IDEAS
ACTION
RESULTS

Guaranteeing Integrated Care for Dual Eligible Individuals

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Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center'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.

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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 experts Henry Claypool and Sara Rosenbaum for their contributions to this report.

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Glossary of Terms

ACA – Affordable Care Act

ADLs – Activities of Daily Living

ALS – Amyotrophic Lateral Sclerosis, or Lou Gehrig's disease

CMS – Centers for Medicare & Medicaid Services

D-SNP – Dual Eligible Special Needs Plan

ESRD – End-Stage Renal Disease

FAI – Financial Alignment Initiative

FIDE SNP – Fully Integrated Dual Eligible Special Needs Plan

HCBS – Home and Community-Based Services

HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan

LTSS – Long-Term Services and Supports

MA – Medicare Advantage

MMCO – Medicare-Medicaid Coordination Office

PACE – Program of All-Inclusive Care for the Elderly

SHIP – State Health Insurance Assistance Program

SPA – State Plan Amendment

SSI – Supplemental Security Income

Executive Summary

In July 2020, BPC released a report urging integration of Medicare and Medicaid services for all individuals who are eligible for both programs (commonly referred to as dual eligible individuals). In that report, BPC recommended that Congress and the U.S. Department of Health and Human Services (HHS) provide incentives to states to integrate care for this population, including technical assistance and financial resources. The report also recommended a federal "fallback" program for states that choose not to integrate care.

WHY FEDERAL ACTION IS NEEDED

When Medicare and Medicaid services are not integrated, dual eligible individuals must navigate separate programs to receive health care, long-term services and supports, and other services. In states that contract with managed care plans to deliver Medicaid services, some of which may separately provide, or "carve out," certain benefits, a dual eligible individual must navigate not only separate programs but also multiple Medicaid plans. Individuals may choose to receive Medicare benefits through managed care or fee-for-service. They may obtain some Medicaid services on a fee-for-service basis but may be required to enroll in one or more Medicaid managed care plans for other services. In extreme cases, a dual eligible individual could be enrolled in five separate programs or plans to get the full range of Medicare and Medicaid benefits. These programs include:

1. A Medicare Advantage (MA) plan (or fee-for-service Medicare) for Medicare-covered services.
2. A Medicaid managed care plan for behavioral health services.
3. A Medicaid managed care plan for dental services.
4. A Medicaid managed care plan for long-term services and supports.
5. Medicaid fee-for-service or yet another Medicaid managed care plan for health services not covered by Medicare or one of the managed care carve-out plans listed above.

The current system makes it extremely difficult for health care providers to deliver patient-centered care, and incredibly challenging for beneficiaries and their families to navigate care, appeal a coverage decision, or determine who to call for help.

BPC believes that states are best positioned to integrate Medicare and Medicaid services for two reasons. First, states have decades of experience contracting for

home and community-based services, which are financed through Medicaid. Second, although some beneficiaries are relatively healthy, others have complex medical conditions, have mental health or substance use disorders, are homeless, or experience a combination of these issues. Accordingly, they may need providers with special training and experience in delivering services and addressing social needs. Many patient advocates believe that these health care providers are best identified at the state level. However, federal intervention is needed when states decide not to integrate services for this vulnerable population.

KEY CHARACTERISTICS OF DUAL ELIGIBLE INDIVIDUALS

On average, dual eligible individuals have higher than average health care needs, resulting in greater costs. They may be older adults or younger individuals with disabilities. Average per capita Medicare spending on dual eligible individuals is more than twice that of Medicare-only beneficiaries.[1] Although integration will require short-term investment, particularly in home and community-based services, fully integrating care for dual eligible individuals may improve quality of care and lower total costs over the long term.[2]

Based on discussions with a broad range of stakeholders, BPC defines "full integration" as:

1. Fully aligned benefits and financing with a single plan or provider organization that is responsible for providing all covered Medicare and Medicaid services to dual eligible individuals within a service area.

2. One benefit package that includes all Medicare- and Medicaid-covered services, including medical benefits, behavioral health, dental, and long-term services and supports.

3. A single enrollment period, a single set of member materials, a single point of access for enrollees to direct questions and coverage decisions, and a single grievance and appeals process.

4. A process that ensures that beneficiaries are informed of and understand their options and rights within an integrated program, and that provides sufficient time to allow them to make decisions regarding enrollment, with strong safeguards to protect beneficiaries.

5. A process that allows plans and providers to identify high-risk enrollees and provide for prompt assessments. This process should also provide for the use of an interdisciplinary care team using a standard assessment to develop an individualized person-centered care plan that is designed to meet the unique needs of high-risk enrollees and that is updated as needed to address beneficiaries' changing needs over time and across settings.

6. A single and streamlined set of measures across the two programs, including quality and performance measures developed for complex populations, to be used for quality improvement and to help beneficiary decision-making.

Existing models that meet that definition include Medicare Advantage Dual Eligible Special Needs Plans (FIDE SNPs), the Program of All Inclusive Care for the Elderly (PACE), and a managed fee-for-service model, based on a program developed in Washington state as part of the Financial Alignment Initiative.

Despite nearly 50 years of data showing the benefits of integration for dual eligible individuals, only about 12 percent (or 1.1 million of the 12.3 million dual eligible beneficiaries)[3] receive care through an integrated model.[4] Despite the common-sense reasons for integrating Medicare and Medicaid services and financing, some states will choose not to integrate care for a range of reasons including lack of resources or competing priorities, resulting in the need for federal intervention.

FEDERAL FALLBACK

States should take the lead in integrating care for dual eligible individuals. However, if states do not integrate services, the secretary of HHS should have authority to implement a federally administered integration model–essentially a federal "fallback" program that would operate in states that choose not to integrate care. In these states, the secretary should contract directly with FIDE SNPs or PACE organizations to provide integrated Medicare and Medicaid services. States should provide notice to the secretary of HHS of their intent to either integrate care themselves or request the secretary integrate care through the federal fallback program.

This structure would be based on the framework established for the federal insurance exchange under the Affordable Care Act (ACA). Under the ACA, states may establish and operate health insurance exchanges. If they do not, individuals residing in that state can obtain coverage through the federal exchange. Under this approach, states would retain the right to fully integrate care for dual eligible individuals at a later time.

MEDICARE FREEDOM-OF-CHOICE

BPC recommends auto-enrollment of dual eligible individuals into fully integrated plans. However, because Medicare provides a guaranteed right to receive Medicare-covered services from the provider of their choice, beneficiaries would retain the right to opt out of the integrated plan and to choose another fully integrated model. They also could return to traditional Medicare fee-for-service. As under current law, states would retain the right to require enrollment in Medicaid managed care for Medicaid-covered services. Under this structure, all dual eligible

beneficiaries would have access to services, but they would not be required to receive them through a fully integrated care model. Permitting beneficiaries to opt out is critical to preserving long-standing patient-provider relationships and to ensuring beneficiaries have access to providers with experience in treating patients with special needs.

Many of the policy recommendations in this report were included in BPC's 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*. BPC included those recommendations in this report to provide a comprehensive list of recommendations in a single document and to provide context for the federal fallback program. Recommendations are listed below. Please see the full report for more details.

Recommendations

I. Establish a 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 set date, Congress should:

A. Establish a full integration standard of coverage and care for dual eligible beneficiaries as defined above.

B. Require the secretary of HHS to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals in partnership with states, similar to the approach taken under the Financial Alignment Initiative demonstration. The secretary would make integrated care available in states that decide not to integrate.

