



IDEAS  
ACTION  
RESULTS

# A Pathway to Full Integration of Care for Medicare- Medicaid Beneficiaries

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Bipartisan Policy Center

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## HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

## ADVISORS

The Bipartisan Policy Center staff produced this report in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank Henry Claypool and Tim Westmoreland for their contributions to this report, as well as Aparna Higgins for providing qualitative analysis for the policy recommendations.

## ACKNOWLEDGMENTS

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## DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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# Glossary of Terms

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Activities of Daily Living (ADLs)

Administration for Community Living (ACL)

Amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease)

Centers for Medicare & Medicaid Services (CMS)

Dual Eligible Special Needs Plan (D-SNP)

End-stage renal disease (ESRD)

Federal poverty level (FPL)

Financial Alignment Initiative (FAI)

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP)

Long-term Services and Supports (LTSS)

Medicaid and CHIP Payment and Access Commission (MACPAC)

Medicare Advantage (MA)

Medicare-Medicaid Coordination Office (MMCO)

Medicare-Medicaid Plan (MMP)

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

State Health Insurance Assistance Programs (SHIP)

Supplemental Security Income (SSI)

U.S. Department of Health and Human Services (HHS)

# Executive Summary

BPC has worked for a number of years to improve integration of services for those who are eligible for Medicare and Medicaid.<sup>a</sup> In continuing that work over the past year, BPC conducted research, hosted roundtable discussions, and interviewed key stakeholders to better understand the barriers to integration of these programs and the challenges faced by those who must navigate them. BPC also commissioned a study (see Appendix I) to better understand the challenges and successes of federal and state demonstrations to align these programs.

The primary goals in recommending alignment are to improve beneficiary experience, outcomes, and well-being. Given the lack of coordination in the current system, BPC believes there is also potential for savings over the long term, primarily in the form of reduced hospitalizations, hospital readmissions, emergency department visits, and post-acute care. However, before those savings can be achieved, there will need to be up-front investments to provide resources to states and to the office within CMS that administers the program, to develop infrastructure where it is currently lacking. Finally, this proposal would guarantee a simplified and seamless integrated care option by a certain date.

Efforts to better integrate care should recognize the heterogeneity of the dual eligible population, and the importance of a transition to integrated care for distinct populations. Dual eligible individuals should have comprehensive information about the benefits and drawbacks of enrolling in a fully integrated care model. There should be ample time for community-based education to help beneficiaries understand their enrollment options and the benefits available to them before they are enrolled in integrated care programs. Also, while these models should deliver a less complex and costly care experience, beneficiaries should be given the opportunity to opt-out of them at any time.

BPC's recommendations are designed to create strong incentives to states to integrate care. The report identifies three care models from which states can choose to achieve full integration:

1. improved Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) that reflect lessons learned from the Financial Alignment Initiative (FAI) demonstration's Medicare-Medicaid Plans (MMPs)

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<sup>a</sup> Previous reports from the Bipartisan Policy Center that address dual eligible individuals include: [Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid, September 2016](#), [A Policy Roadmap for Individuals with Complex Care Needs, January 2018](#), [Next Steps in Chronic Care: Expanding Innovative Medicare Benefits, July 2019](#).

2. the Programs of All-Inclusive Care for the Elderly (PACE)
3. a flexible model negotiated between the secretary of the U.S. Department of Health and Human Services (HHS) and a state, building off the managed fee-for-service model used by the State of Washington

Each model must cover all Medicare and Medicaid benefits and meet all integration requirements identified in this report. These recommendations are intended to build on best practices of the past 40 years in integrating care for full-benefit dual eligible individuals.

These recommendations provide significant incentives to states in the form of planning grants, technical assistance, and guaranteed shared savings, if integration of services reduces costs over time. They also include provisions to help dual eligible individuals better understand the benefits and trade-offs of receiving care through a fully integrated plan, by providing federal resources for consumer education, and by recommending closer coordination between the Centers for Medicare & Medicaid Services (CMS) and the Administration for Community Living (ACL).

To guarantee an integration option for all populations of dual eligible individuals in every state by a date certain, these recommendations include the framework for a federal fallback program to operate in states that choose not to integrate care. Under this approach, the secretary of HHS would contract with improved FIDE SNPs, which would be based on best practices from the FAI demonstration's Medicare-Medicaid plans. PACE would also continue to be available as an option.

Over the last decade, stakeholders—including state and federal policymakers, consumer advocates, health plans, and providers—have worked to improve the complex challenges associated with improving care for those who rely on Medicare and Medicaid to address their health and long-term care needs. BPC is one of a small but growing group of organizations and agencies seeking to accelerate integration of care for dual eligible individuals. BPC does not hold a monopoly on good ideas and recognizes there are many paths forward. BPC welcomes the opportunity to work with policymakers and other organizations to identify viable solutions to improve care and lower costs for a vulnerable and high-cost population.

## RECOMMENDATIONS

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### I. Framework for the Integration of Medicare and Medicaid Services for Dual Eligible Individuals

*To ensure that all full-benefit dual eligible individuals have access to fully integrated care models by a date certain, Congress should:*

#### A. Define “full integration” for programs serving dual eligible individuals.

**The definition should include:**

1. Fully aligned financing, with a single entity responsible for Medicare and Medicaid funding in all counties/regions of a state
2. A single set of benefits, including medical benefits, behavioral health, and long-term services and supports
3. A single point of access, which requires a single plan or sponsor offering the full range of benefits with one enrollment period, one set of member materials, one enrollment and identification process, one point of access for all benefits, one point of contact for benefit decisions, and a single grievance and appeals process
4. A process that makes sure beneficiaries are informed of and understand their options and rights within an integrated program, and provides sufficient time to make decisions regarding enrollment, with strong safeguards to protect beneficiaries
5. Health plan access to claims and encounter data for new enrollees to identify high-risk enrollees and provide prompt assessments, including a standard functional assessment tool, a single primary care provider, and an interdisciplinary care team to develop an individualized person-centered care plan that is designed to meet the unique needs of high-risk enrollees; the care plan should include primary, specialty, acute and post-acute care, and pharmacy services. The care plan should be updated as needed to address beneficiaries needs as they change over time and across care settings
6. Provider access to integrated information systems and care transitions, to be able to identify high-risk enrollees, to assure timely individual assessments, and to provide smooth care transitions without disruptions in services
7. A single and streamlined set of measures across the two programs, including a set of quality measures and performance evaluations developed for complex populations, to be used for quality improvement and to serve as a basis for quality reporting to help beneficiary decision-making

**B. Require states to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals.** Provide resources and technical assistance to states to implement full integration of services. A federal fallback would go into effect in states that do not integrate services.

**C. Provide the Medicare-Medicaid Coordination Office with direct funding and full regulatory authority for all programs serving dual eligible individuals—including integrated care models implemented by states and the federal fallback program.** This would require increased staffing and resources.

- D. Provide general waiver authority to the secretary of HHS to align administrative differences between the Medicare and Medicaid programs, excluding issues related to eligibility, benefits, access to care, Medicare freedom-of-choice protections, or beneficiary due process rights.**
- E. Direct the secretary of HHS to adopt best practices from the Financial Alignment Initiative demonstration and apply them to Fully Integrated Dual Eligible Special Needs Plans. The secretary should convene a working group to identify best practices where they have yet to be identified.** The group should be composed of state agency officials, representatives of consumer organizations, private health insurance plans, consumer advocacy and other experts to develop uniform standards in the following areas:
- Care management standards for integrated clinical health services, behavioral health, and LTSS
  - Network adequacy standards appropriate for dual eligible individuals
  - Standard materials for marketing, plan notices, and other member materials
  - A single open enrollment period process
  - A process for joint oversight of plans by CMS and states

## **II. Enrollment and Eligibility**

*To ensure all full-benefit dual eligible individuals are able to enroll in fully integrated plans, Congress should:*

- A. Limit enrollment in fully integrated models to full-benefit dual eligible individuals.**
- B. Allow auto-enrollment into state-implemented, fully integrated care models with a beneficiary opt-out available at any time. Auto-enrollment with beneficiary opt-out should be the default in the federal fallback program.**
- C. Permit and encourage states to implement 12-month, continuous Medicaid eligibility for dual eligible individuals.**

## **III. State-Administered Integration of Care**

*To encourage states to integrate Medicare and Medicaid for dual eligible individuals, Congress should:*

- A. Define and develop fully integrated models for states that choose to integrate care.** States would choose from three models meeting the definition of “full integration” defined above: (1) improved FIDE SNP, (2) PACE, and (3) a flexible model negotiated between the secretary and a state, building off the model used by the State of Washington.

- B. Provide financial and technical assistance to states that fully integrate care.** For those states that notify the secretary of the intent to integrate care as outlined above, the secretary should make available to states adequate resources to develop, implement, and sustain a process for integration of services. States should also receive technical assistance at a level similar to assistance made available as part of demonstrations, building on and expanding the existing Integrated Care Resource Center to help advise individual states.
- C. Provide the secretary of HHS with authority to develop a guaranteed shared savings program for integrated care.**

#### **IV. Federal Fallback Program for States that Do Not Integrate Care**

A federal fallback program is critical to a well-functioning program of Medicare and Medicaid integration. The following section provides a general framework for the fallback, if states are not able or willing to implement an integrated solution. BPC plans to fully explore the critical details of the federal fallback—including eligibility, benefits, consumer protections, reimbursement, contracts and procurement, and numerous other details—as a next step to improve care for dual eligible individuals.

*To ensure all dual eligible individuals have access to fully integrated care models, Congress should:*

- A. Create a federal fallback to be implemented in states that decide not to implement an integrated program.** The federal fallback program could include one or more of the integration models developed for state implementation. PACE organizations would be considered an integrated option; however, the existing state and federal oversight structure would continue.
1. **Eligibility** – Options could include SSI eligibility, state-specific eligibility levels as of the date of enactment or some hybrid.
  2. **Services** – All Medicare and Medicaid-covered benefits offered by an improved FIDE SNP should be offered as a single benefit package that includes medical services, behavioral health services, and long-term services and supports (LTSS). LTSS benefits would be available to eligible individuals meeting the Health Insurance Portability and Accountability Act of 1996 standard of a deficit of two or more activities of daily living (ADLs) or a need for supervision as a result of cognitive impairment.
  3. **Delivery System** – The primary delivery system for the federal fallback should be through a risk-based model, similar to the FIDE SNP. PACE would also qualify as an integrated care model.
  4. **Financing** – Financing for the federal fallback would be existing state and

federal spending for dual eligible individuals. This would be similar to the recoupment, or “clawback,” of funding authorized under Medicare Part D.

- B. Provide authority for the secretary to require Medicare Advantage carriers to offer one fully integrated plan in each service area in which they offer coverage.** States could also request that the secretary exercise this authority as part of state-based integration efforts. This requirement is necessary to ensure an integrated coverage option is available in service areas that otherwise might not have a plan offering.

## **V. Improving Beneficiary Experience**

*To ensure beneficiaries have a seamless experience in integrated care models, Congress should:*

- A. Direct the secretary of HHS to require collaboration between CMS, the Administration for Community Living, and states to implement model standards for outreach and education, and increase funding to the State Health Insurance Assistance Program to expand and improve information and counseling available for dual eligible individuals.**
- B. Provide resources and technical assistance to states for consumer, provider, and plan engagement and education, and encourage states to prioritize partnerships with community-based organizations and local governments.**
- C. Direct the secretary to improve and expand training for insurance brokers to include a training module on fully integrated plans.**

# Introduction

BPC has worked for a number of years to improve integration of services for those who are eligible for Medicare and Medicaid. Earlier this year, BPC released two [white papers](#). The first provided background on key characteristics of dual eligible individuals, the integrated payment and delivery models serving this population, and information on each model's characteristics and performance.<sup>1</sup> The second white paper outlined policy options to better integrate Medicare and Medicaid services for dual eligible individuals.<sup>2</sup>

Since that time, BPC has hosted roundtable discussions and interviewed key stakeholders to obtain feedback on these options. Stakeholder groups included current and former state and federal officials, consumer-based organizations, Medicaid managed care plans offering health benefits and those offering long-term services and supports, health care providers, and other experts. Additional feedback was collected through an online comment process. BPC also commissioned a study (see Appendix I) to examine key considerations for policymakers on integration. The policy recommendations outlined in this report reflect a broad range of stakeholder input.

Common themes heard through these efforts include:

- The current system is too complex and does not serve beneficiaries, states, or the federal government, leading to poor care and wasted resources.
- There is broad support across stakeholder groups for better integration of care.
- The secretary of HHS needs additional administrative authority to achieve greater Medicare and Medicaid integration.
- States are best positioned to implement integration of care, given the complexity of developing networks of providers for long-term services and supports.
- Some states have made significant progress; however, most states need financial and/or technical assistance to fully integrate care.
- Without a forcing mechanism, such as a requirement, integration of Medicare and Medicaid will not happen in all states.
- Availability of integrated care is not sufficient. Dual eligible individuals need support to enroll in integrated programs.

In past reports, BPC defined “integrated care” as the alignment of the financing and administration of Medicare and Medicaid services for dual eligible individuals. At the suggestion of multiple stakeholders, a more comprehensive definition was adopted as part of the recommendations included in this report. Most dual eligible

individuals do not receive integrated care now and have to navigate Medicare and Medicaid as separate programs with different eligibility requirements, benefits, and payers. The goal of integration is to provide a seamless experience for enrollees, which should include a single point of contact, a single set of member materials, and a unified grievances and appeals process.

## **PRINCIPLES BEHIND RECOMMENDATIONS**

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BPC's primary goals in recommending integration are to improve consumer experience, outcomes and well-being, while maintaining eligibility, benefits, and due-process rights for dual eligible individuals. Given the lack of coordination in the current system, BPC believes there is potential for savings over the long-term, primarily in the form of reduced hospitalizations, hospital readmissions, emergency department visits, and post-acute care. However, before those savings can be achieved, there will need to be up-front investments to provide resources to states and to develop infrastructure where it is currently lacking. BPC believes that these investments and other policies can guarantee a simplified, seamless integrated care option by a certain date.

Efforts to better integrate care should take into account the heterogeneity of the dual eligible population and should phase in integration of care for distinct populations in a way that does not interfere with existing provider-patient relationships. These recommendations are designed to improve care for dual eligible individuals, but do not eliminate Medicare freedom of choice. Dual eligible individuals should have comprehensive information to make informed decisions regarding enrollment in a fully integrated care model, and these models should offer experiences that are less complex and costly. Ensuring ample time for community-based education will be critical to help beneficiaries understand the options and benefits available through integrated care, while at the same time making plans, providers, and enrollment brokers aware of the need for integration and the unique cultures and concerns of special populations.

## KEY DATES – INTEGRATION OF MEDICARE AND MEDICAID SERVICES

- 1973** In San Francisco, On Lok Senior Health Services established a senior day health center to provide health and long-term care services.
- 1986** On Lok expanded through federal waivers.
- 1998** Arizona Long Term Care System created.
- 1995** Minnesota Senior Health Options demonstration began.
- 1997** PACE established through the Balanced Budget Act of 1997; start of the Wisconsin Partnership Program.
- 2003** Massachusetts managed-care plan demonstration; temporary authorization for Medicare Advantage plans for beneficiaries with unique needs.
- 2005** Massachusetts Senior Care Options Program becomes operational.
- 2006** First Medicare Advantage Special Needs Plans offered.
- 2010** Creation of the Medicare-Medicaid Coordination Office.
- 2011** The Financial Alignment Initiative demonstration established.
- 2018** Permanent authorization and increased integration requirements for Medicare Advantage Dual Eligible Special Needs Plans. Medicare-Medicaid Coordination Office given regulatory authority over the plans.

