.g., default and passive enrollment) for Medicare and Medicaid — offering states new mechanisms to increase the number of beneficiaries in integrated models.[12]

Up until 2015, PACE program sponsors could only be not-for-profit or public entities. In recent years, a number of entities have taken advantage of relatively new flexibility to launch for-profit PACE organizations. CMS in turn finalized a rule on May 28, 2019 to strengthen patient protections, improve care coordination, and expand operational flexibilities for PACE organizations.[13] There is also an opportunity to test enrolling individuals under age 55 into PACE programs.

Factors Influencing State Investment and Successful Program Launch

The factors influencing whether a state invests in and successfully launches an integrated care model vary and may change over time. This section summarizes the critical elements that drove state success in pursuing integrated models, as identified through CHCS interviews with states. Understanding the presence of these factors (summarized in Exhibit 4) can help states just beginning to evaluate options for integrated care as well as those that are actively pursuing or operating a particular model. For early adopter states, many of these factors were initial barriers that took considerable time and effort to address.

Exhibit 4. Key State-Level Factors Driving Success for Integrated Care

Factor	Description
Environment	■ Market and political climate ■ Stakeholder support and engagement resources
Incentives	■ Shared savings opportunities with Medicare ■ LTSS rebalancing goals
Internal Capacity	■ Organizational and staffing capacity ■ Medicare expertise ■ Leadership champions ■ Data and analytic capabilities

Environment

Market and political climate. Environmental factors directly influence state investment in and stakeholder support for integration efforts. States without Medicaid managed care experience are less likely to launch an integrated care model on a D-SNP or demonstration platform. Several state-level market characteristics increase the likelihood of launching an integrated care model, including:

■ **Legislative mandates and/or state administration priorities.** Interest in integration from a governor, cabinet, and/or state legislature can accelerate the flow of state resources or stakeholder supports. Other states noted considerable progress achieving stakeholder buy-

in and support in program design as a result of specific executive or legislative direction to develop or expand integrated programs. Related LTSS reforms can impact how integrated care is prioritized as well. For example, flexibility to remove program enrollment caps and resulting waitlist caps has enabled new integrated models to achieve the greatest LTSS rebalancing strides, but this typically requires legislative budget authority.

- **Medicaid managed care.** A successful history with enrolling dually eligible beneficiaries into Medicaid managed care may bolster the internal capacity needed to manage integrated care programs. This can also increase the likelihood of obtaining stakeholder buy-in when providers, beneficiaries, advocates, and others can see a benefit of managed care or are at least familiar with it. The decision to launch an MLTSS program has historically been a good predictor of future state willingness to develop a corresponding strategy to fully integrate and coordinate care for dually eligible beneficiaries.

- **Medicare managed care.** The presence of D-SNPs, including D-SNPs that align with the same service areas and populations enrolled in the state's Medicaid managed care program, is another key success factor for states. Additionally, for states with a limited presence of D-SNPs in their market, another factor for success has been the presence of plans with experience operating other types of Medicare Advantage organizations. Some of these plans have been willing to stand up a D-SNP product alongside a Medicaid managed care plan. Plan representatives have specifically pointed to

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having multiple lines of business within a state as a lever driving their decisions whether to operate a D-SNP product. In addition, plan willingness to support states in building capacity can impact states' integration efforts. A handful of states with limited experience working with Medicare Advantage health plans have tied their integrated care success to collaboration with health plans during program development and launch.

Lastly, integrated managed care programs are most effective when Medicare and Medicaid enrollment, benefits, and administrative practices are aligned under either one health plan or another entity. Some early adopter states created programs with full benefit integration and significant administrative alignment immediately, whereas others phased in integrated or highly coordinated elements over time. In either case, these are factors that can impact service utilization, access to home- and community-based services, beneficiary experience of care, and other key program components.

Stakeholder engagement. An early and uniform lesson across states with successful integrated care models has been the need to devote considerable and ongoing resources to targeted stakeholder engagement efforts. Obtaining successful buy-in hinges on involving stakeholders in all steps of program development regarding what integration and care

coordination means for them. Some states have seen MLTSS and/or integration efforts derailed due to stakeholder opposition — either early or late in program design, or prior to launch. Effective messaging and education about the value of integration for them is extremely important. After programs are launched, states have continued to engage with stakeholders to share data on early outcomes and keep stakeholder feedback channels open to promote transparency and maintain support for these new models. States note that effective stakeholder engagement is achievable with sufficient resources and leadership champions to support provider, beneficiary, and internal buy-in.