C. Provide the Medicare-Medicaid Coordination Office with funding and regulatory authority to establish and oversee full integration in all programs serving dual eligible individuals—including integrated care models implemented by states and the federal fallback program.

D. Provide 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 also convene a working group to identify best practices where they have yet to be identified.

II. Improve Enrollment and Eligibility

To ensure all full-benefit dual eligible individuals can enroll in fully integrated plans, Congress should:

A. Limit enrollment in full integration models to full-benefit dual eligible individuals. The secretary of HHS should also consider limiting beneficiary enrollment to fully integrated MA plans, if such an approach does not limit beneficiary access to supplemental benefits.

B. Allow auto-enrollment into state-implemented or federal fallback integration models with a beneficiary opt-out available at any time for Medicare-covered services.

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

III. Provide Incentives for State-Administered Integrated Care Programs

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

A. Define and develop full integration models for states that choose to integrate care.

B. Provide financial and technical assistance to HHS to support state implementation of full integration in states that notify the secretary of HHS of their intention to integrate care. This support should include financial support to plan, develop, and implement these models.

C. Provide the secretary of HHS with authority to develop a guaranteed shared savings program for full integration models.

IV. Establish a Federal Fallback Program for States that Request the HHS Secretary to Integrate Care

To ensure that fully integrated programs are available in states that choose not to integrate care, Congress should:

A. Direct the secretary of HHS to fully integrate Medicare and Medicaid services for full-benefit dual eligible individuals. The federal government should recoup payments for enrolled individuals that

would have otherwise been made to the state, similar to the approach taken in Medicare Part D for prescription drugs.

B. **Permit state participation in all aspects of policy development for integration programs.**

C. **To ensure beneficiaries in all counties have options, authorize the secretary of HHS to require MA plans to offer at least one fully integrated plan in each service area in which they offer coverage.**

V. Improve 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 (ACL), and states to implement model standards for outreach and education. 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 training for insurance brokers by including a training module on fully integrated plans.**

Background

In 2019, an estimated 12.3 million people qualified for both Medicare and Medicaid.[5] Medicare-Medicaid beneficiaries, commonly known as "dual eligible individuals," include low-income adults of all ages, many with physical or developmental disabilities. Although most dual eligible individuals are over age 65, 37.9% are under 65.[6] In 2019, about 38% of dual eligible individuals qualified for Medicare based on disability, while the remaining 62% qualified because of their age. Additionally, the dual eligible population is more racially and ethnically diverse than the Medicare-only population: 48% of dual eligible beneficiaries were people of color, compared with 21.6% of Medicare-only beneficiaries.[7] Although some dual eligible individuals are relatively healthy, they generally have poorer health and functional status than those eligible for Medicare only.

According to the Medicare-Medicaid Coordination Office (MMCO) within the U.S. Department of Health and Human Services, 70% of dual eligible individuals have three or more chronic conditions (compared with 52% of Medicare-only beneficiaries), and 41% have at least one mental health diagnosis (compared with 16% of Medicare-only beneficiaries).[8] The average dual eligible individual receiving full Medicare and Medicaid benefits, also known as a "full-benefit" dual eligible individual, has six chronic conditions, while Medicare-only beneficiaries average four.[9] Depression and Alzheimer's disease or related dementia were among the most prevalent conditions for full-benefit dual eligible individuals.[10] The COVID-19 pandemic has disproportionately affected dual eligible individuals. Based on preliminary Medicare data, dual eligible individuals accounted for twice as many cases and three times as many hospitalizations due to COVID-19 than their Medicare-only counterparts.[11]

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. In 2018, 25% of dual eligible individuals had limitations in one to two ADLs, compared with 16% of non-dual eligible individuals, and 26% had limitations in three to six ADLs, compared with 8% of non-dual eligible individuals.[12] As a result, dual eligible individuals are among the most medically complex cases and often have wide-ranging health care needs that require additional services and supports.[13]

These additional services and supports are expensive, but the cost only partly explains the relatively high spending on this population. Other significant drivers include care provided in last-resort settings, such as emergency rooms and hospitals, and higher utilization of long-term services and supports (LTSS) in

comparison with their peers. Additionally, for individuals enrolled in Medicare value-based purchasing programs, the Office of the Assistant Secretary for Planning and Evaluation at HHS found that dual eligible status was the most powerful predictor of poor Medicare outcomes among social risk factors.[14]

ELIGIBILITY AND BENEFITS

Medicare

Individuals become eligible for Medicare through one of several pathways. The most common is age-based eligibility. In 2019, 92% of all Medicare beneficiaries qualified by being 65 or older, while 8% of beneficiaries qualified on the basis of disability.[15] However, for those dually eligible, 62.5% qualified for Medicare based on age, while 37.5% qualified because of a disability.[16]

For those 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.[17] In addition, beneficiaries may qualify for Medicare coverage if they have either amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) or end-stage renal disease (ESRD). In 2018, ESRD and ALS patients were eligible for Medicare irrespective of their age and any disabling conditions, and made up 0.8% of the overall Medicare population.[18]

Medicare covers clinical health services, such as inpatient hospitalization, professional office visits, and outpatient surgical procedures. It also covers prescription drugs and, in certain circumstances, home health care, skilled nursing facility care, and rehabilitation and other services.[19] Beneficiaries may remain in traditional Medicare fee-for-service, which includes Parts A and B. Part A covers the cost of inpatient and outpatient hospital services, home health, and skilled nursing care, and it has a deductible and copays.[20] Employer and employee payroll taxes finance Part A.[21] 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.[22] Part B has a separate deductible and copays and is financed through beneficiary premiums and federal taxes.[23]

Alternatively, Medicare beneficiaries, as well as dual eligible individuals, may elect to receive their Medicare coverage through Part C or Medicare Advantage – Medicare's managed care option offered through private insurance companies, inclusive of all Part A and Part B services.[24] A combination of payroll taxes, beneficiary premiums, and federal taxes finance Part C.[25] Private managed care plans or pharmacy benefit managers offer Medicare Part D, similar to Part C.[26] Those in Medicare fee-for-service may purchase prescription drug coverage through Part D.[27]

Medicaid

As with Medicare, dual eligible beneficiaries qualify for Medicaid coverage through one of several pathways.[28] Low income or a disabling condition is one route; a second pathway is for individuals who are eligible to receive cash assistance under the Supplemental Security Income (SSI) program or through another covered group.[29] 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 "wraparound," coverage.[30] 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.[31] In 2013, the most recent year with comprehensive Medicaid data, 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.[32] The remaining 19% became eligible for Medicaid through less common pathways, such as Section 1115 waivers.[a, 33]

Full-Benefit and Partial-Benefit Dual Eligible Individuals

Not all dual eligible individuals qualify for all Medicaid-covered services; eligibility varies based on the individual's income and resource limits. 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.[34] Medicaid covers a range of mandatory and optional LTSS, with coverage varying across states.[35] LTSS services include many that help address beneficiaries' impairments with daily living activities in either an institutional setting such as nursing homes or through personal-care services and services provided in home and community-based settings.[36] Partial-benefit dual eligible individuals still receive the full range of Medicare benefits, but they are ineligible for medical benefits or LTSS covered under Medicaid.[37] Instead, Medicaid covers Medicare premiums, deductibles, and copays, but that coverage varies based on income. In 2019, partial-benefit dual eligible individuals made up 28.9% of all dually enrolled beneficiaries.[38]