# Background

In 2018, there were an estimated 12.2 million people who qualified for both Medicare and Medicaid.<sup>3</sup> Medicare-Medicaid beneficiaries, commonly known as “dual eligible individuals,” include low-income adults of all ages, many with physical or developmental disabilities. While most dual eligible individuals are over age 65, 39% are under age 65.<sup>4</sup> About half of dual eligible individuals first qualify for Medicare based on disability and about half qualify when they turn 65.<sup>5</sup>

Dual eligible individuals generally have poorer health and functional status than those eligible for Medicare only. According to the Medicare-Medicaid Coordination Office (MMCO), 60% of dual eligible individuals have multiple chronic conditions, 41% have at least one mental health diagnosis, and 49% have functional limitations, making them eligible for long-term services and supports (LTSS).<sup>6</sup> The average dual eligible individual receiving full Medicare and Medicaid benefits, also known as full-benefit dual eligible individuals, has six chronic conditions, while Medicare-only beneficiaries average only four.<sup>7</sup> Depression and Alzheimer’s disease or related dementia were among the most prevalent conditions for full-benefit dual eligible individuals.<sup>8</sup> A CMS preliminary data snapshot revealed dual eligible individuals had a much higher infection rate of COVID-19 and likelihood of hospitalization compared to Medicare-only beneficiaries.<sup>9</sup>

Dual eligible individuals are also more likely to have greater limitations in activities of daily living (ADLs), such as bathing and dressing, than non-dual eligible individuals.<sup>10</sup> In 2016, 26% of dual eligible individuals had limitations in one to two ADLs, compared to 18% of non-dual eligible individuals, and 28% had limitations in three to six ADLs, compared to 9% of non-dual eligible individuals.<sup>11</sup> As a result, dual eligible individuals are among the most medically complex individuals and often have wide-ranging health care needs that require additional services and supports.<sup>12</sup>

These additional services and supports are expensive to provide, but only partly explain the relatively high spending on this population. Other significant drivers are care provided in last-resort settings, such as emergency rooms and hospitals, and higher utilization of LTSS in comparison with their peers. Accordingly, the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation has found that dual eligible status was the most powerful predictor of poor Medicare outcomes among social risk factors.<sup>13</sup>

## CHALLENGES AND BENEFITS OF INTEGRATING CARE

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Whether or not full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual eligible beneficiaries will likely depend on the care delivery model and state implementation, but there is potential for improved quality and greater value. An evaluation of the Minnesota Senior Health Options program by RTI International, for example, demonstrated that from 2010 to 2012 the fully integrated program achieved a 48% reduction in inpatient hospitalizations and a 26% reduction in the total number of hospital stays for patients who were hospitalized during the year.<sup>14</sup> In addition, the fully integrated program was successful in reducing emergency department visits and increasing the use of home and community-based LTSS.<sup>15</sup>

While the Minnesota study compares individuals in Medicare Advantage Special Needs Plans fee-for-service, which is not coordinated, with those enrolled in fully integrated plans, other evidence indicates that fully integrated Medicare Advantage Special Needs Plans demonstrate higher quality than non-integrated Special Needs Plans, particularly for individuals with disabilities. In a 2014 report, the Government Accountability Office noted that Fully Integrated Dual Eligible Special Needs Plans were far more likely than other Dual Eligible Special Needs Plans (D-SNPs) to meet criteria for high quality.<sup>16</sup>

In light of these factors, it is unsurprising that policymakers are concerned that 90% of dual eligible individuals receive fragmented care. However, integrating the two programs has proven challenging. There are differences in eligibility, benefits, providers, reimbursement, how the programs are administered and by whom, and a host of other program rules. While both programs may use managed care as a means of payment and delivery, there are significant differences in the way managed care plans are regulated under Medicare and Medicaid.

Medicare Advantage (MA) plans are regulated by CMS under federal rules, and Medicaid managed care plans are state-regulated. MA plans follow the calendar year with benefits starting in January, while Medicaid plans typically follow state fiscal years, the majority of which begin in July. Medicare and Medicaid plans have different network adequacy requirements, grievance and appeals processes, and rules and resources to address social determinants of health and risk factors. Outside federal demonstrations, the secretary does not have the authority to align many of these differences.

A brief overview of the Medicare and Medicaid programs further illustrate the significant differences and challenges associated with integrating services into a single plan. For more detailed information, see the BPC white paper, [“Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update.”](#)

## MEDICARE

Individuals become eligible for Medicare through one of several pathways. The predominant eligibility pathway for Medicare enrollment is age-based eligibility. In 2016, roughly 84% of all Medicare beneficiaries qualified on the basis of being age 65 or older.<sup>17</sup> An additional 15% of beneficiaries are eligible for Medicare coverage on the basis of disability.<sup>18</sup> In 2013, however, for those dually eligible, 46% qualified for Medicare based on age, while 53% qualified because of a disability.<sup>19</sup>

For these Medicare beneficiaries with disabilities, Medicare eligibility is triggered by the individual having received Social Security Disability Income payments for a permanent disability for at least 24 months.<sup>20</sup> Finally, beneficiaries may qualify for Medicare coverage on the basis of having either amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) or end-stage renal disease (ESRD). ESRD and ALS patients are eligible for Medicare irrespective of their age and any disabling conditions and make up 0.8% of the overall Medicare population.<sup>21</sup>

Medicare covers clinical health services such as inpatient hospitalization, professional office visits, outpatient surgical procedures, prescription drugs, and in certain circumstances, home health care, skilled nursing facility care, and rehabilitation and other services.<sup>22</sup> Medicare beneficiaries may remain in traditional Medicare fee-for-service, which includes Medicare Part A and B. Part A covers the cost of inpatient and outpatient hospital services, home health, and skilled nursing care, and has a deductible and copays.<sup>23</sup> Part A is financed through employer and employee payroll taxes.<sup>24</sup> Part B covers professional services, including those of physicians, advance-practice registered nurses, physician assistants, physical and occupational therapists, and other health professional-provided services.<sup>25</sup> Part B has a separate deductible and copays and is financed through beneficiary premiums and federal taxes.<sup>26</sup>

Alternatively, dual eligible individuals may elect to receive their Medicare coverage through Medicare Part C, or Medicare Advantage – this is Medicare's managed care option offered through private insurance companies, inclusive of all Part A and Part B services.<sup>27</sup> Part C is financed through a combination of payroll taxes, beneficiary premiums, and federal taxes.<sup>28</sup> Medicare Part D, similar to Part C, is offered by private managed care plans or pharmacy benefit managers.<sup>29</sup> Those in Medicare fee-for-service may purchase prescription drug coverage through Part D.<sup>30</sup>

## MEDICAID

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As with Medicare, dual eligible beneficiaries qualify for Medicaid coverage through one of several eligibility pathways.<sup>31</sup> Beneficiaries have low incomes, disabling conditions or are eligible to receive cash assistance under the Supplemental Security Income (SSI) program.<sup>32</sup> They may be low-income adults who qualify for Medicaid and age into Medicare, at which point Medicare becomes the primary insurer and Medicaid provides secondary, or wrap-around, coverage.<sup>33</sup> A dual eligible individual may also be an older adult who exhausts their savings, or has monthly medical and LTSS expenses that cause the beneficiary to “spend-down” into Medicaid coverage.<sup>34</sup> In 2013, 35% of dual eligible individuals were eligible for Medicaid based on participation in the SSI program, 38% were eligible based on income, and 9% qualified after spending-down their assets.<sup>35</sup> The remaining 19% became eligible for Medicaid through less common eligibility pathways, such as Section 1115 Waivers.<sup>b, 36</sup>

## FULL-BENEFIT AND PARTIAL-BENEFIT DUAL ELIGIBLE INDIVIDUALS

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States must cover certain mandatory benefits under Medicaid, while other services are optional.<sup>37</sup> For full-benefit dual eligible individuals, who qualify for the full range of Medicaid-covered benefits, Medicaid covers clinical health services not covered by Medicare, as well as non-clinical services, such as targeted case-management services and transportation to medical appointments.<sup>38</sup> Medicaid covers a range of both mandatory and optional LTSS, with coverage varying across states.<sup>39</sup> LTSS services include many services dealing with beneficiaries’ impairments with ADLs, in either an institutional setting for nursing facility residents or via personal-care services and services provided in a beneficiary’s home or in a community setting.<sup>40</sup> Partial-benefit dual eligible individuals receive the full range of Medicare benefits, but are not eligible for medical benefits or LTSS under Medicaid.<sup>41</sup> Instead, Medicaid covers Medicare premiums, deductibles and copays, but that coverage varies based on income. See Figure 1.

## SPENDING

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Given the severity of illness and disabilities, average per-capita Medicare spending on dual eligible individuals is more than twice as high than for Medicare-only beneficiaries.<sup>42</sup> The average Medicare fee-for-service per capita spending for a dual eligible in 2016 was approximately \$18,280.<sup>43</sup> The average Medicare fee-for-service per capita spending for Medicare-only beneficiaries came in significantly lower, at \$8,817 per person.<sup>44</sup> While dual eligible individuals

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<sup>b</sup> Percentages do not sum to 100% due to rounding.

comprise 20% of the Medicare population, they account for 34% of total Medicare expenditures.<sup>45</sup> Similarly, dual eligible individuals comprise only 15% of the Medicaid population, but account for 32% of total Medicaid expenditures.<sup>46</sup>

**Figure 1: Comparing “Partial-Benefit” and “Full-Benefit” Dual Eligible Beneficiaries<sup>47</sup>**

Partial-Benefit Dual Eligible		
Designation	Income and Resource Limits <sup>c</sup>	Benefits
Qualified Medicare Beneficiary (QMB) Program	Income up to 100% federal poverty level (FPL).  Resources cannot be more than three times the SSI resource limit, increased annually by the Consumer Price Index (CPI).	Medicaid pays Part A and Part B premiums.  Medicaid pays Medicare deductibles, coinsurance, and copayments.
Specified Low-Income Medicare Beneficiary (SLMB) Program	Income between 100% and 120% FPL.  Resources cannot be more than three times the SSI resource limit, increased annually based on the CPI.	Medicaid pays Part B premiums.
Qualifying Individual (QI) Program	Income between 120% and 135% FPL.  Resources cannot be more than three times the SSI resource limit, increased annually by the CPI.	Medicaid pays Part B premiums.  There is an annual cap on the amount of money available, which may limit the number of individuals in this group.
Qualified Disabled Working Individual (QDWI) Program	Income up to 200% FPL.  Resources up to two times the SSI resource limit.	Medicaid pays Part A premiums.
Full-Benefit Dual Eligible		
Designation	Income and Resource Limits <sup>d</sup>	Benefits
QMB Plus	Income up to 100% FPL.  Meet the state-determined eligibility and resources criteria for full Medicaid coverage.	Full Medicaid coverage.  Medicaid pays Part A and Part B premiums.  Medicaid pays Medicare deductibles, coinsurance, and copayments.
SLMB Plus	Income between 100% and 120% FPL.  Meet the state-determined eligibility and resources criteria for full Medicaid coverage.	Full Medicaid coverage.  Medicaid pays Part B premiums.
Full-benefit dual eligible (not eligible for the Medicare Savings Program)	States determine income and resources criteria.	Full Medicaid coverage.  Beneficiary pays no more than amount allowed by the State Plan for services covered by both Medicare and Medicaid. For services that Medicare does not cover, Medicaid may cover the service and pay the amount specified in the State Plan.

<sup>c</sup> Additional qualifications may apply for each program.

<sup>d</sup> Additional qualifications may apply for each program.

## INTEGRATED CARE MODELS

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There are a number of delivery and payment models designed to increase the integration of Medicare and Medicaid. These models vary in the degree to which they integrate care, as some models support a higher level of integration than others. States choose which model(s) may operate in their state today. These delivery and payment models range from Medicare Advantage Dual Eligible Special Needs Plans, which offer all Medicare services and may also offer Medicaid-covered services, to the Programs of All-Inclusive Care for the Elderly, a provider-led integration effort that provides medical and social services using adult day care centers. There are advanced versions of D-SNPs known as Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs), which are not required to cover all services under a single plan.<sup>e, 48</sup> This contrasts with a Fully Integrated Dual Eligible Special Needs Plan, which provides virtually all Medicaid services including both LTSS and behavioral health.<sup>f, 49</sup>

The Centers for Medicare & Medicaid Innovation and MMCO, within CMS, have also partnered to allow states to test capitated and managed fee-for-service demonstration models under the FAI demonstration that feature a high level of integration.<sup>50</sup> BPC released a [white paper](#) in April 2020 that describes each of the payment and delivery models for integration in depth.<sup>51</sup>

Evidence demonstrates that individuals in models that integrate Medicare and Medicaid generally experienced decreases in hospitalizations and hospital admissions, as well as greater beneficiary satisfaction.<sup>52</sup> Depending on the specific model, evidence also suggests associated benefits related to improved access to care coordination, better health outcomes, and the potential for cost-savings, among other benefits.<sup>53</sup> As policymakers move forward, experts agree that integrated models must build on lessons learned from the FAI demonstrations.

Despite the availability and benefits of these models that integrate Medicare and Medicaid, many dual eligible individuals are enrolled in separate Medicare and Medicaid managed care plans that do not provide integrated care or

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e A HIDE SNP is a type of D-SNP “offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements: (1) The capitated contract is between the MA organization and the Medicaid agency, or (2) The capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.” 42 C.F.R. § 422.2.

f A FIDE SNP is a type of D-SNP: “(1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State; (2) Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.” 42 C.F.R. § 422.2.

care coordination for all services. As a result, these individuals may receive fragmented care, and incentives for their providers and payers to deliver the best care at the lowest cost can be misaligned.<sup>54</sup> While the number of dual eligible individuals in integrated programs has grown significantly in recent years, a relatively small percentage, roughly 8.25% according to MMCO, are enrolled in programs that fully integrate Medicare and Medicaid.<sup>55</sup> Figure 2 outlines the various types of plans that have some level of integration of Medicare and Medicaid. FIDE SNPs, MMPs, and PACE are considered to be “fully integrated” plans.

**Figure 2: Types of Medicare Plans that Integrate with Medicaid in Some Way**

	D-SNP			MMP	PACE
	Total	Regular	FIDE SNP		
<b>Authorization</b>	Permanent	Permanent	Permanent	Demonstration	Permanent
<b>States where plan is available</b>	43	40	10	9	31
<b>Number of Plans</b>	445	400	45	46	126
<b>Enrollment</b>	2,162,127	1,977,848	184,279	388,098	44,440
<b>Level of integration</b>	Varies widely, generally low	Varies widely, generally low	High	High	High

**Note:** D-SNP (Dual Eligible Special Needs Plan), FIDE SNP (Fully Integrated Dual Eligible Special Needs Plan), MMP (Medicare-Medicaid Plan), PACE (Programs of All-Inclusive Care for the Elderly). The District of Columbia is treated as a state. Figures do not include Puerto Rico. Many states have more than one type of plan. Ten states have tested the use of MMPs, but one state (Virginia) has ended its demonstration. The numbers of regular D-SNPs and FIDE SNPs are based on combinations of contract and plan number; the numbers of MMPs and PACE plans are based on contracts. Enrollment figures are for January 2019. Starting in 2021, regular D-SNPs that have a Medicaid contract to provide long-term services and supports, behavioral health, or both will be classified as highly integrated dual eligible special needs plans (HIDE SNPs). CMS created this category to implement new requirements for D-SNPs that were enacted in the Bipartisan Budget Act of 2018. The number of plans that will qualify as HIDE SNPs is not yet known.

**Source:** MedPAC. Report to Congress: Promoting integration in dual-eligible special needs plans, June 2019, 10.

# Recommendations

## I. FRAMEWORK FOR FULL INTEGRATION OF MEDICARE AND MEDICAID SERVICES

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*To ensure that all full-benefit dual eligible individuals have access to fully integrated care models by a date certain, Congress should:*

### A. Define “full integration” of programs serving dual eligible individuals.

While a number of states have taken steps to better integrate care, many states continue to offer fragmented services by carving out benefits such as behavioral health and long-term services and supports. As a result, in some states, dual eligible individuals remain in Medicare fee-for-service but receive Medicaid benefits through one or more managed care plans. Or, they may have signed up for Medicare Advantage, Medicare’s managed care program, and receive Medicaid services through fee-for-service. Dual eligible individuals can enroll in Medicare and Medicaid managed care plans offered by the **same carrier**, only to find that the two plans operate independently and do not coordinate with each other. While CMS and states have made some progress in integrating care, much of that care is not truly integrated. Dual eligible beneficiaries may experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integration of care will streamline and simplify services and, when done well, will improve health outcomes.

Congress should define full integration of Medicare and Medicaid services, to ensure they are seamless to the beneficiary, by requiring integration to have:

1. Fully aligned financing, with a single entity responsible for Medicare and Medicaid funding in all counties/regions of a state
2. A single set of benefits, including medical benefits, behavioral health, and long-term services and supports
3. A single point of access, which requires a single plan or sponsor offering the full range of benefits with one enrollment period, one set of member materials, one enrollment and identification process, one point of access for all benefits, one point of contact for benefit decisions, and a single grievance and appeals process

4. A process that makes sure beneficiaries are informed of and understand their options and rights within an integrated program, and provides sufficient time to allow them to make decisions regarding enrollment, with strong safeguards to protect beneficiaries
5. Health plan access to claims and encounter data for new enrollees to identify high-risk enrollees and provide prompt assessments, including a standard functional assessment tool, a single primary care provider, and an interdisciplinary care team to develop an individualized person-centered care plan that is designed to meet the unique needs of high-risk enrollees; the care plan should include primary, specialty, acute and post-acute care, and pharmacy services, and should be updated as needed to address beneficiaries' needs as they change over time and across care settings
6. Provider access to integrated information systems and care transitions, to be able to identify high-risk enrollees, to assure timely individual assessments, and to provide smooth care transitions without disruptions in services
7. A single and streamlined set of measures across the two programs, including a set of quality measures and performance evaluations developed for complex populations, to be used for quality improvement and to serve as a basis for quality reporting to help beneficiary decision-making

**B. Require states to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals, either by integrating care themselves, or through a federal fallback program if they decide not to integrate.**

States should integrate services within eight years of enactment, with mutually agreed-upon milestones between states and the secretary.<sup>g</sup> The secretary should develop a process for states to provide notice of intent to fully integrate care, meeting the definition outlined in Part I. The secretary should have the authority to extend the deadline for two additional years. For states that do not agree to implement an integrated solution, the secretary would develop a federal fallback to be operational within five years of enactment. The shorter timeframe is a recognition, that where states do not intend to move forward with integration, the secretary should proceed, rather than waiting eight years.