Incentives

Shared Medicare savings. The success factor with perhaps the greatest potential to spur new investments is whether states will have a way to share in the Medicare savings that may accrue from better coordinated care. Examples of potential savings pathways include the FAI demonstration model, more effective and coordinated care management at the health plan level, and increasing the proportion of individuals served in the community compared to institutional settings, among others. While recent state experience with demonstration programs shows that it may take time for a return on investment to be realized, the opportunity to capture savings continues to spur state interest.

LTSS rebalancing goals. One goal of integrated programs is to increase the proportion of LTSS provided in the community compared to institutional settings. The increased demand for LTSS associated with aging demographics will likely keep rebalancing a priority for states eager to use integration as a lever to manage LTSS budget pressures. There are potential budgetary implications for providing care in the community. Several states have made efforts to create a direct link between a successful integrated model of care and access to community-based LTSS, and a few early adopter states have quantified the rebalancing impacts of integrated care models.[14,15] As state leaders seek potential savings or levers to slow cost growth, the potential for integrated care programs to promote LTSS rebalancing and encourage appropriate utilization can drive leadership and stakeholder support for these programs.

> *"Patience is needed since integration is a lengthy process — it is in the nature of the cycles (i.e., contracting, demonstration, Medicare Advantage, etc.) — anything you do here will take a while."*
>
> *— State official*

Internal Capacity

Organizational and staffing capacity. States rarely had access to new staffing resources to launch and oversee their integrated care models and had to think creatively about how to repurpose capacity for already busy staff. States that successfully launched programs had dedicated staff or close ties with consultants with relevant expertise, as well as organizational structures that enabled access to needed resources for program development, implementation, and ongoing oversight. Essential functions include developing knowledge about the dually

eligible population, overseeing and managing contractors, and troubleshooting systems problems.

Many states with MLTSS programs rely on their existing managed care oversight capacity to manage Medicare-Medicaid integrated models. Others broaden the scope of responsibility for existing operating units, including those overseeing other managed care products in the state or LTSS programs, such as fee-for-service home- and community-based waiver policy and programs. Recently, some states with established programs have reorganized existing, disparate resources to create new staff teams that align management of both LTSS and integrated program elements.

Medicare expertise. Building and sustaining Medicare knowledge is another key success factor. This entails: (1) keeping up-to-date with constantly evolving Medicare Advantage policy, regulations, and market activity; (2) conducting educational activities to address potential staff turnover and leadership changes once programs are in place; and (3) for states that are just beginning, building foundational knowledge among internal and external parties to understand how Medicare policy interacts with the state's policy goals and program options.

Building Medicare expertise, especially considering the complexity of the Medicare market, can be particularly challenging. Early adopting states often struggled with "not knowing what they don't know" when building foundational Medicare knowledge, which makes it difficult to frame the right issues and questions. Furthermore, many states do not have dedicated resources to develop basic education about how traditional Medicare and Medicare Advantage programs work and where the potential for alignment exists. Some states have found plans with experience operating integrated models to be very helpful partners as they work to climb a steep Medicare learning curve.

Leadership champions. Leadership champions who fundamentally understand the value of integration and who make these programs a state priority are critical to program success. While making integrated care a key goal or priority is important for initial progress, long-term, ongoing leadership investment ensures that state staff can maintain capacity for program improvements and evolution. Leadership champions are important at agency, gubernatorial, and legislative leadership levels since all of these parties have to understand and value

> *"You have to have champions (internal and external) who are passionate about integration, you need someone who really wants to keep integrating and keep tabs on it."*
>
> *– State official*

integration enough to be willing to invest the resources needed. States without a leadership champion to bring these programs into a priority spotlight tend to struggle with building internal capacity to manage them.

Data integration and analytic capacities. One key advantage for states with integrated models is access to and capacity for using Medicare data to analyze the full range of service utilization, costs, and gaps in care across Medicare and Medicaid. Successful states built

technical capacity to integrate Medicaid and Medicare data and created analytic resources that were critical for both early program development and ongoing program oversight. Integrated datasets help states analyze population trends, needs, and the impact of care delivery models over time. Amassing the capacity to build and work with integrated Medicare and Medicaid data sets is a common challenge that all states faced.