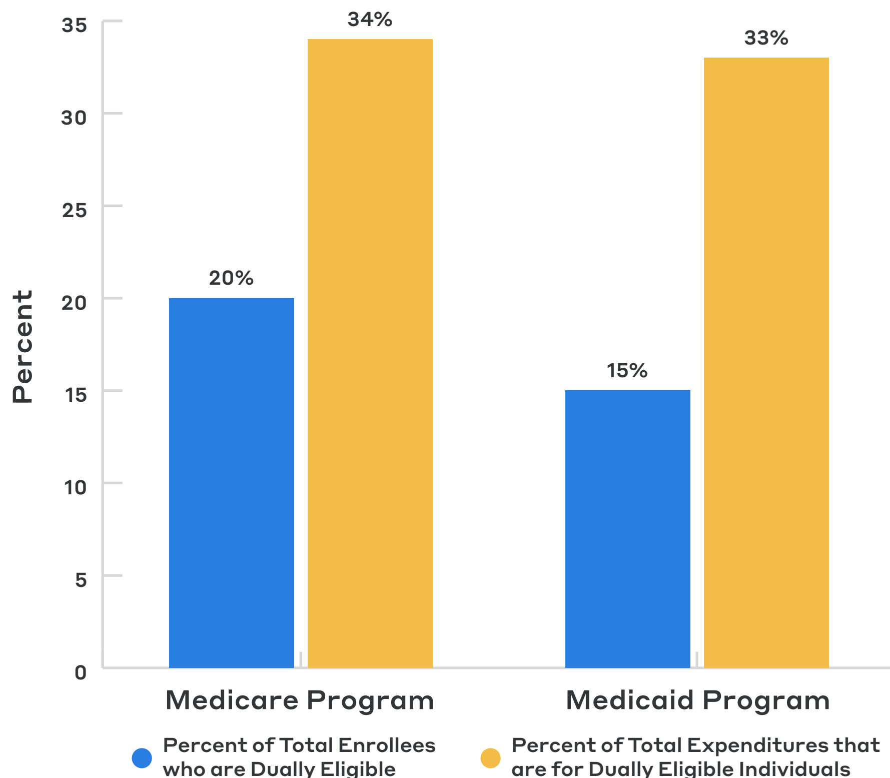
SPENDING

Given the severity of illness and disabilities, average per capita Medicare spending on dual eligible individual is more than twice as high than for Medicare-only beneficiaries.[39] The average Medicare fee-for-service per capita spending for a dual eligible individuals in 2018 was approximately $21,390, more than two times the average Medicare fee-for-service per capita spending for Medicare-only

a Percentages do not add up to 100% due to rounding.

beneficiaries, at $10,072 per person.[40] Dual eligible individuals compose 20% of the Medicare population, but account for 34% of total Medicare expenditures.[41] Similarly, dual eligible individuals compose only 15% of the Medicaid population, but account for 33% of total Medicaid expenditures (Figure 1).[42] Care for dual eligible individuals also makes up a large share of state Medicaid spending. In fiscal year (FY) 2010, the most recent year with data available, Medicaid spending on this population ranged from 20% in Arizona to 55% in North Dakota.[43]

Figure 1: Share of Medicaid and Medicare Enrollment and Costs Associated with Dually Eligible Individuals, 2012[44]



Source: MMCO, People Dually Eligible for Medicare and Medicaid

INTEGRATED CARE MODELS

Numerous delivery and payment models are 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 or models they will offer. These delivery and payment models include:

- **Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs)**, which offer all Medicare services and may also offer Medicaid-covered services.[b]
- **Programs of All-Inclusive Care for the Elderly (PACE)**, a provider-led integration effort that provides medical and social services using adult day care centers.
- **Models established through the Financial Alignment Initiative (FAI) demonstration**.

D-SNPs vary in the degree to which they integrate care but must meet certain minimum integration requirements. There are generally three types of D-SNPs. At the lowest level of integration, D-SNPs must notify the state, or its designee, of hospital or skilled nursing facility admissions for at least one group of high-risk, full-benefit dual eligible individuals. More-advanced versions of D-SNPs are known as Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs), which provide coverage of Medicaid LTSS and/or behavioral health services, but are not required to cover all services under a single plan.[c, 45] This contrasts with the most advanced type of D-SNP, known as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNPs), which provides virtually all Medicaid services, including both LTSS and behavioral health, under a single plan.[d, 46]

The PACE program is a provider-led model that offers comprehensive health care services to frail adults who are age 55+ and require a nursing home level of care.[47] Nearly 90% of PACE participants are dually eligible for Medicare and Medicaid.[48] For those beneficiaries, the program fully integrates Medicare and Medicaid services and financing for dual eligible individuals. As of August 2021, PACE was serving approximately 51,000 individuals in 30 states.[49] The ability to expand the

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b Medicare Advantage (MA) special needs plans (SNPs) are coordinated care plans designed to provide targeted care and services to individuals with unique needs. D-SNPs are one type of MA SNP, and they limit enrollment to Medicare-Medicaid beneficiaries. Other SNPs include Chronic Condition SNPs (C-SNPs), which limit enrollment to Medicare beneficiaries with specific severe or disabling chronic conditions, and Institutional SNPs (I-SNPs), which limit enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a LTC facility setting. C-SNPs also serve individuals who live in the community but require an institutional level of care. § 1859(b)(6) of the Social Security Act. 42 CFR § 422.2. In 2021, among SNP enrollees, about 2% are in I-SNPs, 10% are in C-SNPs, and 88% are in D-SNPs, according to a Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files.

c 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.

d 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.

spread and scale of PACE continues to be limited by the startup costs associated with establishing adult day care centers and eligibility limitations.

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

Evidence demonstrates that individuals in models that integrate Medicare and Medicaid saw fewer hospitalizations and hospital admissions, as well as greater satisfaction with services.[52] Depending on the specific model, evidence also suggests, among other benefits, improved access to care coordination, better health outcomes, and the potential for cost savings.[53] As policymakers move forward, experts agree that integrated models must build on lessons learned from the FAI demonstrations.

Despite the availability and benefits of models that integrate Medicare and Medicaid, many dual eligible individuals are enrolled in separate Medicare and Medicaid coverage options that do not provide integrated care or 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.[54] Although the number of dual eligible individuals in integrated programs has grown significantly in recent years, a relatively small percentage, about 12% according to MMCO, are enrolled in programs that fully integrate Medicare and Medicaid.[55]

Challenges

Despite the benefits of integrated care, at least 14 states and the District of Columbia do not have an integrated program available to full-benefit dual eligible individuals.[56] Additionally, among the 36 states that have at least one integrated program available,[e] enrollment varies greatly, from 0.2% in Alabama and Maryland to almost 40% in Rhode Island.[57]

In 2020, BPC contracted with Ananya Health to complete an in-depth analysis with states, consumer organizations, and other state/federal organizations to determine key challenges and best practices for states that have integrated care for this population. Through those discussions with stakeholders, Ananya Health and BPC identified the following key challenges that states often experience in pursuing integrated models:[f]

- Overcoming a lack of resources for adopting and implementing integrated models to achieve full integration;
- Getting stakeholder buy-in and support;
- Achieving continuity of state leadership;
- Increasing enrollment and retention in integrated models;
- Ensuring network adequacy and provider participation, especially in rural areas;
- Sharing data sharing and improving infrastructure;
- Ensuring plan readiness;
- Solving the misalignment of Medicare and Medicaid;
- Overcoming the variability and stringency in state requirements; and
- Overcoming the lack of incentives for states to pursue integration.