**Timeline**

In the April 2020 policy options white paper, BPC recommended full integration of care within five years. BPC received comments from states and other experts indicating that it would be difficult for some states to integrate

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<sup>g</sup> Examples of milestones from Ananya Health's data brief are outlined in Appendix I.

care within this timeframe, especially in light of the challenges states face as a result of the COVID-19 pandemic. Experts recommended providing resources to states that choose to fully integrate care, along with agreed-upon milestones demonstrating progress, with a goal of full integration within 10 years. The revised timeline was devised to provide additional time to states if mutually agreed-upon milestones are met. Others raised concerns that, without a federal requirement with a certain date, integration would not occur. BPC adopted this hybrid approach to provide ample time and resources to states that choose to move forward, along with a five-year timeline for a federal program in states that choose not to integrate the programs. See Figure 3.

**Figure 3: Timeline for the full integration of care in states that choose to integrate**

- Year 1** States notify secretary of intent to integrate services
- Year 2** MMCO works with states to develop timeline and milestones for state integration
- Year 5** MMCO implements fallback program that goes into effect for states that do not integrate
- Year 8** States that integrate offer fully integrated plans (states may request two additional years if needed, provided there is demonstrated progress on milestones)

### **C. Provide the Medicare-Medicaid Coordination Office with direct funding and full regulatory authority for all programs serving dual eligible individuals – including integrated solutions implemented by states and the federal fallback program.**

As part of the Bipartisan Budget Act of 2018, Congress directed the secretary of HHS to provide regulatory authority for programs for dual eligible individuals to the MMCO “to the extent feasible.”<sup>56</sup> While CMS has provided additional regulatory authority to the MMCO, not all programs affecting dual eligible individuals were included, e.g. PACE. Lack of staffing and resources requires the MMCO to rely on other offices within CMS for many functions. Without full authority, other offices within CMS can hinder full integration of services. Congress should direct CMS to provide full regulatory authority to the MMCO: for all dual eligible programs, including the improved FIDE SNPs and PACE; to serve as a full partner with states seeking to integrate care; and to implement the federal fallback program. The MMCO should have the authority to issue regulations and guidance for all dual eligible programs. This transfer of authority will require a strong commitment from the secretary of HHS and the CMS

administrator. The MMCO will need increased staffing and direct funding for the office. Until a single agency within CMS has full authority for the regulation of all aspects of programs serving dual eligible individuals, programs serving dual eligible individuals will continue as two separate programs with different interests and priorities.

**D. Provide general waiver authority to the secretary of HHS to align administrative differences between the Medicare and Medicaid programs, excluding issues related to eligibility, benefits, access to care, Medicare freedom-of-choice protractions, or due-process rights.**

Under the FAI demonstrations, CMS was able to use the waiver authority provided to the Center for Medicare & Medicaid Innovation to assure full administrative alignment between programs. As CMS sought to implement the Bipartisan Budget Act of 2018 to align Medicare and Medicaid for FIDE SNPs, the secretary concluded that the agency did not have the authority to replicate Medicare-Medicaid Plan alignment.<sup>57</sup> At the same time, unlimited waiver authority may not adequately protect beneficiaries. Congress should preclude the waiver of any provision that limits eligibility, benefits, access to care, Medicare freedom-of-choice protractions, or due-process rights.

**E. Direct the secretary of HHS to adopt best practices from the Financial Alignment Initiative demonstration and apply them to Fully Integrated Dual Eligible Special Needs Plans. The secretary should convene a working group to identify best practices where they have yet to be identified.**

While the variation permitted under the current regulatory structure distinguishing fully integrated and highly integrated D-SNPs may serve a transitional function, over time the distinction between the two should be eliminated and all states should be required to meet the definition of integration outlined in Part I.

The secretary should convene a working group and implement standards agreed upon by the working group to adopt best practices from the FAI demonstration and apply them to FIDE SNPs. The group should be composed of state agency officials; representatives of consumer organizations; private health insurance plan providers; health care and non-health care providers with experience in serving complex populations, including those who have expertise in identifying and developing programs for consumer advocacy; and other experts to develop uniform standards in the following areas:

- Care management standards for integrated clinical health services, behavioral health, and LTSS, consistent with the home and community-based settings rule for non-elderly persons with disabilities
- Network adequacy standards, including flexible, data-driven standards for Medicaid long-term services and supports, as well as resources needed to address social determinants and risk factors, appropriate for dual eligible individuals
- Standard materials for marketing, plan notices, and other member materials, including templates where appropriate
- A single open enrollment period process
- A process for joint oversight of plans by CMS and states
- Alignment of Medicare and Medicaid measures, including measures of access to care, beneficiary experience, clinical quality, care coordination, person-centeredness, and appropriateness of financial incentives among plans, providers, states, and the federal government<sup>h</sup>
- A model outreach and engagement plan to help inform and educate enrollees and providers on the requirements and benefits of fully integrated care models (see recommendation to improve the enrollee experience below)

In developing standards, the secretary should ensure they are consistent with the current home and community-based services settings rule for non-elderly persons with disabilities. The secretary should also consider the National Quality Forum's work on establishing performance measures for care provided to dual eligible individuals.

## II. ELIGIBILITY AND ENROLLMENT

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*To ensure that all full-benefit dual eligible individuals are able to enroll in fully integrated plans, Congress should:*

### **A. Limit enrollment in fully integrated models to full-benefit dual eligible individuals.**

Full-benefit dual eligible individuals are eligible for the full range of Medicare- and Medicaid-covered services. Partial-benefit dual-eligible individuals are not eligible for Medicaid benefits and only receive assistance with Medicare premiums, copays, and deductibles, based on income. This bifurcation of benefits has prevented the development of uniform materials. Limiting enrollment to full-benefit dual eligible individuals should have little impact on enrollees. The Medicare Payment Advisory Commission found relatively few partial-benefit dual eligible individuals later qualify for full Medicaid benefits,

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<sup>h</sup> Efforts are underway to develop standard quality measures for complex care programs beyond cost and utilization. For more information, see: <https://www.nationalcomplexcare.org/research-policy/resources/publications-reports/measuring-complexity-moving-toward-standardized-quality-measures-for-the-field-of-complex-care/>

and those with partial Medicaid benefits fare equally well in MA plans.<sup>58</sup> States that have implemented FIDE SNPs have recognized this and every state with a FIDE SNP limits enrollment in those plans to full-benefit dual eligible individuals.<sup>59</sup>

**B. Allow auto-enrollment into state-implemented, fully integrated care models with a beneficiary opt-out available at any time. Auto-enrollment with beneficiary opt-out should be the default in the federal fallback program.**

The FAI demonstration states were permitted to implement a system of “passive enrollment” through which dual eligible beneficiaries were auto-enrolled in a managed care plan and permitted to opt out at any time. Surveys of patients enrolled in the FAI indicate high rates of satisfaction with the care they received.<sup>60</sup> Focus groups conducted by the University of California show high satisfaction with the California financial alignment demonstration. On a scale from one to ten, the average satisfaction score for those enrolled in Cal MediConnect was eight, with beneficiaries citing expanded care-coordination services helpful in navigating their managed care plan and determining satisfaction.<sup>61</sup> Individuals who opt-out of the program will remain in Medicare fee-for-service or the MA plan of their choice. For those dual eligible individuals who opt-out, the state would continue to provide Medicaid services.

One benefit of auto-enrollment would be to identify and enroll individuals who are eligible but not enrolled in Medicaid or in the low-income assistance programs. This is especially important in assuring that beneficiaries are not charged for Medicare premiums, copays, and cost sharing, or balance billed when Medicaid does not cover the entire cost-sharing amount. At the same time, both plans and insurance experts have indicated that passive enrollment with a beneficiary opt-out would assure greater plan participation and plan choice in both the state program and federal fallback programs.

**C. Permit and encourage states to implement 12-month, continuous Medicaid eligibility for dual eligible individuals.**

States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP;<sup>62</sup> and evidence demonstrates the policy has been effective.<sup>63</sup> However, states do not have the option of offering continuous enrollment to adults in Medicaid unless they seek a waiver.<sup>64</sup> The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that Congress extend a statutory option for 12 months of continuous eligibility for adults in Medicaid, similar to the state option for children.<sup>65</sup> That recommendation should be implemented to promote continuity of care for dual eligible individuals.

Because of federal requirements related to eligibility redeterminations, almost one-third of new full-benefit dual eligible individuals lose their Medicaid coverage for at least one month within 12 months of initial transition to that status.<sup>66</sup> Within that population, most lost their coverage for three months or longer. The most common reason is the failure to comply with administrative requirements, such as not completing paperwork on time.<sup>67</sup> Transitioning in and out of Medicaid results in disruptions in the continuity of care. Loss of coverage also causes individuals to forgo primary and preventive care that can curb more costly health care utilization and costs to the state associated with disenrolling and re-enrolling individuals.<sup>68</sup>

State and federal policymakers should work to reduce administrative burdens on enrollees and ease stringent eligibility requirements by shortening and simplifying applications, lengthening the time between eligibility redeterminations, especially with this population whose income does not tend to fluctuate from month to month. Policymakers should also consider eliminating or raising asset and income limits to help dual eligible individuals enroll in integrated care models and stay enrolled.

### III. STATE-ADMINISTERED INTEGRATED CARE PROGRAM

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Because states have decades of experience in providing care for vulnerable populations, including the provision of LTSS, BPC supports efforts to encourage states to fully integrate Medicare and Medicaid services for dual eligible individuals.

*To encourage states to integrate Medicare and Medicaid for dual eligible individuals, Congress should:*

#### **A. Define and develop fully integrated models for states that choose to integrate care.**

These recommendations are designed to create strong incentives for states to integrate care. The report identifies three care models from which states can choose to achieve full integration:

1. improved FIDE SNPs that reflect lessons learned from the FAI demonstration's Medicare-Medicaid plans
2. the Program of All-Inclusive Care for the Elderly (PACE)
3. a flexible model negotiated between the secretary and a state, building off the model used by the State of Washington

All models must cover all Medicare and Medicaid benefits and meet all integration requirements identified under Part I, building on best practices of the past 40 years in integrating care for full-benefit dual eligible individuals.

One concern raised by states seeking to integrate care is the need for a clear roadmap to achieve integration. Establishing three models and clearly defining these models in the law would help to address this challenge. Under this approach, states would still have the flexibility to design models that meet individual state needs, including unique geographic challenges. The improved FIDE SNP should include auto-enrollment with a beneficiary opt-out. Individuals who opt-out of the program will remain in Medicare fee-for-service or the MA plan of their choice. For those dual eligible individuals, the state would continue to provide Medicaid services.

**B. Provide financial and technical assistance to states that fully-integrate care. For those states that notify the secretary of the intent to integrate care as outlined above, the secretary should make adequate resources available to each state to develop and implement a model of full integration.**

There is a clear recognition that states will require both financial and technical assistance to achieve full integration of Medicare and Medicaid services. For example, when the State of Massachusetts implemented integrated care for their under-65 dual eligible population, the mental health needs of the newly-enrolled populations exceeded the state's capacity to provide services. As a result, the state had to invest to bring more outpatient mental health centers online.

Some commenters to BPC's options paper noted the usefulness of contract management teams utilized in the FAI. These teams created an opportunity for states and MMCO staff to work together, allowing for a more fluid, coordinated response to issues that arose during the demonstration. States and CMS should be encouraged to continue these partnerships as additional states move forward.

Integration also requires resources to hire staff and absorb additional legal costs associated with aligning the programs, revising contracts and plan materials, and other costs associated with rolling out a new program.<sup>i</sup> Policy options that create a pathway to full integration could support states in these efforts by providing technical assistance with additional funding to support states in achieving full integration.

In their June 2020 report, MACPAC recommended additional federal funding to train state staff in Medicare and to cover up-front costs of designing and implementing new models.<sup>69</sup>

For those states that notify the secretary of the intent to integrate care as outlined above, the secretary should make adequate resources available to

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<sup>i</sup> See Actions at the Federal Level to Support States Seeking to Achieve Integration in the data brief in Appendix I.

<sup>j</sup> See Conduct Environmental Scan and Assessment of State Environment in Figure 7 in Appendix I.

states until expended to develop and implement a process for integration of services. To be eligible, states would be required to appoint a single individual responsible for care integration and would have to demonstrate state and community-level support for integrating services.<sup>1</sup>

### **C. Provide the secretary of HHS with authority to develop a guaranteed shared savings program for integrated care.**

One issue frequently mentioned by states is the lack of financial incentives to integrate care. In many cases, integration requires increased state spending under Medicaid and to the extent that savings are achieved, they arise from reduced utilization of emergency departments or inpatient hospitalization. These savings accrue to the Medicare program and go to the federal government. For example, research has demonstrated that investments in Medicaid home and community-based services can reduce hospital readmissions and emergency department visits. Absent a mechanism for sharing the Medicare savings and program investments, such as those built into the FAI demonstrations,<sup>70</sup> states are reluctant to move forward with integration.

While the FAI demonstration permitted states to share in some of the Medicare savings, shared savings aren't permitted at all outside of the demonstration. In developing each of these models, the secretary should assure that states have the ability to share in a portion of the Medicare savings associated with the alignment of programs and that those savings be guaranteed, meaning that rates to FIDE SNPs, PACE, or under an alternative model be set in such a way that incorporates reductions in the total cost of care on a per capita basis.

While BPC does not recommend a specific model at this time, Congress could consider an approach similar to that which is used in the FAI. For example, CMS could develop a benchmark payment to improved FIDE SNPs that includes: 1) the state's per capita Medicaid costs for a dual eligible individual, and 2) the MA county-level, risk-adjusted benchmark. While savings are not guaranteed, and attributing savings is complex, this combined benchmark could be reduced by 1-2% in the first year and indexed by the overall growth in national expenditures for dual eligible individuals going forward. To the extent that savings are achieved, total savings should be shared between the federal government and the states (Figure 4). At a minimum, states should be able to share in 33% of total savings.

**Figure 4: Hypothetical Guaranteed Savings Example**

**Example of a Guaranteed Savings Benchmark Calculation**

**Year 1:** Medicare-Medicaid benchmark representing 1-2% savings from prior year total FFS spending for dual eligible individuals in the state

**Years 2-5:** Year 1 calculation indexed to the overall growth in national dual eligible spending

**Guaranteed Savings Benchmark and Distributed Savings (Year 1)**

1. Per capita spending on dual eligible individuals (2012)

Medicare:	\$17,847
Medicaid:	\$12,772
<b>Total:</b>	<b>\$30,619</b>

2. Calculating Benchmark and Savings

Assuming a 2% reduction in the combined benchmark, in Year 1 an improved FIDE SNP would receive \$30,006.62 for each dual eligible enrolled, resulting in a guaranteed per capita savings of **\$613**, excluding additional savings achieved.

3. Distribution of \$613 in Savings

Entity	Share of Savings	Savings
Federal Government	67%	\$410.71
State	33%	\$202.29

**Note:** This example is used solely for the purposes of illustrating how a shared savings program could work. BPC does not suggest these will be actual savings.

**IV. FEDERAL FALLBACK PROGRAM  
FOR STATES THAT DO NOT  
INTEGRATE CARE**

A federal fallback program is critical to a well-functioning program of Medicare and Medicaid integration. The following section provides a general framework for a fallback (see Figure 5), which experts agreed is necessary to encourage and incentivize states to move forward with their own integration plans. BPC plans to fully explore the critical details of the federal fallback—including eligibility, benefits, consumer protections, reimbursement, contracts and procurement, and numerous other details—as a next step in our efforts to improve care for dual eligible individuals.

*To ensure all dual eligible individuals have access to fully integrated care models, Congress should:*

## A. Create a federal fallback to be implemented in states that decide not to implement an integrated program.

The federal fallback program could include:

1. **Eligibility** – Options include SSI eligibility, state-specific levels as of the date of enactment or some hybrid.
2. **Services** – All Medicare and Medicaid-covered benefits offered by an improved FIDE SNP should be benefits offered as a single benefit package that includes medical services, behavioral health services, and LTSS. In defining LTSS, the secretary could define benefits based on those services most frequently offered under FAI MMPs. The LTSS benefits would be available to eligible individuals meeting the Health Insurance Portability and Accountability Act of 1996 standard of a deficit of two or more ADLs or need for supervision as a result of cognitive impairment.
3. **Delivery System** – The primary delivery system for the federal fallback should be through an improved FIDE SNP. PACE organizations would be considered an integrated option, i.e. dual eligible individuals can be auto-enrolled into this option, but the federal government will not oversee PACE organizations.
4. **Financing** – Financing for the federal fallback would be through existing state and federal spending for dual eligible individuals. In determining the state share, the secretary should calculate state-specific per capita rates based on state spending for dual eligible individuals as of the date of enactment. For any individual who is auto-enrolled in a Medicare-Medicaid plan the secretary would recoup the state's share of the per capita amount from payments that would otherwise have been made to the states for this population. This should be similar to the recoupment of funding authorized for prescription drugs when Medicare Part D was established.<sup>k</sup>

## B. Provide authority for the secretary to require Medicare Advantage carriers to offer one fully integrated plan in each service area in which they offer coverage.