Conclusion

New federal opportunities for states to pursue or continue to enhance integrated care models have created a stimulus for states to refresh their thinking and refocus on programs that serve the dually eligible population. Concurrently, states and the federal government are grappling with how to address the growing demands on their Medicaid LTSS systems as well as strains on the Medicare program as the U.S. population ages. Having coordinated systems of care that promote community-based options for older adults and others with complex needs will become even more critical in the years ahead. In this review, early state adopters of integrated care identified critical factors that will impact state investment in these care models, including state capacity and resources, the right policy environment, and the potential to impact state budgets. As new states prepare to launch programs for the first time and other states work to enhance existing programs, several factors will increase the likelihood of success, including: access to targeted, technical support; development of Medicare knowledge among key staff; strategic opportunities to build state capacity; and the presence of internal champions. The mix of policy, programmatic, and practical insights from pioneering states presented in this brief can help guide states and relevant stakeholders as they develop more coordinated and person-centered systems of care that can meet the complex needs of dually eligible beneficiaries.

ENDNOTES

[1] Centers for Medicare & Medicaid Services. "Medicare Medicaid Coordination Office FY 2018 Report to Congress." February 2019. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf.

[2] Integrated Care Resource Center. "Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, January 2019 to January 2020." January 2020. Available at: https://www.integratedcareresourcecenter.com/resource/monthly-enrollment-medicare-medicaid-plans-plan-and-state-january-2019-january-2020.

[3] New York ended a capitated model FAI demonstration, Fully Integrated Duals Advantage (FIDA) on December 31, 2019. It is working to expand its FIDE-SNP program. The six FIDA plans have a Medicaid Advantage Plus (MAP) plan aligned with D-SNPs in the same service

area. New York continues to operate a small capitated model demonstration — FIDA-I/DD — for individuals with intellectual and developmental disabilities.

[4] Centers for Medicare & Medicaid Services. "Special Needs Plan Comprehensive Report." January 2020. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.

[5] Fully- integrated D-SNP programs include states with presence of and considerable enrollment in FIDE-SNPs or D-SNP/MLTSS aligned contracts that are closely overseen by the state. Partly-integrated D-SNP programs include states with: (1) a very limited number of FIDE SNPs; (2) programs in which a dually eligible beneficiary receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans; or (3) D-SNP contracts that require plans to coordinate care or align benefits beyond the minimum but carve-out important benefits for Medicaid enrollees (E.g., LTSS or behavioral health).

[6] Integrated Care Resource Center. "Program of All Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization." January 2020. Available at: https://www.integratedcareresourcecenter.com/resource/program-all-inclusive-care-elderly-pace-total-enrollment-state-and-organization-5.

[7] New York transitioned from its capitated model FAI demonstration to a NY Medicaid Advantage Plus (MAP) and Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) program on January 1, 2020. California plans to end its capitated model FAI demonstration, Cal MediConnect, on December 31, 2022. It will transition to a statewide partly-integrated D-SNP model on January 1, 2023.

[8] Centers for Medicare & Medicaid Services, State Medicaid Director Letter: Re: Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare. April 24, 2019. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf.

[9] Ibid.

[10] A. Tumlinson, M. Burke, and G. Alkema. The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs. The SCAN Foundation, March 2018. Available at: https://www.thescanfoundation.org/publications/the-chronic-care-act-of-2018-advancing-care-for-adults-with-complex-needs/.

[11] Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021. 84 FR 15680. April 16, 2019. Available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23599.pdf.

[12] In some circumstances, states can promote the use of "default enrollment" to increase aligned enrollment into D-SNPs and affiliated MCOs when existing Medicaid managed care enrollees become newly eligible for Medicare by virtue of age or disability. Additionally, states and D-SNPs can seek approval from CMS to conduct passive enrollment into D-SNPs to promote integrated care and continuity of care for a full-benefit dual eligible beneficiaries who are currently enrolled in an integrated dual eligible special needs plan to address the limited circumstance in which integrated care coverage would otherwise be disrupted (i.e., due to Medicaid re-procurements or a Medicare Advantage plan non-renewal.

[13] Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021. 83 Fed. Reg. 54982. November 1, 2018. Available at: https://www.federalregister.gov/documents/2018/11/01/2018-23599/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare.

[14] W. Anderson, Z. Feng, S. Long. Minnesota Managed Care Longitudinal Analysis, March 2016. Available at: https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis.

[15] The Ohio Department of Medicaid "MyCare Ohio Evaluation 2018." June 2018. Available at: http://www.jmoc.state.oh.us/Assets/documents/reports/MyCare_Ohio_Evaluation_2018.pdf.