A lack of resources for state implementation may contribute to or exacerbate each of these challenges. Many states do not have the capacity or resources needed to address these challenges and successfully build out fully integrated options for dual eligible individuals.

e The Health Management Associates issue brief defines an integrated program as including the Financial Alignment Initiative demonstrations, PACE, or a FIDE SNP.

f For a detailed description of these challenges, see BPC's *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* (July 2020).

LACK OF RESOURCES FOR STATE IMPLEMENTATION

Successfully implementing fully integrated programs for dual eligible individuals often requires substantial upfront investments to design programs and build necessary infrastructure.[58] At the beginning of the Financial Alignment Initiative, CMS awarded up to $1 million to states that chose to participate in the demonstration to design strategies for implementing person-centered models that fully integrate all clinical, LTSS, and behavioral health services.[59] In addition to designing and implementing their integrated care programs, states used these awards to hire additional staff, engage contractors, and strengthen their data systems.[60]

Having the resources to invest in staff for integrated programs and in staff with Medicare expertise is critical in the success of models serving dual eligible individuals. Because these individuals receive services from Medicare, administered by the federal government, and Medicaid, a program administered by a federal-state partnership, those staff members integrating care should have a good understanding of both programs. However, state Medicaid offices rarely have the Medicare expertise necessary to fully understand Medicare and how its policies interact with the state's Medicaid program.[61] Although CMS provides some technical assistance to states directly and through the Integrated Care Resource Center, expertise at the state-level can aid integration efforts.

One significant factor affecting the amount of state resources available to advance integration is the continuity of leadership at the gubernatorial, state legislative, and state Medicaid director levels. Priorities often change each legislative session, and the average tenure of state Medicaid directors is only two years. The turnover in leadership worsens staffing shortages and resource shortfalls that already exist at the state Medicaid department level. States that have successfully been integrating care have cited leadership focused on this mission as a key to ensuring that integration efforts can be maintained over the long term.[62]

LIMITED AVAILABILITY OF HCBS CREATING A LACK OF ACCESS TO CARE

The availability of home and community-based services (HCBS) varies significantly by state. Because dual eligible individuals are more likely to need assistance with daily living activities, discussions to expand the availability of home and community-based services will have a significant impact on this population.

States are required to provide LTSS in institutional settings such as nursing homes and some home health. States can also go further, offering a broader array of medical and non-medical services intended to keep people well by providing home and community-based services. These services may include case management services, homemaker/home health aide services and personal care

services, adult day health services, habilitation services, respite care, and other services requested by the state and approved by the secretary of HHS.[63]

States can provide optional HCBS using a variety of authorities, including 1915(c) and 1115 waivers, and 1915(i), 1915(j), and 1915(k) state plan amendments. In providing HCBS, the most common authority is the 1915(c) waiver, which allows states to target services to specific populations, geographic locations, ages, diagnosis, or other criteria.[64] States may also cap enrollment in 1915(c) waivers, providing the state with budget certainty. States' ability to target services has created long waiting lists for HCBS, with almost 820,000 individuals on lists across 41 states in 2018.[65] However, because states manage HCBS waiting lists differently, they are not an accurate measure of unmet need for services.[66, 67] For more information on the authorities that cover HCBS, see BPC's June 2021 white paper, *Streamlining and Simplifying Medicaid HCBS Part 1*.

The numerous pathways make it challenging for states to apply for and maintain these benefits—it represents a significant administrative burden. Additionally, the variation creates inequitable access to HCBS both within and between states. Because of these inequities, it is harder for dual eligible individuals to receive LTSS in their homes or community-based settings in some states compared with others. BPC further described these challenges in a report released in October 2021 on *Streamlining and Simplifying State HCBS Authorities*. In the report, BPC recommends that Congress consolidate existing HCBS authorities into a single state plan amendment (SPA) option. This SPA would advance equitable access to HCBS while still providing states with the flexibility to design their own programs with some level of budget certainty.

WHY A FEDERAL FALLBACK IS NECESSARY

With nearly 50 years of data showing the benefits of integration for dual eligible individuals, only about 12 percent (or 1.1 million of the 12.3 million dual eligible beneficiaries)[68] receive care through an integrated model.[69] Despite the common-sense reasons for integrating Medicare and Medicaid services and financing, some states will choose not to integrate care for a variety of reasons. For example, integrating care—and reducing hospitalizations and emergency department visits—requires spending increases on non-medical services generally financed by Medicaid. Because Medicare covers hospital services, any savings realized from reduced hospitalizations would accrue to the federal Medicare program; thus, while state Medicaid programs may invest the necessary upfront resources into integrating care, certain potential savings may instead accrue to the federal Medicare program and this may be a disincentive for states to integrate care. Additionally, some states may carve out benefits, such as long-term services and supports, by contracting with Medicaid managed care plans. While these contracts may save states money relative to fee-for-service, those savings may