States could also request that the secretary exercise this authority as part of state-based integration. This policy is designed to address concerns that not all counties will have integrated plan offerings.

BPC's April 2020 white paper included a policy option to require all MA carriers to offer one fully integrated plan in each service area in which they

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<sup>k</sup> In 2012, the federal government financed approximately 81.84% of the cost of care for full-benefit dual eligible individuals when taking into account combined spending on Medicare and Medicaid services for this population.

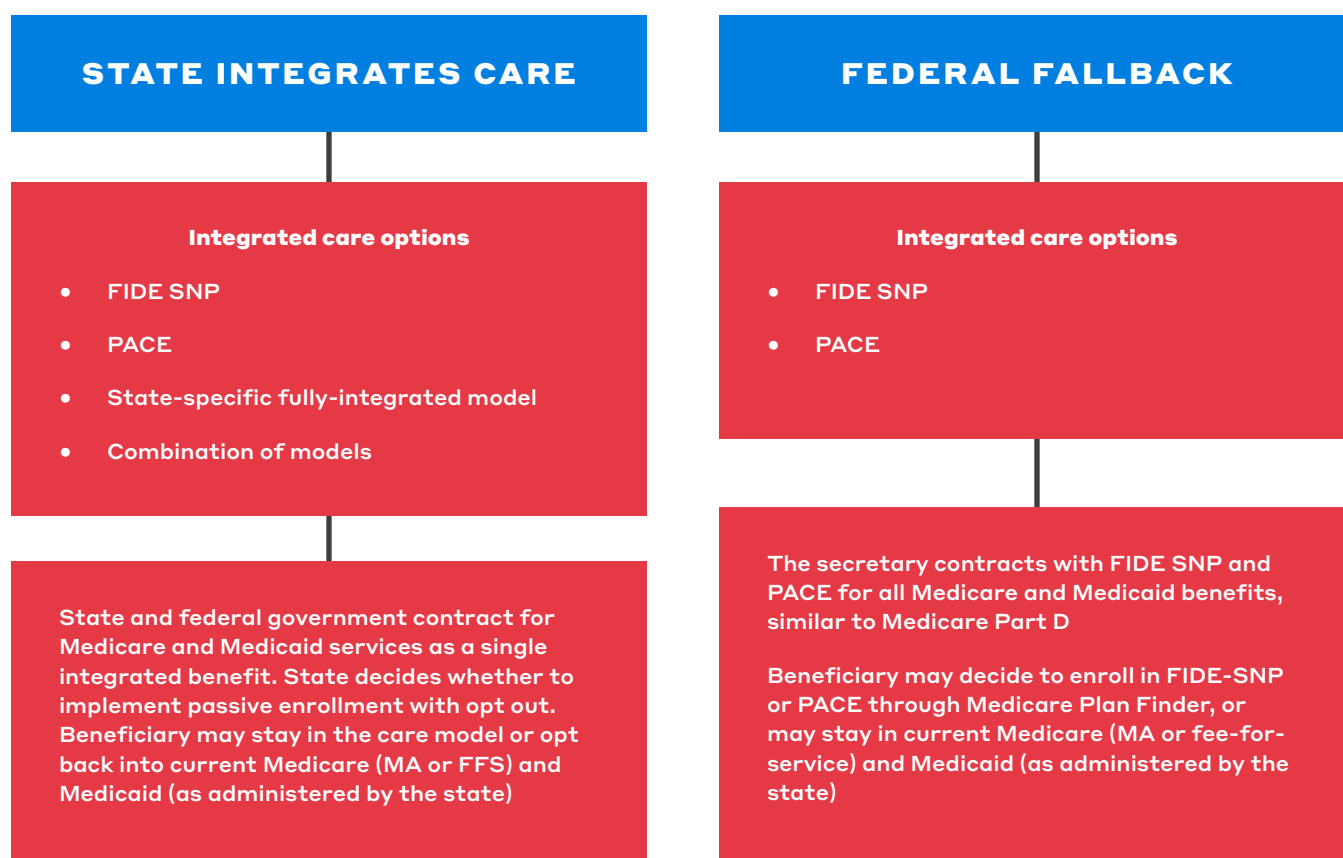
Reflecting the variation in state FMAP, in 2012, the federal share ranged from a high of 91.93% to a low of 67.51%. For more information see Appendix III.

offer a MA plan. This was proposed as a means of assuring that dual eligible individuals have enrollment options. While there was some support for this option as a means of assuring choice and access to care for dual eligible individuals, others raised concerns in the following areas:

- Not all insurance carriers have a commitment to focusing on high-risk vulnerable populations, and carriers without expertise or commitment to become experts should not be required to participate.
- The viability of plan offerings is dependent on having adequate market share and requiring plans to offer in all areas could limit plan viability, and in some cases, could cause carriers to withdraw their MA plan in a service area.
- Some also expressed concern that states should have the ability to decide the number of plans offered in the state.

To address these concerns, BPC has limited the requirement to those states that choose not to integrate care, leaving this decision to states. Rather than requiring all MA plans to offer one integrated plan, BPC suggests giving the secretary the authority to require plan offerings, if the secretary deems it necessary to assure access to integrated plans.

**Figure 5: Comparison of Integration Options in States that Integrate vs. the Federal Fallback**



## V. IMPROVE THE BENEFICIARY EXPERIENCE

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*To ensure beneficiaries have a seamless experience in integrated care models, Congress should:*

**A. Direct the secretary of HHS to require collaboration between CMS, the Administration for Community Living, and states to implement model standards for outreach and education, and increase funding to the State Health Insurance Assistance Program to expand and improve information and counseling available for dual eligible individuals.**

A fundamental goal of integrating care for dual eligible individuals is to eliminate the administrative complexities of accessing needed care and improving overall health and well-being. The federal government, through the State Health Insurance Assistance Programs (SHIP), assists Medicare-eligible individuals in better understanding coverage options, Medicare premiums, and cost-sharing, and assists beneficiaries in applying for Medicaid.<sup>71</sup> The ACL, within HHS, administers SHIP program grants to provide funding for free local health coverage counseling and assistance for Medicare-eligible individuals and their families.

While the complexity of coverage options for dual eligible individuals has grown with the addition of new coverage options, budget proposals for FY 2021 propose reducing funding for SHIP by \$16 million.<sup>72</sup> Funding for this program should be increased, not reduced, to better assist dual eligible individuals in understanding the potential benefits and drawbacks of enrollment in a fully integrated care model.

Experts also suggested that increased funding be used to help improve counseling services by providing better education and training. As part of the collaboration between agencies, CMS should revise the Medicare Plan Finder to address the unique challenges associated with making information available to dual eligible beneficiaries. Development and maintenance of web-based decision support and enrollment tools should be a priority, as well as integrated, person-centered systems designed to inform older individuals and people with disabilities about the full range of benefits for which they are eligible. CMS and ACL can draw from existing tools to address this need,<sup>73</sup> e.g., California's [MyCareMyChoice](#).

## **B. Provide resources and technical assistance to states for consumer, provider, and plan engagement and education, and encourage states to prioritize partnerships with community-based organizations and local governments.**

States play a significant role in beneficiary outreach and education. A major challenge to enrollment in fully integrated programs has been the lack of education for consumers and health care providers. In the initial FAI states, dual eligible individuals were enrolled in integrated health plans with little understanding of the program or the plans in which they were enrolled.<sup>74</sup> At the same time, health care providers who did not want to participate in the plans encouraged their patients to disenroll. Because dual eligible individuals are permitted to disenroll at any time—an important beneficiary safeguard—the result was a significant drop in enrollment.<sup>75</sup>

Since the early days of FAI implementation, states have begun to invest in the education of consumers and providers. However, states with limited resources have been less able to do this. The Assistant Secretary for Planning and Evaluation has encouraged states to take a more active role in educating dual eligible individuals on the benefits of enrolling in integrated programs, and the results have been positive.<sup>76</sup> However, states need resources to support these activities. Solutions could include an ombudsman program, as well as special employment initiatives to encourage plans to hire consumers to provide insight on beneficiary concerns and ways to address those concerns.<sup>1</sup> For example, ongoing beneficiary education in Arizona “has made beneficiaries more aware of the advantages of being in aligned plans for their Medicaid and Medicare benefits.”<sup>77</sup>

## **C. Direct the secretary to improve and expand training for insurance brokers to include a training module on fully integrated plans.**

A recurring theme in stakeholder comments was the concern about insurance brokers potentially causing confusion for dual eligible individuals. There seemed to be a consensus that if brokers were more knowledgeable about fully integrated plans and the needs of dual eligible individuals, then plans and beneficiaries would be better served. CMS sets requirements for training of insurance brokers authorized to enroll beneficiaries in MA plans. CMS should expand training to include education on fully integrated plans and dual eligible individuals.

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<sup>1</sup> See Lessons Learned and Critical Success Factors in the data brief in Appendix I.

# Conclusion

Over the last decade, stakeholders, state and federal policymakers, and other organizations have worked to improve the complex challenges associated with improving care for those who rely on Medicare and Medicaid to address their health and long-term care needs. BPC is one of a small but growing group of organizations and government agencies seeking to accelerate integration of care for dual eligible individuals. BPC does not hold a monopoly on good ideas and recognizes there are many paths forward. BPC welcomes the opportunity to work with policymakers and other organizations to identify viable solutions to improve care and lower costs for a vulnerable and high-cost population.

# Appendix I

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## Achieving Medicare-Medicaid Integration for Dual Eligible Populations – Considerations for Policymakers, provided by Ananya Health

### INTRODUCTION

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Dual eligible beneficiaries are individuals who qualify for Medicare and Medicaid based on their income, age, or disability status. In 2019, there were approximately 12 million dual eligible beneficiaries enrolled in Medicare and Medicaid programs who received either full or partial benefits.<sup>78</sup> According to the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2019 Report to Congress, nearly 70% of dual eligible individuals were diagnosed with three or more chronic conditions, over a third of this population reported a disability, and approximately 40% had also been diagnosed with at least one mental illness.<sup>79</sup> MedPAC found that in 2016, 19% of the Medicare fee-for-service (FFS) population was dual eligible but accounted for 33% of the total Medicare FFS spending.<sup>80</sup> The average total spending for dual eligible beneficiaries in 2016 was \$28,970 compared to \$15,079 for non-dual eligible beneficiaries, with higher costs driven by increased use of the different services covered by Medicare.<sup>81</sup> Disparities in accessing medical care are also prevalent, with dual eligible individuals with at least one disability reporting an inability to access needed care at higher rates than those without a disability.<sup>82</sup>

The complexity of the medical and psychosocial needs of the dual eligible population, combined with varying and arcane rules for coverage, payment, and other policies under Medicare and Medicaid, present significant challenges for the coordinated and seamless delivery of medical, behavioral, and other long-term services and supports (LTSS) for this population. To address these challenges and to better integrate care for the dual eligible population, the federal government and several states have embarked on a variety of efforts to promote integrated models of care, achieve improved health outcomes, patient experience and access, and optimize costs of care. Twenty-two states have implemented programs to integrate care for the dual eligible population through participation in the financial alignment initiative (FAI), use of Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), the Program for All-Inclusive Care for the Elderly (PACE), or a combination of these approaches.<sup>83</sup> Despite these efforts, only one million out of the 12 million dual eligible beneficiaries were enrolled in integrated programs in 2019.<sup>84</sup> Therefore,

there is tremendous opportunity to design and implement integrated models that benefit this population while also optimizing federal and state spending.

The Bipartisan Policy Center (BPC) has worked for a number of years on policies to promote better integration of Medicare and Medicaid services for dual eligible individuals. The BPC sought to develop and advance a set of policy recommendations to accelerate adoption of integration models for dual eligible beneficiaries. To help refine BPC's policy options, Ananya Health conducted additional research to address the following key questions:

1. How is integration defined or characterized for dual eligible beneficiaries?
2. What does the scope of integration include?
3. What are lessons learned and ongoing challenges to achieving full integration efforts under the FAI?
4. What approaches can states take relative to achieving integration?
5. What are milestones that can measure states' progress towards achieving integration?
6. What efforts should states undertake to ensure readiness to implement an integrated model of care for dual eligible beneficiaries?
7. What types of federal support do states need to successfully design and implement models of integration?

In this issue brief, Ananya Health summarizes the findings and analysis from research that was focused on addressing the key questions listed above. Ananya Health's findings and analysis are based on a targeted environmental scan and fourteen interviews with a convenience sample of individual experts and organizations including government agencies, academics, former state Medicaid Directors and other regulators who led integration efforts, consumer advocacy groups, trade associations, and health plans. For a description of methodology, please see Appendix II.

## FINDINGS AND ANALYSIS

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**Objectives of Integration Models for Dual Eligible Beneficiaries** – Although approaches taken by state and federal policy makers to integrate care for dual eligible beneficiaries vary, Ananya Health observed some commonalities in the main objectives of the integration models for dual eligible beneficiaries. These objectives can be categorized by stakeholder type and are listed below:

### **For the Beneficiary**

- Improve beneficiary experience
  - Create a person-centered care model to coordinate supports and services that links to all aspects of delivery system
  - Promote program simplicity and streamline administrative processes
- Improve health and health status, outcomes, and well-being
- Promote independent living and transition from institutional to community settings
- Access to appropriate care: right care, right setting, right time
- Meet health and functional needs
- Minimize health disparities

### **For the provider**

- Reduce provider burden
- Streamline administrative processes

### **For state and federal policymakers**

- Generate budget savings
- Reduce cost shifting between Medicare and Medicaid
- Reduce health disparities

### **For the health plan**

- Reduce burden and streamline requirements
- Provide flexibility to enable plans to transform care delivery in partnership with providers

## **Defining or Characterizing Integration**

In advancing policies that promote integration models for dual eligible beneficiaries, it is important to ensure a shared understanding of how integration is defined or characterized. Based on the targeted environmental scan and interviews with experts, key themes emerged relative to defining or characterizing integration.

Integration is **defined** as the achievement of a seamless, culturally and linguistically sensitive experience for the dual eligible beneficiary, who receives the full range of needed and meaningfully coordinated medical, behavioral, LTSS and other services that address the social determinants of health (SDOH).

To achieve this ideal state requires the following three components:

- Benefits and care integration
- Financial integration
- Administrative integration

**Benefits and care integration** – Benefits and care integration refers to the seamless management of Medicare and Medicaid benefits and delivery of coordinated care that is holistic, person-centered, and addresses specific individual needs. Optimal management of benefits and delivery of covered services is based on comprehensive assessment of physical, behavioral, functional health, and LTSS needs of beneficiaries and the development of individualized care plans. Benefits and care integration also require strong links to, and involvement of, primary care clinicians (e.g. physicians, advanced practice nurses), and to community and other supports to address the social determinants of health.<sup>m</sup>

**Financial integration** – Financial integration refers to the ability (of the accountable entity managing dual eligible beneficiaries) to combine and freely deploy the Medicare and Medicaid dollars to deliver the appropriate mix of Medicare and Medicaid covered services to meet individual needs. The ability to use Medicare dollars to cover Medicaid services and vice versa is a key aspect of financial integration. Such integration was viewed by the interviewees as important to effective integration of benefits and care delivery.

**Administrative integration** – Administrative integration refers to the establishment of streamlined and unified processes, procedures, and policies across state and Medicare to minimize burden on all stakeholders and ensure a seamless experience for the beneficiary. From a beneficiary perspective, examples of administrative functions that are typically integrated include beneficiary enrollment, beneficiary materials, single identification card, appeals and grievances, and streamlined marketing. Other aspects of administrative alignment can include harmonized network adequacy and care management standards and use of aligned quality or performance measures across Medicare and Medicaid that are focused on streamlining requirements of providers and plans.

Experts we interviewed generally agreed that achieving true integration will require implementation of all three components described above but noted that achieving such an ideal state may need to occur over time and use a phased approach. Ways to phase integration could include focus on specific subpopulations, specific regions within the state, or subsets of Medicaid benefits. Additionally, integration focused on one component

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<sup>m</sup> Social determinants of health refer to availability/accessibility of services such as food, housing, non-medical transportation etc., that can impact the health and well-being of individuals.

may not necessarily lead to integration of the other two components. For example, states' experience has shown that integrating the financing streams of different medical and LTSS programs did not lead to benefits and care integration. The latter was viewed as critical to ensuring unhindered access for beneficiaries and improving health outcomes.