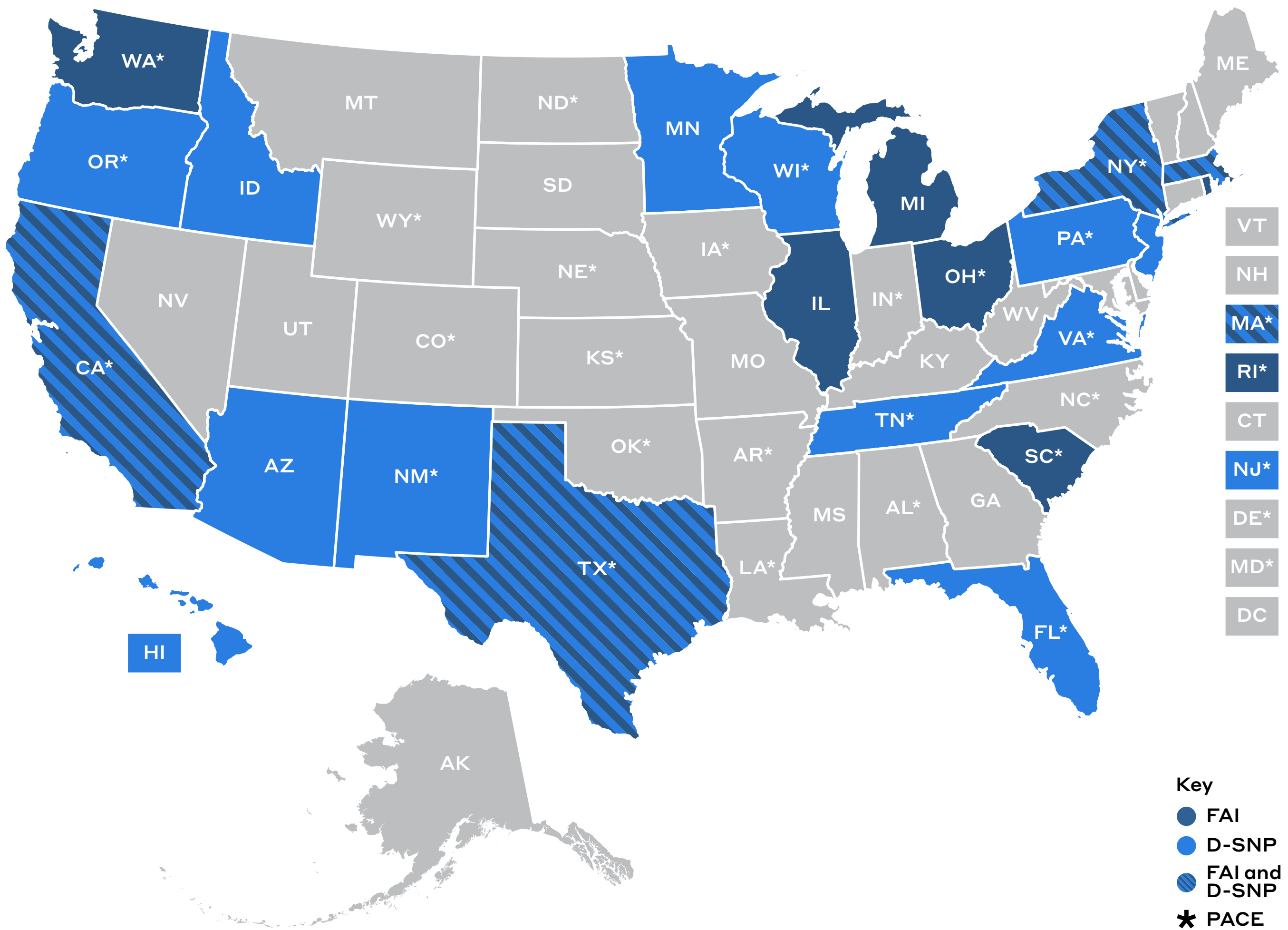
not over the short term reduce the total cost of care in a fully integrated model that improves access to those services. Other states may have abandoned their care integration model altogether after failing to achieve short-term savings. Additionally, the integration of Medicare and Medicaid requires time, resources, and Medicare expertise at the state level. Finally, states may be forced to choose between integrating services and financing competing priorities.

Over the years, the federal government has sought to better integrate Medicare and Medicaid for dual eligible individuals. The Affordable Care Act authorized fully integrated D-SNPs and directed HHS to establish a single office, known as the Medicare-Medicaid Coordination Office (MMCO), dedicated to integrating the coverage and payment of Medicare and Medicaid benefits for dual eligible individuals.[70] The ACA also established the Center for Medicare Medicaid Innovation, which later authorized the FAI demonstration.[71] More recently, the Bipartisan Budget Act of 2018 directed the secretary of HHS to better integrate the two programs. It granted MMCO the authority to develop regulations and guidance related to: (1) the implementation of a unified grievance and appeals process for D-SNPs, and (2) integration or alignment of policy and oversight under the Medicare and Medicaid programs regarding D-SNPs.[72]

Nevertheless, access to fully integrated plans still varies significantly across the United States. In 2020, 10 states were operating programs under the Financial Alignment Initiative, 10 states had fully integrated D-SNPs, 6 states had partly-integrated D-SNPs, and 31 states had PACE programs (Figure 2).[73] Although at least one model is available in most states, enrollment remains low, with only approximately 12% of the full-benefit dual eligible population enrolled in those care models in 2019.[74]

Because states have more experience contracting for long-term services and supports, BPC recommends providing states with the incentives described below to integrate care themselves. Despite these financial and technical assistance resources, BPC recognizes that some states will choose not to integrate care. To ensure all dual eligible individuals have access to fully integrated care, BPC has concluded that a federal fallback program is necessary. It may motivate some states to integrate care themselves to avoid federal involvement. In other states, the fallback program will ensure that dual eligible individuals have at least one fully integrated option available. Under the fallback, the federal government would control implementation and operations of the integrated plans through plan contractors, as it does with Medicare Advantage.

Figure 2: Integrated Care Models Offered by State, 2020



Some states operate both FAI demonstrations and integrated D-SNPs.

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

Source: Center for Health Care Strategies., State Efforts to Integrate Care for Dually Eligible Beneficiaries: 2020 Update

Recommendations

BPC believes that all dual eligible individuals should have the ability to access integrated care, and therefore Congress should require states to offer fully integrated options. Although states are in the best position to integrate Medicare benefits with their state Medicaid programs, not all states have the resources required to integrate care for this population. BPC also recognizes that some states choose not to integrate care, for reasons outlined above. To advance integration of Medicare and Medicaid, BPC's recommendations include incentives to encourage states to integrate care themselves, as well as details for a federal fallback program for states that choose not to integrate care. These policies include recommendations from BPC's July 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.[g]

I. Establish a 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 set date, Congress should:

A. Establish a "full integration" standard of coverage and care for dual eligible beneficiaries.

Although a number of states have taken steps to better integrate care, many 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 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. Although 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.

g BPC's previous report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* includes additional recommendations that include a framework for the integration of Medicare and Medicaid, enrollment and eligibility considerations, and policies that would improve the beneficiary experience.

Based on discussions with a broad range of stakeholders, BPC defines "full integration" to include:

1. Fully aligned benefits and financing, with a single plan or provider organization that is responsible for providing all covered Medicare and Medicaid services to dual eligible individuals within a service area
2. One benefit package that includes all Medicare and Medicaid covered services, including medical benefits, behavioral health, dental, and long-term services and supports
3. A single enrollment period, a single set of member materials, a single point of access for enrollees to direct questions and coverage decisions, and a single grievance and appeals process
4. A process that ensures that beneficiaries are informed of and understand their options and rights within an integrated program, and that provides sufficient time to allow them to make decisions regarding enrollment, with strong safeguards to protect beneficiaries
5. A process that allows plans and providers to identify high-risk enrollees and provide for prompt assessments. It also provides for the use of an interdisciplinary care team using a standard assessment to develop an individualized person-centered care plan that is designed to meet the unique needs of high-risk enrollees and that is updated as needed to address beneficiaries' changing needs over time and across settings
6. A single and streamlined set of measures across the two programs, including quality and performance measures developed for complex populations, to be used for quality improvement and to help beneficiary decision-making

B. Require the secretary of HHS to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals in partnership with states, similar to the approach taken under the Financial Alignment Initiative demonstration. The secretary would make integrated care available in states that decide not to integrate.

Once enacted, states may either choose to integrate care themselves or allow HHS to integrate care through the federal fallback program. For states that choose to integrate themselves, services should be integrated within eight years of enactment, with mutually agreed-upon milestones between states and the secretary. The secretary should develop a process for states to provide notice of intent to fully integrate care, meeting the definition outlined above (which has been taken from BPC's July 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*). The secretary should have the authority to extend the deadline for two additional years for states integrating care that request an extension. 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 the secretary should proceed, rather than waiting eight years.

Timeline

In the July 2020 final report, BPC recommended full integration of care within eight years. BPC had initially proposed a five-year timeline in the April 2020 white paper, but revised the timeline in response to stakeholder feedback. BPC received comments from states and other experts indicating that it would be difficult for some states to integrate care within five years, 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 deadline, 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 themselves. See Figure 3. Also see "Federal Fallback For States that Request the HHS Secretary Integrate Care" below for a detailed description of BPC's federal fallback model.

Figure 3: Timeline for the Full Integration of Care in States That Choose to Integrate

Year 1	States notify HHS 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 request the HHS secretary to integrate care.
Year 8	States pursuing their own integration must offer fully integrated models (states may request two additional years if needed, provided it demonstrates progress on milestones).

C. Provide the Medicare-Medicaid Coordination Office with funding and regulatory authority to establish and oversee full integration in all programs serving dual eligible individuals—including integrated care models implemented by states and the federal fallback program.

For certain programs for dual eligible individuals, Congress, under the 2018 Bipartisan Budget Act, directed the secretary of HHS to provide regulatory authority to MMCO "to the extent feasible." Although the Centers for Medicare & Medicaid Services has provided additional regulatory authority to MMCO, it did not include all programs affecting dual eligible individuals, one example being PACE. Lack of staffing and resources requires the Medicare-Medicaid Coordination Office to rely on other offices within CMS for many functions. Without full authority, these offices can hinder the full integration of services and create differing requirements for the various models, with potentially unintended consequences.

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 also 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. Until a single agency within CMS has full authority to regulate all aspects of programs serving dual eligible individuals, these programs will remain separate, with different interests and priorities.

D. Provide 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.

Under the Financial Alignment Initiative demonstrations, CMS was able to use the waiver authority provided to the Center for Medicare & Medicaid Innovation to ensure full administrative alignment between programs. When CMS sought to align Medicare and Medicaid for FIDE SNPs under the Bipartisan Budget Act of 2018, the HHS secretary concluded that the agency lacked the authority to do so.[75] At the same time, unlimited waiver authority could harm 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 also convene a working group to identify best practices where they have yet to be identified.**

The variation permitted under the current regulatory structure distinguishing fully integrated and highly integrated D-SNPs has its uses during the transitional phase. However, 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 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. The secretary should implement standards agreed upon by the working group, with the goal of adopting best practices from the FAI demonstration and applying them to FIDE SNPs. The group should 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 the 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 process for a single open enrollment period;
- 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;[h]
- 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).

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h Efforts are underway to develop standard quality measures for complex care programs beyond cost and utilization. For more information, see Heidi Bossley and Keziah Imbeah, "Measuring complexity: Moving toward standardized quality measures for the field of complex care," May 21, 2020. Available at: https://www.nationalcomplex.care/wp-content/uploads/2020/05/Quality-measures-report_final.pdf.

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. Improve Enrollment and Eligibility

To ensure all full-benefit dual eligible individuals can enroll in fully integrated plans, Congress should:

A. Limit enrollment in fully integrated models to full-benefit dual eligible individuals. The secretary of HHS should also consider limiting beneficiary enrollment to fully integrated MA plans, if such an approach does not limit beneficiary access to supplemental benefits.

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 receive only 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 that relatively few partial-benefit dual eligible individuals later qualified for full Medicaid benefits, and those with partial Medicaid benefits fared equally well in MA plans.[76] 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.[77]

To encourage fully integrated care for dual eligible individuals, the secretary should also consider limiting enrollment to fully integrated MA plans, if such an approach does not limit beneficiaries' access to supplemental benefits.

B. Allow auto-enrollment into state-implemented or federal fallback integration models with a beneficiary opt-out available at any time for Medicare-covered services.

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 allowed to opt out at any time. Surveys of patients enrolled in the FAI indicate high rates of satisfaction with the care they received.[78] Focus groups conducted by the University of California show high satisfaction with California's financial alignment demonstration. On a scale from one to 10, the average satisfaction score for those enrolled in Cal MediConnect was eight, with beneficiaries reporting that expanded coordination services helped them navigate their managed care plan.[79] Individuals who opt-out of the program will remain in Medicare fee-for-

service or other integrated model of their choice. For those dual eligible individuals who opt out, the state will 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 are in the low-income assistance programs. This is especially important in ensuring 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 participation and choice in both the state and federal fallback programs. Auto-enrollment should also be coupled with consumer education (see recommendation B in section V below) about integrated care models.

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;[80] and evidence demonstrates the policy is effective.[81] However, states do not have the option of offering continuous enrollment to adults in Medicaid unless they seek a waiver.[82] The Medicaid and CHIP Payment and Access Commission 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.[83] That recommendation should be implemented to promote continuity of care for dual eligible individuals.

Because of federal eligibility requirements, almost one-third of dual eligible individuals temporarily lose their Medicaid coverage—usually for at least one month—within a year of receiving full benefits.[84] 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 failing to complete paperwork on time.[85] Transitioning in and out of Medicaid disrupts continuity of care. Loss of coverage also causes individuals to forgo primary and preventive care that can curb more costly health care utilization. Disenrolling and re-enrolling individuals also is costly to states.[86]

State and federal policymakers should work to reduce administrative burdens on beneficiaries and ease stringent eligibility requirements by shortening and simplifying applications, and lengthening the time between eligibility redeterminations, especially since this population's income typically does not 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. Provide incentives for State-Administered Integrated Care Programs

To incentivize states to integrate Medicare and Medicaid for dual eligible individuals themselves rather than taking advantage of the federal fallback, Congress should:

A. Define and develop full integration 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 HHS secretary and a state, based on the model used by the state of Washington.

Building on the best practices of the past 40 years, all models must cover all Medicare and Medicaid benefits and meet all integration requirements identified in *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* (BPC, 2020).

One concern raised by states is the need for a clear roadmap to achieve integrated care. Establishing three models and clearly defining them in 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 other integrated model of their choice. For those dual eligible individuals, the state would continue to provide Medicaid services. To encourage fully integrated care for the dual eligible, the secretary should consider limiting enrollment to fully integrated MA plans, if such an approach does not limit beneficiaries' access to supplemental benefits.

B. Provide financial and technical assistance to HHS to support state implementation of full integration in states that notify the secretary of HHS of their intention to integrate care. This support should include financial support to plan, develop, and implement these models.

Stakeholders and others recognize that states will require both financial and technical assistance to fully integrate Medicare and Medicaid services. For example, when Massachusetts 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, Massachusetts had to spend more to bring additional outpatient mental health centers online.

At the beginning of the FAI demonstration, states could apply for up to $1 million in grant funding to cover the costs of designing programs and building the infrastructure necessary to integrate care. Additionally, some stakeholders noted the usefulness of contract management teams utilized in the FAI. These teams created opportunities 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 requires resources to hire staff and cover additional legal costs associated with aligning the programs, revising contracts and plan materials, and paying for other costs associated with rolling out a new program.[i] States also need technical assistance and additional funding as they seek to achieve full integration.

In its June 2020 report, the Medicaid and CHIP Payment and Access Commission recommended additional federal funding to train state staff in Medicare and to cover upfront costs of designing and implementing new models.[87]

For those states that notify HHS of their intent to integrate care as outlined above, the secretary should make adequate resources available to states to develop and implement a process for integration. To be eligible, states would be required to make one individual responsible for care integration and would have to demonstrate state and community-level support for integrating services.[j]

C. Provide the secretary of HHS with authority to develop a guaranteed shared savings program for full integration models.

One issue that states frequently mention is the lack of financial incentives to integrate care. In many cases, integration requires increased state spending under Medicaid. To the extent that savings are achieved, they arise from reduced utilization of emergency departments or inpatient hospitalization. Absent a mechanism for sharing the Medicare savings and program investments, such as those built into the FAI demonstrations, states are reluctant to move forward with integration.