## Integration Mechanisms

States have a variety of mechanisms to pursue integration, and the choice of mechanism also impacts the level of integration that can be achieved. Available mechanisms fall along a continuum in terms of their ability to achieve full integration and include use of state administrative processes, managed FFS, aligned D-SNPs, Highly Integrated Dual Eligible -Special Needs Plan, Fully Integrated Dual Eligible-Special Needs Plan, Medicare Medicaid Plans, or PACE. Below, we discuss some of these mechanisms, the pros and cons of each approach, and the level of integration that can be achieved relative to the definition above.

**Use of state administrative processes to advance integration** – Although this approach does not result in the full integration defined above, it can potentially lead to limited but meaningful advances in a beneficiary's timely access to Medicare and Medicaid services while minimizing confusion and burden to providers and suppliers. These administrative changes can also prepare states for success as they move along the continuum to a full integration model. Such changes pertain to policies such as authorization of durable medical equipment prior to Medicare denial, executing a Part A buy-in agreement for qualified Medicare beneficiaries, increased frequency of sharing MMA and Medicare buy-in data files with CMS, and harmonizing Medicare Savings Program's asset disregard and CMS low income subsidy policies. All of these changes are expected to increase timely access to needed services for beneficiaries and reduce administrative burden on all stakeholders.<sup>85</sup>

**D-SNPs** – The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 included specific provisions—subsequently amended by the Affordable Care Act (ACA)—that require D-SNPs to contract with Medicaid agencies of the states in which they operate. In addition, MIPAA specifies eight minimum requirements for state D-SNP contracts.<sup>86</sup>

States have flexibility in how to structure their contracts with D-SNPs and can certainly choose to include provisions that extend beyond the minimum MIPAA requirements. Arizona, Minnesota, Massachusetts, Hawaii, Texas, Tennessee, and Wisconsin are examples of states that have implemented several contract provisions in their D-SNP contracts that go beyond the minimum requirements. These include requiring:

- MLTSS plan to offer a companion D-SNP or, by including into their MLTSS contracts D-SNP requirements;
- Coordination of all healthcare services and, in some states like Tennessee, coordination of all Medicare and Medicaid services for full benefit dual eligible beneficiaries including those services that are not part of the D-SNP benefits package;
- Submission (to states) of marketing materials for review to help streamline communications to beneficiaries; and
- Sharing of MA encounter and Part D drug event, MA quality performance, and appeals and grievances data.<sup>87</sup>

Finally, several provisions in the 2018 Bipartisan Budget Act (BBA 2018) help advance integration, including permanent authorization of D-SNPs, greater authority for the Medicare-Medicaid Coordination Office (MMCO), integration requirements for plans to either provide notice of hospital or skilled nursing facility admissions to ensure better coordinated care during care transitions or be designated FIDE SNPs or HIDE SNPs, and unified appeals and grievances processes for beneficiaries.<sup>88</sup> In addition, the BBA 2018 requires a coordinated appeals and grievances process for all D-SNPs and uniform appeals and grievances processes for FIDE and HIDE SNPs. Of the various ways in which states can use D-SNPs to promote integration, the most promising are the use of FIDE SNPs or HIDE SNPs because they can help advance integration as defined earlier.

For states that have historical experience with Medicaid managed care or managed LTSS (MLTSS) programs, D-SNPs can be a viable pathway for achieving integration. Using D-SNPs also allows the states to leverage existing regulatory authority granted by MIPAA, the ACA, and the BBA 2018 to design and implement integration models. By instituting contract provisions with D-SNPs, states have an opportunity to tailor the integration model based on the needs of their population, including achieving better care coordination across all relevant services, and implementing individualized care plans that meet the needs of the beneficiaries. Competition among D-SNPs can result in meaningful innovations in implementation of integrated models.

However, this option may not be suitable for all states, or all areas within a state, especially ones that do not have high rates of managed care penetration.<sup>89</sup> Specifying contract provisions that truly lead to integration beyond the minimum MIPAA requirements requires states to have dedicated staff resources focused on the dual eligible population combined with deep expertise in Medicare. Such staffing resources are scarce across most states and they may not have financial resources to augment their staffing capabilities. Also, depending on the scope of integration, beneficiaries may still need to navigate two systems, and the plans may need to comply with two sets of regulatory requirements. Since the funding streams are not integrated in

this model, there is less flexibility regarding deployment of benefits and services. Similar to other models of integration, with the exception of the FAI demonstration, states do not share in any savings generated by reductions in use of Medicare covered services. Finally, achieving true on-the-ground integration will depend on how siloed internal plan functions are under a single parent organization. Even if the D-SNP and Medicaid managed care organization are under the same parent organization, they may not necessarily have unified systems, staff, and other resources to deliver a coordinated experience for the beneficiary.

**PACE** – Similar to MMPs discussed below, this program integrates care and financing for dual eligible beneficiaries and involves a three-way contract between CMS, the state, and the PACE entity thereby helping streamline requirements. PACE helps achieve the concept of full integration as defined earlier. In addition, experts noted that given their size, PACE organizations may be better positioned to pivot more quickly and respond to changing situations compared with large managed care plans. For example, one interviewee noted PACE organizations rapidly deploying telehealth and virtual care models in response to the COVID-19 pandemic. The PACE model suffers from certain disadvantages including: restrictions on eligibility that limit access to certain populations, institutional focus for care delivery at the PACE center that may not be attractive to all dual eligible beneficiaries who qualify for PACE, and limits on the ability to scale such an intensive care delivery model state wide. Additionally, under the PACE program, states do not have the ability to share in any Medicare savings resulting from integration and state investments to foster such integration.

**MMP** – MMPs are unique to the financial alignment initiative (FAI) demonstration and have been the chosen approach for all states that participated in the FAI except Washington and Colorado.<sup>n</sup> Similar to PACE, MMPs have the potential to achieve full integration across the three components described earlier and, similar to D-SNPs, competition among MMPs can result in innovations. MMPs allow for meaningful benefit flexibility, as the combined Medicare and Medicaid dollars can be allocated to different covered services based on the unique needs of the beneficiary; they can also offer supplemental benefits, such as dental, vision, non-medical transportation, health and wellness, etc.<sup>90</sup> One MMP reported rapidly changing their model of care and rules for covered services in response to the COVID-19 pandemic. Changes included extensive wellness checks over the telephone with their members, completion of health risk assessments over the telephone, deploying SWAT teams to conduct home visits to individuals in greatest need, changing the transportation rules to allow someone other than the member to avail of this benefit for grocery shopping or have the personal care assistant

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<sup>n</sup> Minnesota is another exception due to the fact that the scope of their pilot was limited to administrative alignment or integration.

shop for groceries, and helping address SDOH. Finally, MMPs offer states the opportunity to share in Medicare savings, unlike any of the other approaches to integration. However, the structure of the savings as a withhold in capitated MMPs essentially reduces capitated rates and is not viewed as compelling by state legislatures. MMPs, however, may not be the best option, especially for states that do not yet have robust experience with managed care because of the complexity in designing and implementing this model. Additionally, MMPs are temporary and limited to the FAI, and the only way for states to adopt this mechanism is by participation in the demonstration.

**Managed FFS** – In this model states can use either Medicaid health homes, the managed FFS demonstration under the FAI, or primary care case management to achieve integration. The model is built on assigning accountability to a single entity, e.g. a health home, to coordinate medical, behavioral, and LTSS services while relying on the underlying organization of care delivery.<sup>91</sup>

Under the FAI, Washington and Colorado were the only two states that pursued the managed FFS approach, although Colorado ended its demonstration in 2017.<sup>92</sup> In Washington, health homes serve as the entity that is responsible for integration of medical, behavioral and LTSS services for beneficiaries.<sup>93</sup> In contrast to the MMPs, implementation of the managed FFS model is simpler for both states and CMS because all the steps needed in MMP implementation, such as rate setting, contracting, network readiness etc. are not needed in managed FFS. This model also leads to the least amount of beneficiary and provider disruption because existing care delivery networks and relationships are maintained including with community-based organizations. The relative simplicity does, however, have drawbacks in the form of less benefit flexibility and inability to offer meaningful supplemental benefits, including vision, dental, non-medical transportation, and food delivery especially during a pandemic. It also represents an incremental step in integration compared with use of D-SNPs or MMPs. Unlike D-SNPs or MMPs, the managed FFS model also requires significant upfront investment by the state with no guarantee of future returns, which might have discouraged other states from choosing this option. Finally, it is unclear if the model adopted by Washington can be replicated in other states because they built on an existing Medicaid health home program and focused integration on high-needs dual eligible beneficiaries.<sup>94</sup>

## Population and Services in Integrated Models – Inclusions and Exclusions

Irrespective of the integration mechanisms implemented, we found that states choose to carve out certain populations or specific services. Experts agreed that most state efforts typically integrate medical, pharmacy, and LTSS services, with variability across states in integration of behavioral health services. Even if behavioral health services are integrated, there may be carve-outs for services

provided to patients with serious mental illness. In addition to service carve-outs, states also impose eligibility criteria that exclude certain populations. More commonly occurring criteria for eligibility involve restricting program enrollment to full-benefit dual eligible beneficiaries and excluding certain demographics, such as those under age 18 and those with intellectual and developmental disability (I/DD), from integration efforts.

Given the FAI demonstration's emphasis on achieving full integration we examined the models implemented in this demonstration to understand the types of inclusions and exclusions that were adopted. Under the FAI eligibility was limited to full-benefit dual eligible beneficiaries across all participating states. In addition, most states excluded individuals under age 21, and also those with other forms of creditable coverage. In addition, we found that, even in the case of MMPs, states either excluded specific services or specific populations. A sample of some of the types of exclusions for a subset of the FAI demonstration states is shown below in Figure 6.

**Figure 6: Select Inclusion/Exclusion Criteria Under the FAI**

State	Select exclusions <sup>95</sup>
California	Specialty mental health and substance abuse services; beneficiaries receiving services through California's regional centers or state developmental centers or intermediate care facilities for the developmentally disabled; some 1915(c) waiver services. <sup>96</sup>
Illinois	Developmentally disabled (DD) population receiving institutional services or participating in home and community-based services (HCBS) waivers for adults with DD. <sup>97</sup>
Massachusetts	Care management and rehabilitation option services for serious and persistent mental illness (SPMI); individuals enrolled in 1915(c) HCBS waivers and individuals with intellectual disabilities living in intermediate care facilities. <sup>98</sup>
Michigan	Residents of state psychiatric hospitals; hospice; MMPs contract with existing prepaid plans for behavioral health, substance use disorder and/or intellectual/developmental disabilities services. <sup>99, 100</sup>
New York FIDA	Residents of certain psychiatric facilities; some 1915(c) HCBS waiver individuals; DD population. <sup>101</sup>
Ohio	Individuals with intellectual and developmental disabilities (IDD) who are served through an IDD 1915(c) HCBS waiver or intermediate care facilities for individuals with IDD (ICF-IDD). <sup>102</sup>
South Carolina	DD population/services; certain HCBS waivers; residents of certain institutions. <sup>103, 104</sup>
Texas	DD population/services. <sup>105</sup>
Colorado	Individuals who are residents of an Intermediate Care Facility for individuals with intellectual disabilities (ICF/ID). <sup>106</sup>
Washington	HCBS waiver services for DD; DD population. <sup>107</sup>
Virginia	Residents of certain mental hospitals, intermediate care facilities, DD population/services and certain other waiver populations. <sup>108, 109</sup>

There are a variety of reasons states choose, at least initially, to exclude certain services and populations from their integration efforts, such as:

- Strong preferences from the relevant stakeholder community for the status quo and their level of comfort, familiarity and trust associated with their providers.
- Structure and organization of state specific waivers and therefore an easier path to focus on some populations compared with others. For example, in Virginia the I/DD waiver needed to be reformed before bringing the coverage of acute care services for this population under managed care.
- State capacity to deal with the complexity of integrating a broad range of services and therefore the need to use a phased approach to integrating different services and populations.
- Availability and willingness of providers to participate in integrated models based on insufficient experience or fear of working with managed care plans.
- Level of alignment within the state, e.g. if state agencies managing disability services, Medicaid, behavioral health, and mental health services are separate instead of unified under a single organizational structure, carve-outs can ensue.
- Level of penetration of managed care also affects the scope of integration and could restrict implementation to certain regions of a state.
- Need to focus high-touch interventions on high-risk populations and demonstrate return on investment.
- Unique services, such as employment related supports for individuals with developmental disability, that may not lend themselves to traditional medical style management.
- Comprehensive waivers for individuals with developmental disability in certain states like California are widely supported, therefore engendering lack of interest in moving these services into managed care.
- Unique issues with inclusion of individuals with I/DD, such as general exclusion from managed LTSS, lack of strong relationships between managed care plans and service providers, challenges with achieving cost savings, and lack of reliable data to establish capitated rates.<sup>110</sup>
- Differences in needs between populations of different age groups, especially those over versus under 65. For example, the under 65 population tends to have higher rates of serious mental illness, homelessness, or under-housing as well as more people who are interested in being employed; compared to the over 65, who suffer from conditions like dementia and have different needs and for whom caregivers play a more important role.

## Major Challenges

Although each state's environment is unique, experience with integration efforts have highlighted several commonly occurring challenges that states

embarking upon integration should consider when designing their own strategy. Below we discuss some of these key challenges.

**Stakeholder buy-in** – Obtaining broad stakeholder buy-in and support has been a hurdle for several states that have embarked upon integration. Beneficiary concerns about changes to the status quo as well as some providers' lack of willingness to move away from FFS arrangements into managed care were raised during our interviews. Lack of buy-in from these two groups led to problems with FAI implementation, at least initially, including insufficient enrollment, high beneficiary opt-out rates, and inability of health plans to implement robust provider networks.

**Continuity of leadership** – Another challenge at the state level that could impede the progress of integration is lack of sustained legislative or gubernatorial support because of changing priorities or changes in gubernatorial/legislative control as well as turnover in leadership that oversees Medicaid. Experts mentioned an average tenure of two years for state Medicaid directors which makes a sustained focus on integration problematic.

**State capacity** – The lack of state capacity is an oft-cited major challenge to states' adoption of integration and relates to three main areas:

- Lack of staffing resources that focus on integration of the dual eligible population, which makes it difficult to ensure continuity of efforts especially in light of changes to state leadership as stated above.
- Lack of in-house expertise in the Medicare program and policies, and how these policies interact with the state's Medicaid program.
- Variable ability among states to ingest and use Medicare FFS data, which is a critical component of understanding the costs and utilization patterns of dual eligible beneficiaries.

**Enrollment** - Another major challenge in achieving integration relates to enrolling a sufficient number of beneficiaries in integrated models. Given the significant investments needed in staffing, process, and technology to deliver high-touch, integrated, person-centered care, economies of scale are necessary to making the program cost-effective. Such economies can only be achieved by enrolling significant numbers of beneficiaries which has been problematic across many states. There are several reasons for lower initial enrollment and ongoing retention including:

- Medicare emphasis on beneficiary choice leading to many beneficiaries choosing to remain in FFS.
- Opt-outs encouraged by providers in FAI demonstration states due to lack of understanding of the integrated model.
- Competition from MA plans and D-SNP look-alike plans that have enrolled dual eligible beneficiaries but may not have the right kinds of specialization and expertise to effectively serve this population.

- Concerns among beneficiaries about loss of established provider relationships, especially when managed care is used as the vehicle for integration, leading to disenrollment by passively enrolled beneficiaries.
- Differences in marketing and broker-related rules or guidelines between MA plans, D-SNPs, MMPs, and PACE in terms of direct marketing to beneficiaries. Also, brokers may receive commissions for enrolling beneficiaries in MA plans but do not receive commissions or fees for enrolling individuals in MMPs. There is also a lack of guidelines on beneficiary education by brokers about integrated products.
- Lack of incentives for beneficiaries to sign up for integrated models.
- Disenrollment due to temporary changes in Medicaid eligibility caused by administrative reasons.
- Anecdotal evidence of biases among State Health Insurance Assistance Program (SHIP) counselors towards fee-for-service thereby steering beneficiaries away from managed care plans.

In addition to challenges with enrollment, evaluation of the FAI has shown that in some states like California, beneficiaries were confused about enrollment forms that were not field tested and there was no explanation of program benefits to beneficiaries.<sup>111</sup> In Illinois, confusion arose among beneficiaries because they received multiple enrollment and disenrollment notices from MMPs, Part D plans, etc.<sup>112</sup>

**Network adequacy and provider participation** – Given the diverse types of medical and non-medical providers needed to deliver services to the dual eligible population, experts cited challenges with building networks of LTSS providers and finding high quality providers especially in rural areas. For example in South Carolina – an FAI participant – MMPs had difficulty finding cardiologists and oncologists outside of the metropolitan areas, thereby impacting their ability to meet network adequacy requirements and precluding them from operating in certain counties.<sup>113</sup> A major concern in light of the COVID-19 pandemic is provider network viability given the impact of the pandemic on many Medicaid providers including behavioral health, LTSS, and providers of community-based services.