Although the FAI demonstration permitted states to share in some of the Medicare savings, shared savings are not permitted at all outside of the demonstration. In developing each model, the secretary should ensure that states get a share the Medicare savings and that those savings are

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i See "Actions at the Federal Level to Support for States Seeking to Achieve Integration" in the data brief in Appendix I of *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

j See "Conduct Environmental Scan and Assessment of State Environment" in Figure 7 in Appendix I of *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

guaranteed. This means that rates to FIDE SNPs, PACE, or an alternative model would be set in such a way that reductions are incorporated in the total cost of care on a per capita basis.

BPC does not recommend a specific model at this time, but Congress could consider an approach similar to that which is used in the FAI. For example, the Centers for Medicare & Medicaid Services 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. Although savings are not guaranteed and are difficult to determine, the payment under the combined benchmark would likely be reduced by 1-2% in the first year. Going forward, the payment would be indexed to the overall growth in national expenditures for dual eligible individuals. The federal government and the states would then share any savings, with states at a minimum getting 33% of the savings (Figure 4).

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
Total	**$30,619**

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 $612.38, excluding additional savings achieved.

$30,619 x .98	= $30,006.62
$30,619 - $30,006.62	= **$612.38**

3. Distribution of $612.38 in Savings:

Entity	Share of Savings	Savings
Federal Government	67%	$410.30
State	33%	$202.09

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 Request the HHS Secretary Integrate Care

As discussed above, BPC believes that a federal fallback is necessary to ensure that all dual eligible individuals have access to fully integrated care. While BPC hopes that the incentives outlined above will encourage states to integrate care, some states may still choose not to integrate care, in which case the federal government would establish a fully integrated plan through the federal fallback.

To ensure that fully integrated programs are available in states that choose not to integrate care, Congress should:

A. Direct the secretary of HHS to fully integrate Medicare and Medicaid services for full-benefit dual eligible individuals. The federal government should recoup payments for enrolled individuals that would have otherwise been made to the state, similar to the approach taken in Medicare Part D for prescription drugs.

Like the process undertaken as part of the financial alignment demonstration, states and the secretary of HHS would enter into a three-way contract with improved[k] FIDE SNPs or other fully integrated models described below, to offer Medicare and Medicaid services. The secretary should provide guidance to states on the respective roles and responsibilities of the states and federal government. At a state's request, the secretary would establish a federal fallback program. Under that program, the secretary would contract for Medicare and Medicaid services, similar to the federal role in Medicare Advantage. Key features of this federal fallback model are detailed below.

- **Eligibility**: Under the federal fallback model, states would continue to determine eligibility for Medicaid. The state and the secretary of HHS may, however, define the populations covered through a flexible negotiation process that ensures covered populations comply with state law and policy. To ensure beneficiaries do not lose coverage under the federal fallback model, states should meet maintenance-of-eligibility requirements for this population. States would provide the secretary with current beneficiary information for the purposes of enrollment.

  Although this recommendation would not expand Medicaid eligibility, BPC has released a separate recommendation to improve access to HCBS for Medicare beneficiaries who are ineligible for Medicaid. Medicare-only beneficiaries would be able to buy-into a fully integrated model– including

k In *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, BPC recommended that Congress direct the secretary of HHS to adopt best practices from the Financial Alignment demonstration and apply them to FIDE SNPs. BPC refers to these plans as improved FIDE SNPs.

improved FIDE SNPs, PACE, or another model approved by the secretary of HHS— and the federal government would subsidize the cost of the service package for low- to moderate- income individuals. Under this approach, the federal government would fully subsidize the HCBS package for Medicare beneficiaries who are not eligible for Medicaid at date of enactment with incomes up to 300% of SSI (which is 221% of the federal poverty level), and partially subsidize it for those with incomes between 221% and 400% of the federal poverty level. Full details are available in BPC's report, *Bipartisan Solutions to Improve the Availability of Long-term Care.*

- **Covered services**: The federal fallback model should include coverage of all Medicare-covered services, including any supplemental services offered by FIDE SNPs. The federal fallback would also cover all Medicaid services offered by the state, as of the date Congress passes legislation. The state and the secretary of HHS may, however, define the covered services through a flexible negotiation that ensures covered services comply with federal and state law and policy. This process would resemble the negotiation process states and CMS currently engage in to develop the memorandum of understanding under the FAI demonstration. To ensure a seamless beneficiary experience and full-integration of services, no benefits may be carved-out.
- **Care delivery**: The secretary should contract with improved FIDE SNPs to provide fully integrated care. The secretary may also contract with certain provider organizations, including PACE and other fully integrated provider organizations, that meet principles for integration established by the MMCO.
- **Financing and benchmarks**: Financing would continue as under current law. The secretary would be authorized to make payments to plans or provider organizations for both Medicare and Medicaid covered services under the federal fallback program. In calculating the state share, the secretary should calculate state-specific per capita rates that would reflect the amount of 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. The benchmark itself and the inflation rates could be designed in such a way to create incentives to encourage states to serve specific groups of people and benefits to achieve a greater degree of consistency across the country.
- **Enrollment**: Each dual eligible individual would have the option of enrolling in a fully integrated model. Those who decline coverage will be passively enrolled in a fully integrated care model through a "smart assignment" process. To ensure continuity of care, eligible individuals would have the ability to disenroll and re-enroll in another fully integrated plan or to disenroll and remain in traditional fee-for-service for Medicare-covered benefits. Congress should direct the HHS secretary

to allow individuals to disenroll and reenroll in another plan without restriction. For example, if a Medicare-Medicaid beneficiary enrolls in a new plan that does not cover their usual providers, the beneficiary should be able to disenroll and change plans to ensure continuity of care. Recent regulations permit changes every three months; the intent here is to return to previous policy allowing a monthly change.

The secretary of HHS should monitor and enforce regulations prohibiting D-SNP "look-alike" plans, which are non-integrated Medicare Advantage plans with disproportionately high dual eligible enrollment of 80% or more of the plan's total enrollment.[88] These plans are designed to attract dual eligible individuals, but are not subject to D-SNP integration requirements, such as the model of care requirement. To better address enrollment of dual eligible individuals in non-SNP MA plans, the secretary of HHS should prohibit non-SNP MA plans from directly targeting dual eligible individuals in their marketing. As discussed above, the secretary should also consider limiting beneficiary enrollment to fully integrated MA plans, if such an approach does not limit beneficiaries' access to supplemental benefits.

- **Implementation**: The secretary through the MMCO should implement the program.