In addition, many providers who had historically been in fee-for-service arrangements or had previously been in managed care arrangements where payments were delayed or were subject to prior authorization, or had a bad experience with MA plans were reluctant to enter into contracts with managed care plans, resulting in high opt-out rates in some states.<sup>114</sup> Many community-based providers who are “mom and pop” organizations do not have the internal capacity or expertise to enter into contracts with managed care plans or take care of elderly or complex populations. For example, in California, federally qualified health centers (FQHCs) were unaccustomed to caring for dual eligible patients who had complex care needs, placing their resources under strain and leading to delays in patient care.<sup>115</sup>

**Data Sharing and Infrastructure** – Several challenges related to this topic were raised during the interviews. First, health plans cited lack of access to clinical data as a barrier to delivering personalized and coordinated care to beneficiaries. In addition to limitations in exchanging data with providers, some interviewees reported data sharing at a slow pace between MA plans and D-SNPs in some states and additional challenges with agreeing on standardized file formats for data exchange. Some experts reported challenges or delays in getting access to Medicare FFS data as well as data on D-SNPs and supplemental benefits offered by D-SNPs, information that is useful to program design. Evaluations of the FAI demonstration uncovered system challenges especially in the initial stages of the FAI that inhibited exchange of information between plans, providers, and agencies.<sup>116</sup> Apart from problems with data sharing and exchange, the participation of non-medical providers and giving them access to protected health information raises additional issues. Certain types of non-medical community-based providers typically do not have a Health Insurance Portability and Accountability Act (HIPAA) compliant health data infrastructure and need additional time and support to ramp-up their information technology operations.

**Plan readiness** – Our interviews and environmental scan revealed challenges with plan readiness to participate in these models and some of the initial hurdles they experienced. First, there was variability in health plan readiness and capacity to successfully implement integrated models. Experts identified gaps in plan capacity and readiness including lack of knowledge or expertise in long term care, working with community based LTSS providers, understanding of the complex needs of the dual eligible population, and having the internal capacity to support these needs. A review of the FAI experience has shown that across many states, MMPs were initially ill-equipped to manage and pay for nursing home services because of lack of experience or knowledge of Medicaid payment policies even if MMPs had experience with paying skilled nursing facilities under Medicare.<sup>117</sup> In addition, in Michigan, MMPs experienced challenges in transitioning personal care services providers into managed care resulting in delays in payment for these providers.<sup>118</sup> In California, some plans which did not have sufficient MA experience were ill-informed about Medicare rules leading to denials of certain services.<sup>119</sup> In addition to these provider related challenges, MMPs initially had trouble keeping up with the pace of enrollment, conducting timely health risk assessments, and deploying appropriate care plans and care management. Finally, some states like Texas have experienced problems with plan submission of encounter data such as discrepancies between the encounter data and medical expense data included on financial reports, partly stemming from differences in Medicare-Medicaid requirements.<sup>120</sup>

**Misalignment of Medicare and Medicaid** – Although CMS has committed to and is working on addressing misalignment between Medicare and Medicaid policies, such misalignment persists. Examples include coverage and payment variability in policies related to acute and long-term care and home health services, differences

in care coordination requirements at the state level compared with the MA Model of Care, and differences in network adequacy standards and data submission requirements between federal and state governments.<sup>121</sup>

**Variability and stringency in state requirements** – In states that choose managed care as the preferred route for integration, interviewees noted variability in plan requirements related to care coordination such as composition of care teams, staffing ratios, and especially quality measures as key challenges. Although some work has occurred to align quality measures, experts agreed that this area needed further streamlining especially as it pertained to LTSS measurement. Part of the challenge with LTSS measurement is the lack of standardized measures that assess services provided in the community.<sup>122</sup> Benefit packages have commonalities but are associated with nuances across states creating the need for plans to understand those benefits and configure their systems to capture them appropriately to ensure payment for covered services. Finally, some states like New York developed stringent care coordination requirements that made it burdensome for providers especially those that only care for a handful of dual eligible beneficiaries.

**Incentives** – Some experts believed that there was lack of incentives for states to pursue integration and, even when incentives do exist such as in the FAI demo, the structure may not be ideal. Depending on the integration model chosen, states may or may not get to share in the Medicare savings while making upfront investments that potentially generate savings for Medicare. Although the Washington managed FFS demonstration includes a share of Medicare savings for the state, it is still challenging to get buy-in from the state legislature for upfront investments in anticipation of future savings. In addition to state incentives, experts also emphasized the need for appropriate provider incentives to enable them to care for a complex population such as homeless individuals with a serious and persistent mental illness and not rely solely on providers who are mission-driven.

## Lessons Learned and Critical Success Factors

States that have implemented integration models have identified ways to address these challenges and their experiences have shown that there are several factors critical to the success of the design and implementation of integrated models for dual eligible beneficiaries. We describe these lessons learned and critical success factors in this section based on our environmental scan and interviews with experts.

**Leadership buy-in** – Ensuring the buy-in and support of both the governor and the legislature was emphasized by experts as an important success factor. Alignment and commitment to integration across these two branches of state government will help communicate a consistent message to the relevant stakeholders about state priorities and help set the tone for broader stakeholder collaboration and buy-in on substantive discussions about program design and implementation.

**Stakeholder engagement and collaboration** – Engaging the full spectrum of stakeholders in both the design and implementation phases is critical to building trust and collaborative approaches that can help drive the success of state and federal integration efforts. This includes engagement of beneficiaries, consumer advocacy groups, regulators, medical and non-medical providers, community-based organizations, SHIP counselors, and academic experts. In addition, the types and levels of engagement may need to vary depending on the phase of integration efforts. During the pre-planning phase, states should solicit stakeholder input early and often and use a variety of approaches to engage stakeholders in program design. These include issuing requests for information (RFI), hosting town halls and meetings with specific organizations, and establishing workgroups to address key questions. Experts emphasized the importance of a “platform for smart design decisions” and that the specifics related to key program parameters including choice of integration mechanism and population and service inclusion/exclusion should be made by soliciting and taking into account stakeholder feedback and perspectives.

In addition to broad stakeholder engagement in program design decisions, success will also depend on establishing collaboratives that can help create deeper relationships and build trust especially between organizations involved in benefit management and care delivery, irrespective of states’ choice of integration mechanism. For example, in California, regular meetings among MMPs and various types of providers such as skilled nursing facilities, community-based organizations, and home health agencies was fundamental to building trust and relationships among these organizations. Relationships were further enhanced by co-location of managed care staff in community-based organizations to help with care coordination. Other states like Ohio also established collaboratives among MMPs, LTSS, and behavioral health providers to address some of the provider and plan related challenges.<sup>123</sup> Flexibility will also be key in establishing relationships. For example, in South Carolina certain providers were initially reluctant to contract with managed care plans but were willing to execute single case agreements to ensure continuity of care for beneficiaries. MMPs in South Carolina used these arrangements to build trust and relationships with these providers and subsequently succeeded in having them join their networks.<sup>124</sup>

Engagement of beneficiaries and consumer advocacy groups beyond the design phase is also critical. For example, the FAI demonstration requires MMPs to establish consumer advisory councils to provide feedback on their experience with the demonstration. The composition of these councils also varies and is not limited to only beneficiaries and can include family members and social service organization representatives.<sup>125</sup> Experience with these councils has shown that they have helped effectuate key changes to benefits including addressing SDOH and to member communication and outreach strategies.<sup>126</sup> Massachusetts’ formal approach to stakeholder engagement with the establishment of an Implementation Council that is predominantly consumer-driven is viewed as an effective model of consumer engagement.<sup>127</sup>

Finally, effective engagement of beneficiaries in the development of and adherence to their personalized care plan is also important for success. For example, Washington's model places emphasis on engaging beneficiaries in establishing health action goals and working with them to enhance self-management skills.<sup>128</sup>

**Effective education** – In addition to engagement, education of beneficiaries, providers, SHIP counselors, and enrollment brokers/agents is also critical to enrollment, retention, and active participation of these stakeholder groups. Effectively educating these groups will require development of clear communication materials that convey important information about the integration model and the benefits and value of participating in such a model.

Focus groups with dual eligible beneficiaries have shown interest and support for integration when the program is clearly explained to them.<sup>129</sup> In our interviews we learned that in some states like California, health literacy experts were used to develop materials for beneficiary communications and this approach addressed some of the initial missteps. Focusing on the nuts and bolts of educational materials for beneficiaries and election forms used for enrollment was also viewed as important.

In addition to beneficiary education, states participating in the FAI developed toolkits and other training resources to educate providers that helped address some of the provider related challenges discussed earlier and helped promote provider participation in these models.<sup>130</sup>

**Dedicated staff and capacity** – Experts unanimously emphasized the need for staff dedicated to the integration program and underscored the importance of Medicare expertise. States are severely challenged by lack of knowledge of the Medicare program, its policies, and how they interplay with the state's own Medicaid program, and having the deep knowledge of the Medicare program is extremely critical. Experience from states like Arizona that have successfully transitioned to an integrated model has shown the importance of this type of dedicated resource.<sup>131</sup>

In addition, having staff focus on integration can also help mitigate some of the uncertainties associated with turnover of the legislative or executive branch at the state level, ensure continuity of operations, and help educate incoming administrations about the importance and value of integration. In addition to having staff that can focus on integration, it is also important for this staff to involve other agencies within the state that are focused on long-term care, behavioral health and other services that are relevant for this population.

**Phased approach to integration** – The importance of states using a phased approach to integration based on a multi-year strategy was also emphasized during our interviews including pre-planning and beginning years ahead of targeted implementation. States embarking on a path to integration can

initially use a “lighter touch approach to integration” which essentially refers to layering processes over existing systems to improve the experience of dual eligible beneficiaries. Such an approach could include enrolling beneficiaries in Medicare Savings Programs, expanding case management to help coordinate or increase access to other services beyond those covered by Medicaid, choice counseling, and data sharing with CMS including accessing and using Medicare FFS data. From here, states could graduate to using coordinated D-SNPs or promoting PACE and ultimately moving to FIDE SNP or participating in the FAI to promote full integration. Other approaches to phasing in integration include implementation in specific regions with high D-SNP or MA penetration, focusing on integration of specific services or populations, or selecting a single integration mechanism like Arizona.

**Focus on beneficiary experience** – Improving the beneficiary experience with integration models is key to success and needs to encompass all aspects from enrollment to care coordination and management to appeals and grievances. In addition to the beneficiary education materials described above, it is also important to ensure that a person-centered care plan that is linguistically and culturally sensitive is implemented to meet the unique needs of each individual. Beneficiaries also need to be educated on the existence of and the role that care coordinators can play in simplifying the beneficiary experience. Improving health literacy is also critical to ongoing beneficiary engagement and some states like Washington have adopted the patient activation measure (PAM) to assess beneficiary levels of skill and knowledge.<sup>132</sup> Experts also emphasized the importance of beneficiary protections like a dedicated ombudsman program currently available under the FAI, continuity of care protections for a minimum of six months, and ensuring that the HHS secretary’s waiver authority is not used to make changes in eligibility, reduction or loss of benefits, or limits to due process rights.

**Use data and reward performance** – Initially, analysis of combined Medicare and Medicaid data can assist states with understanding costs and utilization profiles of the dual eligible population and help with appropriate program design. Once the program is implemented, data can also be used for population health management similar to efforts in Washington state to target resources, for program monitoring and evaluation, and provider and plan performance assessment. Experts also emphasized the need to appropriately reward plan and provider performance.

## Milestones

States can follow a variety of potential pathways to integration starting with either managed FFS, using D-SNPs, or promoting enrollment in PACE.<sup>133</sup> States like Washington that began by adopting a managed FFS model have viewed it as an initial step in the journey towards full integration. Similarly states that want to pursue integration using D-SNP contracts can also phase in various

levels of integration based on contractual provisions.<sup>134</sup>

Although state environments and specifics of an integration approach vary, our environmental scan and interviews with experts revealed several commonalities in relation to key milestones that can indicate meaningful progress towards integration. There are two main categories of milestones: (1) planning and implementation and (2) evaluation. Figure 7 below describes these in greater detail.

Although it is important to identify these milestones in advance, experts also emphasized the need to embrace a continuous quality improvement or lean process to ensure these endpoints can be modified and adapted based on ongoing learning. As stated earlier, the importance of a phased approach to implementation was also emphasized by many experts during the interviews. For example, states implementing these models may want to first integrate medical services across Medicare and Medicaid, followed by LTSS before adding behavioral health or vice versa, in addition to integrating the administrative aspects of the program. Such an approach could help address some of the complexities of integration and could ensure a smoother experience for beneficiaries and providers.

**Figure 7: Key Milestones to Achieving Integration**

Milestone	Description
Delineate Policy Goals	Clearly outline policy goals to drive design and implementation.
Obtain Leadership Buy-in and Support	Establish support for integration at the state level – both gubernatorial and legislature. Important to also ensure ongoing buy-in and support from state leadership.
Conduct Environmental Scan and Assessment of State Environment	Conduct assessment of key aspects relevant to integration: Characteristics of dual eligible population using publicly available data. MA penetration including by region. Types of MA plans offered. Medicaid managed care penetration. Organization of care delivery for relevant services – medical, behavioral, LTSS. Level of stakeholder interest/readiness for change.

Build State Capacity	<p>Hire staff or consultants to ensure adequate FTE support.</p> <p>Build Medicare expertise.</p> <p>Inventory state data infrastructure including systems used to administer Medicaid, long-term care, and other relevant programs to enable future data sharing.</p> <p>Exchange enrollment files more frequently with CMS and iron out any data issues.</p> <p>Establish integrated Medicare-Medicaid data to analyze and better understand costs and utilization profiles of dual eligible beneficiaries.</p>
Milestone	Description
Engage Stakeholders	<p>Create a robust stakeholder engagement process and framework to include beneficiaries, beneficiary advocates, providers, aging advocates, relevant state agencies, CMS, health plans, and academic experts.</p> <p>Establish a collaborative for ongoing dialogue and to build relationships and trust among relevant stakeholders and with specific emphasis on health plans and providers to promote relationship building especially for states who are pursuing the managed care route to integration.</p> <p>Build strong relationships with state MMCOs and D-SNP Plans (for states pursuing a managed care approach to implementation).</p>
Create a roadmap or plan for integration	<p>Issue RFI and solicit feedback.</p> <p>Work in close collaboration with stakeholders to develop a roadmap that clearly describes the integration approach including incremental steps to integration (managed FFS, D-SNP including FIDE SNP or HIDE SNP, or MMP) with specific timelines and milestones.</p> <p>Detailed plan that accompanies the roadmap that describes what benefits are covered, included/excluded populations, included/excluded geographic regions, marketing and enrollment, beneficiary rights, appeals and grievances, network adequacy, care management plan, ombudsman program etc.</p>
Obtain needed regulatory approvals	<p>Submission and approval of any necessary Medicaid waiver applications and/or State Plan amendments.</p> <p>Obtain any state legislative or budgetary authority.</p>
Take incremental steps to integration	<p>Facilitate timely DME access.</p> <p>Promote beneficiary enrollment in (as applicable):</p> <ul style="list-style-type: none"> <li>Medicare Savings Programs.</li> <li>Existing PACE or aligned D-SNP.</li> </ul> <p>More frequent data exchange with CMS.</p> <p>Train Medicaid waiver case managers to better support beneficiaries' coordination of Medicare benefits.</p>
Issue RFPs and solicit proposals	<p>Publish RFPs that contain specific requirements based on integration approach selected.</p> <p>Under FAI, this step will also involve MMCO.</p>
Contracts with Managed Care or entity accountable for integration	<p>Enter into contracts with managed care plans:</p> <ul style="list-style-type: none"> <li>For MMPs: three-way contract with health plan, state Medicaid Agency, and CMS.</li> <li>D-SNP: contract between states and D-SNP plans.</li> </ul> <p>Alternatively enter into contract with entity accountable for integration such as health homes.</p>
Readiness Reviews	<p>Conduct managed care readiness reviews of systems and capacity to manage delivery of benefits and fulfill integration requirements.</p> <p>Provider training and development.</p>

**Source:** Authors' analysis of the published reports and data collected during expert interviews

In addition to specific milestones to measure demonstrable progress described above, experience with integration efforts across states has shown that achieving full integration is a multi-year process. Experts emphasized the need for a longer

time period for implementation given the complexities associated with the two programs, need for stakeholder buy-in and support, and a variety of the operational issues that need to be addressed. Implementation timeframes can be between five to 10 years depending on the readiness of the state and their respective starting points. Finally, models and timelines that work for states that are more heavily urbanized may not work for states like Montana and Alaska and it would be important to give special consideration to their unique circumstances.

## **Actions at the Federal Level to Support States Seeking to Achieve Integration**

There is widespread acknowledgement in the literature and among the experts we interviewed that states require financial and non-financial support to design and implement integration models for dual eligible beneficiaries. Experts recommended the following specific types of supports that could help advance state integration efforts:

**Increasing authority of MMCO** – One of the recurring themes during our interviews was the importance of giving MMCO full authority over all programs relating to the dual eligible population. There are many models operating under different regulatory structures, and it is important for the MMCO to have full regulatory authority over all the areas pertaining to Medicare-Medicaid integration.

**Increasing awareness of existing resources available to states** – Although the federal government has invested heavily in providing technical assistance by establishing the Integrated Care Resource Center as well as other resources, some experts felt that additional efforts were needed to build greater awareness of the availability of these resources among states and the type of technical assistance they can receive.

**Funding for dedicated staffing and program design** – One of the main challenges as described earlier is the lack of dedicated staffing resources focused on duals and state expertise in the Medicare FFS program. To address this challenge, we heard several suggestions for the federal government to fund hiring of staff at the state level who can focus on duals integration and provide ongoing and sustained leadership for state efforts. In addition, the federal government can also provide states with funds to hire an FTE with deep expertise in Medicare. There was agreement among the experts that such a resource was vital to help states design and implement integrated models.

In addition to staffing, funding for states to help design the integrated program was also emphasized. Designing an integrated model for dual eligible beneficiaries is a complex process with multiple activities that requires dedicated time and resources. Similar to the FAI demonstration, the federal government can provide funding to the states for program design to help accelerate state adoption of integrated models.

**Supporting data sharing and exchange** – The federal government can further promote and foster data sharing between Medicare and Medicaid programs. Specifically, more frequent sharing between CMS and the states of the files used to verify eligibility and Medicare FFS data and additionally, extending the sharing of these files with MCOs would help integration efforts. In addition, some experts felt that it was important for states to also have access to the data on supplemental benefits offered by MA and D-SNPs.

**Incentivizing states** – Another way in which the federal government can help states adopt integrated models would be through the use of incentives or grants. One of the attractive features of the FAI demonstration is the ability for states to share in Medicare savings. However, experts emphasized that these incentives need to be meaningful and that the structure of incentives – bonuses versus withholds – matter. Withholds are challenging because it could lead to insufficient rates that might inhibit upfront investments. Having the right set of incentives for states to invest in programs that help Medicare avoid costs while also improving beneficiary outcomes is therefore important. In addition to shared savings arrangements with states, experts also suggested planning grants similar to FAI to help with program design. Other forms of incentives can also be applied and tied to achievement of specific milestones such as stakeholder engagement, provider training, development of a detailed program design and others discussed in Figure 7. These incentives can take the form of increased federal medical assistance percentages (FMAP) tied to achievement of specific milestones or providing a 100% FMAP match for hiring Medicare experts at the state level. In addition to incentives for states, some experts emphasized the need for beneficiary incentives to promote enrollment in D-SNP plans. Given Medicare’s emphasis on choice, beneficiaries may not always select a D-SNP but may enroll in a traditional MA plan or stay in Medicare FFS. For integration models that require significant investments and where achieving economies of scale through higher enrollment is important, policies like default enrollment or use of beneficiary incentives can help.

**Improving MIPAA D-SNP contract provisions** – Another area where the federal government can be helpful is by working more closely with states (or by using their regulatory authority) in implementing contract provisions that go well beyond the minimum MIPAA standards and help states achieve full integration. One reason that many states default to using minimum standards in MIPAA contracts is lack of capacity and knowledge to establish these standards that is worsened by competing priorities. The federal government can play a role in potentially addressing this capacity issue through use of its regulatory authority to strengthen D-SNP requirements.

**Streamlining policies** – There are a number of opportunities to also streamline policies between Medicare and Medicaid including coverage of durable medical equipment, making available billing codes that can be used by nurse practitioners and not just by physicians, minimizing Medicare-Medicaid

silos at the federal level, and rules pertaining to discharge from hospitals to other settings such as nursing homes, while simultaneously balancing the requirements of program integrity.

**Collaborating with states on supporting plan participation** – When health plans enter new markets and offer integrated products, they face significant uncertainty and an initial set of challenges. These include no historical experience with costs and utilization of this population, rate sufficiency, barriers to establishing robust networks, potential for adverse risk selection etc. To foster plan participation, the federal government can help states create a more predictable environment through the use of risk corridors or other mechanisms that would allow greater health plan interest and participation.

## CONCLUSION

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Our research has shown that a wide variety of mechanisms are available to states to achieve integration although only a subset of options has the capacity for full integration. Experience with these various mechanisms including the FAI has unearthed many challenges but also provided useful lessons learned that can inform states embarking on integration. Key to success of these efforts are leadership buy-in and ongoing support, beneficiary and provider engagement and active participation, and state capacity and resources to embark upon and sustain integration. Given the complexities of the Medicare and Medicaid programs, states should rely on the resources and expertise offered by CMS and also learn from the experience of their peers.

# Appendix II

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## Methodology

To help inform the refinement of BPC's policy options, we conducted additional research to address the following key questions:

1. How is integration defined or characterized for the dual eligible beneficiaries?
2. What does the scope of integration include?
3. What are lessons and ongoing challenges to achieving full integration efforts under the FAI?
4. What approaches can states take relative to achieving integration?
5. What are milestones that can measure states' progress towards achieving integration?
6. What efforts should states undertake to ensure readiness to implement an integrated model of care for dual eligible beneficiaries?
7. What types of federal support do states need to successfully design and implement models of integration?

We performed a targeted environmental scan and conducted interviews with a convenience sample of individuals/organizations to gather the necessary data to address these questions. The targeted environmental scan included reviewing reports on integration efforts from organizations that specialize in these issues including the Integrated Care Resource Center, MACPAC, MedPAC, ADvancing States, RTI evaluations of the ongoing Financial Alignment Initiative, and the Center for Healthcare Strategies.

In addition to the targeted environmental scan we also conducted fourteen semi-structured interviews with individual experts and organizations including government agencies, academics, former state Medicaid Directors and other officials who led integration efforts, consumer advocacy groups, trade associations, and health plans. The interviews were one hour in duration and participants were sent the questions in advance. All interviews included a facilitator and at least one notetaker. Data gathered during the interviews were analyzed to identify common themes as well as unique insights that were gained on policy relevant topics. We finally combined the findings from the environmental scan and the interviews for inclusion in this issue brief.

# Appendix III

## Federal Spending on Dual Eligible Individuals

**Figure 8: Medicare and Medicaid Spending by State and Source of Funds, 2012 (millions)**

State	Total Medicare <sup>135</sup> in dollars	Total Medicaid in dollars <sup>136</sup>	FMAP Percentages <sup>137</sup>	Federal Expenditures in dollars	State Expenditures in dollars	Federal Share	State Share
Alabama	1,710	1,240	68.62%	2,561	389	86.81%	13.19%
Alaska	266	393	50.00%	462	196	70.18%	29.82%
Arizona	3,222	1,461	67.30%	4,205	478	89.80%	10.20%
Arkansas	1,410	1,160	70.71%	2,230	340	86.78%	13.22%
California	26,260	12,087	50.00%	32,304	6,043	84.24%	15.76%
Colorado	1,399	1,120	50.00%	1,960	560	77.77%	22.23%
Connecticut	1,772	2,535	50.00%	3,040	1,268	70.57%	29.43%
Delaware	290	355	54.17%	482	163	74.77%	25.23%
District of Columbia	461	473	70.00%	792	142	84.80%	15.20%
Florida	10,669	4,280	56.04%	13,067	1,881	87.41%	12.59%
Georgia	3,124	1,927	66.16%	4,399	652	87.09%	12.91%
Hawaii	667	485	50.48%	912	240	79.15%	20.85%
Idaho	456	346	70.23%	699	103	87.17%	12.83%
Illinois	6,720	3,693	50.00%	8,567	1,847	82.27%	17.73%
Indiana	2,837	1,901	66.96%	4,110	628	86.74%	13.26%
Iowa	1,190	1,423	60.71%	2,054	559	78.60%	21.40%
Kansas	918	951	56.91%	1,459	410	78.07%	21.93%
Kentucky	1,873	1,347	71.18%	2,831	388	87.94%	12.06%
Louisiana	2,600	1,704	61.09%	3,641	663	84.60%	15.40%
Maine	798	740	63.27%	1,266	272	82.33%	17.67%
Maryland	1,962	1,908	50.00%	2,916	954	75.35%	24.65%
Massachusetts	5,418	4,552	50.00%	7,694	2,276	77.17%	22.83%
Michigan	5,300	2,985	66.14%	7,274	1,011	87.80%	12.20%
Minnesota	2,750	3,190	50.00%	4,345	1,595	73.15%	26.85%
Mississippi	1,714	1,255	74.18%	2,646	324	89.09%	10.91%
Missouri	3,337	2,148	63.45%	4,700	785	85.69%	14.31%
Montana	245	248	66.11%	408	84	82.95%	17.05%

State	Total Medicare <sup>135</sup> in dollars	Total Medicaid in dollars <sup>136</sup>	FMAP Percentages <sup>137</sup>	Federal Expenditures in dollars	State Expenditures in dollars	Federal Share	State Share
Nebraska	730	657	56.64%	1,102	285	79.46%	20.54%
Nevada	587	268	56.20%	738	117	86.28%	13.72%
New Hampshire	409	453	50.00%	636	227	73.72%	26.28%
New Jersey	4,395	3,677	50.00%	6,234	1,838	77.22%	22.78%
New Mexico	650	232	69.36%	811	71	91.93%	8.07%
New York	17,106	19,173	50.00%	26,693	9,587	73.58%	26.42%
North Carolina	4,832	2,807	65.28%	6,665	975	87.24%	12.76%
North Dakota	200	406	55.40%	424	181	70.12%	29.88%
Ohio	5,650	4,938	64.15%	8,817	1,770	83.28%	16.72%
Oklahoma	1,987	1,087	63.88%	2,681	393	87.23%	12.77%
Oregon	1,543	923	62.91%	2,124	342	86.12%	13.88%
Pennsylvania	8,524	5,968	55.07%	11,811	2,681	81.50%	18.50%
Rhode Island	728	717	52.12%	1,102	343	76.26%	23.74%
South Carolina	2,795	1,079	70.24%	3,553	321	91.71%	8.29%
South Dakota	210	246	59.13%	355	100	77.95%	22.05%
Tennessee	3,441	4,705	66.36%	6,563	1,583	80.57%	19.43%
Texas	10,027	5,521	58.22%	13,241	2,307	85.16%	14.84%
Utah	608	417	70.99%	904	121	88.21%	11.79%
Vermont	330	344	57.58%	528	146	78.34%	21.66%
Virginia	2,449	1,946	50.00%	3,422	973	77.86%	22.14%
Washington	2,438	1,666	50.00%	3,271	833	79.70%	20.30%
West Virginia	894	926	72.62%	1,567	254	86.07%	13.93%
Wisconsin	2,839	2,393	60.53%	4,287	944	81.95%	18.05%
Wyoming	131	243	50.00%	252	121	67.51%	32.49%
<b>Total</b>	<b>\$162,872</b>	<b>\$116,697</b>		<b>\$228,805</b>	<b>\$50,764</b>	<b>81.84%</b>	<b>18.16%</b>

**Notes:** This table relied on two sources of data, Calendar Year 2012 data for spending and Federal Fiscal Year 2012 data for FMAP Percentages. Calendar Year and Federal Fiscal Year have a 9-month overlap but count 3 months differently. As a result, the state and federal share numbers should be seen as estimates.

Total Medicare spending was the sum of all Medicare FFS payments, Medicare managed care Part A premium payments, and Medicare managed care Part B premium payments.

Total Medicaid spending was the sum of all Medicaid FFS payments and Medicaid managed care payments.

# Endnotes

- 1 Bipartisan Policy Center, *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update and Policy Options*, Part 1, April 2020. Available at: <https://bipartisanpolicy.org/report/integrating-care-for-beneficiaries-eligible-for-medicare-and-medicaid-an-update/>.
- 2 Bipartisan Policy Center, *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update and Policy Options*, Part 2, April 2020. Available at: <https://bipartisanpolicy.org/report/integrating-care-for-beneficiaries-eligible-for-medicare-and-medicaid-an-update/>.
- 3 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2018*, September 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf>.
- 4 Ibid., 3.
- 5 Ibid.
- 6 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, *Medicare-Medicaid Dually Eligible Individuals Fact Sheet*, March 2019, 1. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf).
- 7 Acumen LLC, prepared on behalf of the Bipartisan Policy Center, *Analysis of Chronic Condition Prevalence and Spending Amongst Beneficiaries Dually Eligible for Medicare and Medicaid*, July 2016.
- 8 Ibid.
- 9 Centers for Medicare and Medicaid Services, *Preliminary Medicare COVID-19 Data Snapshot*, June 23, 2020. Available at: <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.
- 10 MedPAC, “Section 4: Dual eligible beneficiaries,” *June 2019: A Data Book: Health Care Spending and the Medicare Program*, 2019, 40. Available at [http://www.medpac.gov/docs/default-source/data-book/jun19\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0).
- 11 Ibid.
- 12 Acumen LLC, prepared on behalf of the Bipartisan Policy Center, *Analysis of Chronic Condition Prevalence and Spending Amongst Beneficiaries Dually Eligible for Medicare and Medicaid*, July 2016.
- 13 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Report to Congress: Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs*, December 2016, 8. Available at: <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>.
- 14 Wayne L. Anderson, Zhanlian Feng, Sharon K. Long, *Minnesota Managed Care Longitudinal Data Analysis*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2016. Available at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.
- 15 Ibid.
- 16 U.S. Government Accountability Office, *Disabled Dual-Eligible Beneficiaries: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings*, GAO-14-523, August 29, 2014. Available online at: <http://www.gao.gov/assets/670/665491.pdf>.
- 17 MedPAC, *June 2019 Data Book: Health Care Spending and the Medicare Program*, June 2019, 21. Available at: [http://www.medpac.gov/docs/default-source/data-book/jun19\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0).
- 18 MedPAC, *June 2019 Data Book: Health Care Spending and the Medicare Program*, June 2019, 21. Available at: [http://www.medpac.gov/docs/default-source/data-book/jun19\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0).
- 19 MedPAC and MACPAC, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, January 2018, 43. Available at: <https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf>.
- 20 Social Security Act § 226(a)(2). Available online at: [https://www.ssa.gov/OP\\_Home/ssact/title02/0226.htm](https://www.ssa.gov/OP_Home/ssact/title02/0226.htm).
- 21 MedPAC, *June 2019 Data Book: Health Care Spending and the Medicare Program*, June 2019, 21. Available at: [http://www.medpac.gov/docs/default-source/data-book/jun19\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0).
- 22 42 U.S.C. § 1395c through 1395III.
- 23 42 U.S.C § 1395d through 1395e.
- 24 42 U.S.C § 1395i.

- 25 42 U.S.C § 1395k.
- 26 42 U.S.C §§ 1395j, 1395l.
- 27 42 U.S.C § 1395w-21 through 1395w-22.
- 28 42 U.S.C § 1395w-23 through 1395w-24.
- 29 42 U.S.C § 1395w-112.
- 30 42 U.S.C § 1395w-101.
- 31 Sections 1902(a)(10) and 1905(a) of the SSA.
- See also* 42 C.F.R. § 435.100 through 435.236.
- 32 Section 1902(a)(10) of the SSA.
- See also* 42 C.F.R. § 435.120 through 435.138.
- 33 Section 1902(a)(25) of the SSA.
- 34 Sections 1902(a)(17) and 1903(f)(2)(A) of the SSA.
- See also* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, *Analysis of Pathways to Dual Eligible Status: Final Report*, May 2019, viii. Available at: <https://aspe.hhs.gov/system/files/pdf/261726/DualStatus.pdf>.
- 35 MedPAC and MACPAC, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, January 2018, 44. Available at: <https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf>.
- 36 Ibid.
- 37 Sections 1902(a)(10)(A) and 1905(a) of the SSA.
- See also* 42 CFR § 440.1 through 441.745.
- 38 Ibid.
- 39 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, *An Overview of Long-Term Services and Supports and Medicaid: Final Report*, May 2018, 5. Available at: <https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf>.
- 40 Sections 1902(a)(10)(A) and 1905(a) of the SSA.
- See also* 42 CFR § 440.1 through 441.745.
- 41 Centers for Medicare and Medicaid Services, *Dually Eligible Individuals - Categories*, 3-4. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>.
- 42 Bipartisan Policy Center, *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries*, August 2017, 6. Available at: <https://bipartisanpolicy.org/report/update-on-demonstrations-for-dual-eligible-medicare-medicaid-beneficiaries/>.
- 43 MedPAC, *June 2019: A Data Book: Health Care Spending and the Medicare Program*, June 2019, 37. Available at: [http://www.medpac.gov/docs/default-source/data-book/jun19-databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19-databook_entirereport_sec.pdf?sfvrsn=0).
- 44 Ibid.
- 45 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, *Medicare-Medicaid Coordination Office: FY 2019 Report to Congress*, 2019, 3. Available at: <https://www.cms.gov/files/document/mmco-report-congress.pdf>.
- 46 Ibid.
- 47 §§ 1902(a)(10)(E) and 1905(p) of the SSA.
- See also* Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, *Dually Eligible Individuals – Categories*, 1-4, 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>.
- 48 Director Sharon Donovan to Dual Eligible Special Needs Plans, October 7, 2019, Program Alignment Group, Medicare-Medicaid Coordination Office, Subject: CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs). Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf>.
- 49 Ibid.