B. Permit state participation in all aspects of policy development for integration programs.

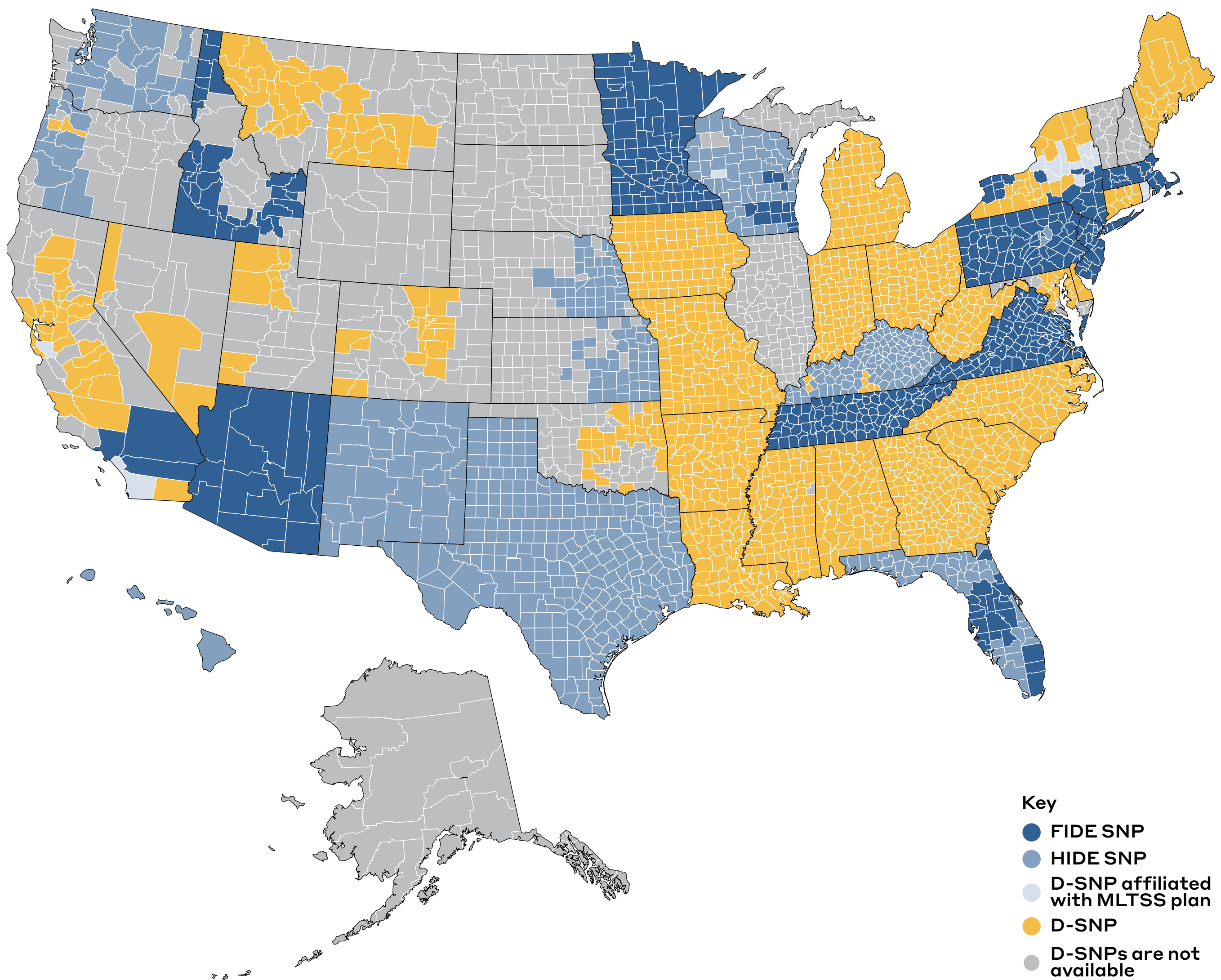
In states that elect to have the secretary integrate care, the secretary should define functions that, at the state's request, the state could perform. For example, the state may choose to have the secretary integrate care, but it would have the opportunity to consult on certain functions, such as determinations of network adequacy, plan readiness reviews, conducting of stakeholder engagement forums, or education and outreach to providers and beneficiaries.

The options for state participation allowed in the federal fallback resemble state involvement in the individual insurance exchanges established by the ACA. When setting up the exchanges, states could allow the federal government to operate the program through a federally facilitated exchange, establish and operate their own state-based exchange, or create a hybrid state-based exchange on the federal platform.[89] The state-based exchanges that are operated on the federal platform rely on HHS for certain functions, such as eligibility and enrollment processes, while the state maintains other functions, such as consumer outreach and assistance.[90] The shared responsibilities between HHS and the state would be similar under the federal fallback.

C. To ensure options for beneficiaries in all counties, authorize the secretary of HHS to require MA plans to offer at least one fully integrated plan in each service area in which they offer coverage.

States could request that the secretary exercise this authority as part of state-based integration. This option is to address the possibility that carriers do not offer plans in every county. In February 2021, 43 states and the District of Columbia were operating D-SNPs, with about 3 million dual eligible individuals enrolled.[91] However, D-SNPs were not necessarily available statewide, and the level of integration of the available SNPs varied from county to country in many states (Figure 5). If carriers were required to offer at least one fully integrated plan in each service area they covered, the availability of fully integrated options would expand greatly, both increasing capacity for and improving access to integrated care for individuals who live in states with existing D-SNPs.

Figure 5: Most Integrated Type of Dual Eligible Special Needs Plan Available by County, 2021



Source: MACPAC, 2021

V. Improve 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. 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 it assists beneficiaries when they are applying for Medicaid.[92] The Administration for Community Living, within HHS, administers SHIP program grants to provide funding for free local health coverage counseling and assistance for Medicare-eligible individuals and their families.

As the complexity of coverage options for dual eligible individuals has grown with the addition of new coverage options, budget proposals for FY2022 propose increasing funding for SHIP by about $3 million.[93] Funding for this program should be increased to better assist dual eligible individuals in understanding the potential benefits and drawbacks of enrolling in a fully integrated care model.

Experts also suggested that increased funding be used to 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 providing information 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,[94] 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. The lack of education for consumers and health care providers is a major challenge to increasing enrollment in fully integrated programs. In the initial FAI states, dual

eligible individuals were enrolled in integrated health plans with little understanding of the program or their plans.[95] 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 can disenroll at any time—an important beneficiary safeguard—the result was a significant drop in enrollment.[96]

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 these integrated programs, and the results have been positive.[97] However, states need resources to support these activities. Solutions include an ombudsman program, as well as special employment initiatives to encourage plans to hire consumers to provide insight on beneficiaries' concerns and ways to address those concerns.[l] For example, ongoing education in Arizona "has made beneficiaries more aware of the advantages of being in aligned plans for their Medicaid and Medicare benefits."[98] The creation of a technical assistance center focusing on consumer education and outreach could support these efforts. This could also increase state adoption of best practices and ensure more uniform consumer experience across state lines.

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 that insurance brokers could potentially confuse dual eligible individuals. There seemed to be a consensus that plans and beneficiaries would be better served if brokers were more knowledgeable about fully integrated plans and the needs of dual eligible individuals. CMS sets requirements for training of insurance brokers authorized to enroll beneficiaries in MA plans. It should expand training to include education on fully integrated plans and dual eligible individuals.

l See: Lessons Learned and Critical Success Factors in the data brief in Appendix I of BPC's report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

Conclusion

Fully integrated programs have the potential to improve the quality of care and lower the total cost of care for the high-need, high-cost dual eligible population. Over the past several years, Congress, multiple administrations, and states have made significant strides in improving the availability of integrated programs for this population. These programs, however, are still not available to all full-benefit dual eligible individuals in every state. To address this inequity, BPC has built on its earlier recommendations to require that all states offer fully integrated programs within a defined timeline. These bipartisan solutions ensure beneficiary choice and offer states the resources and technical assistance to successfully implement integrated programs, while continuing to move the needle in those states that choose not to integrate care.

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