- 50 Centers for Medicare & Medicaid Services, “Financial Alignment Initiative (FAI): Spotlight & Releases,” 2020. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination>.
- 51 Bipartisan Policy Center, *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update and Policy Options*, Part 1, April 2020. Available at: <https://bipartisanpolicy.org/report/integrating-care-for-beneficiaries-eligible-for-medicare-and-medicaid-an-update/>.
- 52 Ibid., Part 1, 16-17.
- 53 Ibid.
- 54 Centers for Medicare & Medicaid Services, *Medicare-Medicaid Coordination Office: FY 2019 Report to Congress*, 2019, 3. Available at: <https://www.cms.gov/files/document/mmco-report-congress.pdf>.
- 55 Ibid., 9.
- 56 § 50311 (b)(1)(A) of the Bipartisan Budget Act of 2018.
- 57 Centers for Medicare & Medicaid Services, “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,” *Federal Register*, 84: 15680, April 16, 2019. Available at: <https://www.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare>.
- 58 MedPAC, Chapter 12: Promoting Integration In Dual-Eligible Special Needs Plans, June 2019, 444. Available at: [http://www.medpac.gov/docs/default-source/reports/jun19\\_ch12\\_medpac\\_reporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0).
- 59 Ibid.
- 60 Carrie Graham, Elaine Kurtovich, Marian Liu, Alice Wong, Karla Tlatelpa, Holly Stewart, “Evaluation of Cal MediConnect: Key Findings from Focus Groups with Beneficiaries,” March 2016. Available online at: [http://www.thescanfoundation.org/sites/default/files/cal\\_medicconnect\\_key\\_findings\\_brief\\_march\\_2016.pdf](http://www.thescanfoundation.org/sites/default/files/cal_medicconnect_key_findings_brief_march_2016.pdf).
- 61 Ibid.
- 62 § 1902(e)(12) of the SSA, 42 CFR § 457.342; § 2105(4)(A) of the SSA, 42 CFR § 457.342.
- 63 MACPAC, *Report to Congress on Medicaid and CHIP, Chapter 2: Promoting Continuity of Medicaid Coverage among Adults under Age 65*, March 2014. Available at: <https://www.macpac.gov/wp-content/uploads/2014/03/Promoting-Continuity-of-Medicaid-Coverage-among-Adults-under-65.pdf>.
- 64 Ibid.
- 65 Ibid.
- 66 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), *Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors And Implications*, May 2019, 17. Available at: <https://bipartisanpolicy.org/report/update-on-demonstrations-for-dual-eligible-medicare-medicaid-beneficiaries/>.
- 67 Ibid., v.
- 68 Leighton Ku, Erika Steinmetz, and Brian K. Bruen, “Continuous-Eligibility Policies Stabilize Medicaid Coverage for Children and Could Be Extended to Adults with Similar Results.” *Health Affairs* March 2013. Available online at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0362>.
- 69 MACPAC, *Report to Congress on Medicaid and CHIP - June 2020*, 32. Available at: <https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.
- 70 Administrator Seema Verma to State Medicaid Director, April 24, 2019, letter re: “Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare,” Centers for Medicare & Medicaid Services, SMDL #19-002. Available at: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf>.
- 71 42 U.S.C. § 1395b-4.
- 72 U.S. Department of Health and Human Services, *Putting America's Health First: FY 2021 President's Budget for HHS*, 159. Available at <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf>.
- 73 [MyCareMyChoice.org](https://www.mycaremychoice.org/), “My Care, My Choice,” 2020. Available at: <https://www.mycaremychoice.org/en>.

- 74 Bipartisan Policy Center, *Update on Demonstrations for Dual-Eligible Medicare-Medicaid Beneficiaries*, August 2017, 16. Available at: <https://bipartisanpolicy.org/report/update-on-demonstrations-for-dual-eligible-medicaremedicaid-beneficiaries/>.
- 75 MedPAC, *Chapter 9: Managed Care Plans For Dual-Eligible Beneficiaries*, June 2018, 251. Available at: [http://medpac.gov/docs/default-source/reports/jun18\\_ch9\\_medpacreport\\_sec.pdf](http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf).
- 76 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), Office of Disability, Aging and Long-Term Care Policy, *Integrating Care Through Dual-Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges*, April 2019, 16-17. Available at: <https://aspe.hhs.gov/system/files/pdf/261046/MMIDSNP.pdf>.
- 77 Ibid., 17.
- 78 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, *Medicare-Medicaid Coordination Office FY 2019 Report to Congress*, 2019, 3. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf>.
- 79 Ibid., 4.
- 80 MedPAC, *Health Care Spending and the Medicare Program*, June 2019, 37. Available at: [http://www.medpac.gov/docs/default-source/data-book/jun19\\_databook\\_entirereport\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/jun19_databook_entirereport_sec.pdf?sfvrsn=0).
- 81 Ibid., 42.
- 82 Centers for Medicare & Medicaid Services, *How Does Disability Affect Access to Health Care for Dual Eligible Beneficiaries?*, Data Highlight, No. 17, July 2019. Available at: [https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight\\_How-Does-Disability-Affect-Access-to-Health-Care-for-Dual-Eligible-Beneficiaries.pdf](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Highlight_How-Does-Disability-Affect-Access-to-Health-Care-for-Dual-Eligible-Beneficiaries.pdf).
- 83 Center for Health Care Strategies, Inc., *State Efforts to Integrate Care for Dually Eligible Beneficiaries: 2020 Update*, February 2020, 2-3. Available at: [https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries\\_022720.pdf](https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf).
- 84 Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office, *Medicare-Medicaid Coordination Office FY 2019 Report to Congress*, 2019, 8. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf>.
- 85 Integrated Care Resource Center, *Building a Stronger Foundation for Medicare- Medicaid Integration: Opportunities in Modifying State Administrative Processes*, November 2018. Available at: <https://www.integratedcareresourcecenter.com/sites/default/files/BldgStrongerIntegratedPrograms.pdf>.
- 86 MACPAC, *Medicare Advantage dual eligible special needs plans aligned with Medicaid managed long-term services and supports*, Accessed July 2020. Available at: <https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/>.
- 87 Integrated Care Resource Center, *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options*, November 2016. Available at: [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_DSNP\\_Issues\\_Options.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues_Options.pdf).
- 88 Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, Medicare-Medicaid Coordination Office, *Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) for Contract Year 2021*, CMCS Informational Bulletin, November 14, 2019, 3-9. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111419-2.pdf>.
- 89 Center for Health Care Strategies, Inc., *Options for Integrating Care for Dual Eligible Beneficiaries*, March 2010, 1. Available at: [http://www.chcs.org/media/Options\\_for\\_Integrating\\_Care\\_for\\_Duals.pdf](http://www.chcs.org/media/Options_for_Integrating_Care_for_Duals.pdf).
- 90 Centers for Medicare & Medicaid Services, *Supplemental Benefits Offered by Medicare-Medicaid Plans in Contract Year 2019*, January 2019, 1. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPSupplementalBenefitsCY201901162019.pdf>.
- 91 Integrated Care Resource Center, *Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model*, February 2012, 1-2. Available at: <https://www.chcs.org/media/ICRCManagedFFSModels2031912.pdf>.

- 92 Centers for Medicare & Medicaid Services, “Colorado Managed Fee-for-Service Financial Alignment Model Demonstration,” 2019. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Colorado>.
- 93 Centers for Medicare & Medicaid Services and the State of Washington, *Washington Managed Fee-for-Service Financial Alignment Model Demonstration*, 14. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAMFFSMOU.pdf>.
- 94 Centers for Medicare & Medicaid Services, “CMS AND WASHINGTON STATE PARTNER TO COORDINATE CARE FOR MEDICARE-MEDICAID ENROLLEES,” October 25, 2012. Available at: <https://www.cms.gov/newsroom/fact-sheets/cms-and-washington-state-partner-coordinate-care-medicare-medicare-enrollees>.
- 95 MACPAC, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*, January 2018, 10-11. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf>.
- 96 RTI International, *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*, November 2018, 8. Available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.
- 97 RTI International, *Financial Alignment Initiative Illinois Medicare-Medicaid Alignment Initiative: First Evaluation Report*, November 15, 2018, 5. Available at: <https://innovation.cms.gov/Files/reports/fai-il-firstevalrpt.pdf>.
- 98 RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, July 18, 2017, F-1. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>.
- 99 RTI International, *Financial Alignment Initiative Michigan MI Health Link First Evaluation Report*, August 2019, ES-1. Available at: [https://www.michigan.gov/documents/mdhhs/MI\\_FAI\\_EvalReport1\\_666833\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MI_FAI_EvalReport1_666833_7.pdf).
- 100 Centers for Medicare & Medicaid Services (CMS) and the Michigan Department of Community Health, *Michigan*
- Capitated Financial Alignment Model Demonstration (MI Health Link)*, 6. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIMOU.pdf>.
- 101 Centers for Medicare & Medicaid Services (CMS) and the State of New York, *New York (NY) Capitated Financial Alignment Model Demonstrations*, 7-8. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOU.pdf>.
- 102 RTI International, *Financial Alignment Initiative MyCare Ohio: First Evaluation Report*, November 15, 2018, 4. Available at: <https://innovation.cms.gov/files/reports/fai-oh-firstevalrpt.pdf>.
- 103 MACPAC, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*, January 2018, 11. Available at: <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf>.
- 104 Marybeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Family Foundation, December 7, 2015, 9. Available at: <https://www.kff.org/wp-content/uploads/2015/12/8426-07-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-dec-2015.pdf>.
- 105 Marybeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Family Foundation, December 7, 2015, 9. Available at: <https://www.kff.org/wp-content/uploads/2015/12/8426-07-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-dec-2015.pdf>.
- 106 Centers for Medicare & Medicaid Services (CMS) and the State of Colorado, *Colorado Managed Fee-for-Service Financial Alignment Model Demonstration*, 8. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/COMOU.pdf>.

- 107 Marybeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Family Foundation, December 7, 2015, 10. Available at: <https://www.kff.org/wp-content/uploads/2015/12/8426-07-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-dec-2015.pdf>.
- 108 Centers for Medicare & Medicaid Services (CMS) and The Commonwealth of Virginia, *Virginia Capitated Financial Alignment Model Demonstration (Commonwealth Coordinated Care)*, 8-10 and 66-67. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/VAMOU.pdf>.
- 109 Marybeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Family Foundation, December 7, 2015, 10. Available at: <https://www.kff.org/wp-content/uploads/2015/12/8426-07-financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-dec-2015.pdf>.
- 110 MACPAC, *Tailoring MLTSS Programs for Individuals with Intellectual and Developmental Disabilities*, March 1, 2018, 6. Available at: <https://www.macpac.gov/wp-content/uploads/2018/03/Tailoring-MLTSS-Programs-for-Individuals-with-Intellectual-and-Developmental-Disabilities.pdf>.
- 111 RTI International, *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*, November 2018, 37-38. Available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.
- 112 RTI International, *Financial Alignment Initiative Illinois Medicare-Medicaid Alignment Initiative: First Evaluation Report*, November 15, 2018, 20-21. Available at: <https://innovation.cms.gov/Files/reports/fai-il-firstevalrpt.pdf>.
- 113 RTI International, *Financial Alignment Initiative South Carolina Healthy Connections Prime: First Evaluation Report*, August 2019, 12. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCEvalReport1.pdf>.
- 114 RTI International, *Financial Alignment Initiative South Carolina Healthy Connections Prime: First Evaluation Report*, August 2019, 7-8. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCEvalReport1.pdf>.
- 115 Brooke Hollister et al., *Integration of Medicare and Medicaid in California: Provider Perspectives of Cal MediConnect*, January 2018, 2. Available at: [https://www.calhospital.org/sites/main/files/file-attachments/provider\\_perspectives\\_final\\_010818.pdf?1516401559](https://www.calhospital.org/sites/main/files/file-attachments/provider_perspectives_final_010818.pdf?1516401559).
- 116 RTI International, *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*, November 2018, 72-75. Available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.
- 117 RTI International, *Financial Alignment Initiative MyCare Ohio: First Evaluation Report*, November 15, 2018, 13. Available at: <https://innovation.cms.gov/Files/reports/fai-oh-firstevalrpt.pdf>.
- 118 RTI International, *Financial Alignment Initiative Michigan MI Health Link First Evaluation Report*, August 2019, 16. Available at: [https://www.michigan.gov/documents/mdhhs/MI\\_FAI\\_EvalReport1\\_666833\\_7.pdf](https://www.michigan.gov/documents/mdhhs/MI_FAI_EvalReport1_666833_7.pdf).
- 119 RTI International, *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*, November 2018, 27-28. Available at: <https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf>.
- 120 RTI International, *Financial Alignment Initiative Texas Dual Eligible Integrated Care Demonstration Project: First Evaluation Report*, April 2019, 54. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXEvalReportDY1042019.pdf>.
- 121 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (ASPE), Office of Disability, Aging and Long-Term Care Policy, *Integrating Care Through Dual-Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges*, April 2019. v. Available at: <https://aspe.hhs.gov/system/files/pdf/261046/MMIDSNP.pdf>.

- 122 Sabiha Zainulbhai, Lee Goldberg, Weiwen Ng, and Anne H. Montgomery, *Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative*, March 2014, 5. Available at: [https://www.commonwealthfund.org/sites/default/files/documents/\\_media\\_files\\_publications\\_issue\\_brief\\_2014\\_mar\\_1724\\_zainulbhai\\_care\\_integration\\_dual\\_eligibles\\_ib.pdf](https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_issue_brief_2014_mar_1724_zainulbhai_care_integration_dual_eligibles_ib.pdf).
- 123 RTI International, *Financial Alignment Initiative MyCare Ohio: First Evaluation Report*, November 15, 2018, 119. Available at: <https://innovation.cms.gov/files/reports/fai-oh-firstevalrpt.pdf>.
- 124 RTI International, *Financial Alignment Initiative South Carolina Healthy Connections Prime: First Evaluation Report*, August 2019, 13. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCEvalReport1.pdf>.
- 125 Rachel Isaacson, Leena Sharma, Marc Cohen, and Renée Markus Hodin, *An Exploration of Consumer Advisory Councils within Medicare-Medicaid Plans Participating in the Financial Alignment Initiative*, January 2019, 6. Available at: [https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report\\_Final.pdf](https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-Report_Final.pdf).
- 126 Center for Consumer Engagement in Health Innovation, *The Role of Consumer Advisory Councils in the Financial Alignment Initiative*, January 2019. Available at: [https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-OnePager\\_Final.pdf](https://www.healthinnovation.org/resources/publications/body/Consumer-Advisory-Council-OnePager_Final.pdf).
- 127 RTI International, *Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare*, July 18, 2017, 81-83. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf>.
- 128 RTI International, *Financial Alignment Initiative Washington Health Home MFFS Demonstration: Third Evaluation Report*, August 2019, 8-9. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf>.
- 129 MACPAC, *Experiences with Financial Alignment Initiative Demonstration Projects in Three States: Feedback from Enrollees in California, Massachusetts, and Ohio*, May 2015, 7. Available at: <https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-Demonstrations-in-Three-States.pdf>.
- 130 RTI International, *Financial Alignment Initiative: Massachusetts One Care: Second Evaluation Report*, April 2019, 11. Available at: <https://innovation.cms.gov/files/reports/fai-ma-secondevalrpt.pdf>.
- 131 MACPAC, *Report to Medicaid and CHIP - June 2020*, 38. Available at: <https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.
- 132 Integrated Care Resource Center, *Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences*, February 2019, 6. Available at: [https://www.chcs.org/media/Washington-case-study\\_Final.pdf](https://www.chcs.org/media/Washington-case-study_Final.pdf).
- 133 Nancy Archibald and Michelle Herman Soper, *Starting from Square One: Considerations for States Exploring Exploring Medicare-Medicaid Integration*, ADvancing States, May 2020, 13-14. Available at: <https://www.chcs.org/media/State-Considerations-Starting-from-Square-One-5-27-20.pdf>.
- 134 Integrated Care Resource Center, *State Pathways to Integrated Care*, 2019, 19-22. Available at: [https://www.integratedcareresourcecenter.com/sites/default/files/ICRC\\_Pathways\\_to\\_Integration\\_04.15.19.pdf](https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Pathways_to_Integration_04.15.19.pdf).
- 135 Centers for Medicare & Medicaid Services, *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF)*, December 13th, 2016. Available at: [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMLEADS\\_PUF\\_EXCELTABLES\\_2006-2012.xlsx](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMLEADS_PUF_EXCELTABLES_2006-2012.xlsx).
- 136 Ibid.
- 137 Office of the Secretary, Department of Health and Human Services, *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2011 through September 30, 2012*, 75 FR 69082.





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