

CHCS

Center for
Health Care Strategies, Inc.

Resource Paper

Encouraging Integrated Care for Dual Eligibles

By:
Melanie Bella
Lindsay Palmer

Made possible through support from The Commonwealth Fund.

July 2009

Contents

Introduction	3
Integrated Care Overview	4
Current Vehicles for Integrating Care: Special Needs Plans.....	6
Alternative Models for Integration.....	9
Gainsharing Demonstrations.....	9
Medicaid Duals Demonstration.....	10
Challenges to Promoting Integrated Care	11
Administrative/Operational Challenges	11
Financial Misalignment.....	11
Low Enrollment	12
Forging State-SNP Relationships.....	12
Developing and Bringing Model SNPs to Scale	13
Wisconsin Public Franchising Model.....	13
Conclusion: Opportunities for Promoting Integrated Care	14

Introduction

When policymakers created the Medicare and Medicaid programs 40 years ago, they did not envision that over eight million Americans would end up being eligible for both programs.¹ Nor could they have anticipated the intense care needs and exceedingly high costs associated with their care. Today, these beneficiaries (known as “dual eligibles”) and the state and federal officials responsible for their care are frustrated by the myriad financial misalignments and delivery system inefficiencies between these two programs. The opportunity to integrate care across service settings and funding streams offers great potential for improving the quality, coordination, and cost-effectiveness of care for this high-need population.

In the current health care system, far too many dual eligible beneficiaries receive uncoordinated fee-for-service medical and long-term care. In spite of recent efforts under the Medicare Modernization Act of 2003 (MMA) to create vehicles for integrating care through Special Needs Plans (SNPs), more than 80 percent of dual eligibles remain in fee-for-service systems that keep them in “treatment silos” connecting with one provider at a time—even when they have five doctors—and getting one prescription at a time—even when they take 15 different pills a day. And although the Centers for Medicare and Medicaid Services (CMS) has encouraged the integration of care via SNPs, state Medicaid agencies have struggled to create meaningful arrangements with these plans. While this may be due in part to bureaucratic inertia or competing demands, conflicting rules for the two programs further hinder integration. With a new Administration, increasing recognition of the current system’s costs and failures, as well as recent legislation establishing new requirements for SNPs,² states and health plans have additional opportunities to pursue integrated solutions that improve the quality and cost-effectiveness of care for dual eligibles.

For the last few years, the Center for Health Care Strategies (CHCS) has worked with leading states that are committed to achieving a system of truly integrated care for dual eligibles. Along the way, CHCS has also worked closely with CMS to identify ways to overcome key barriers to integration. Based on CHCS’ experiences in the field, this resource paper provides the rationale for integrating care for duals, reasons why integration has not taken hold thus far, and current and emerging vehicles for integration. It highlights the following promising policy directions that federal and state policymakers could consider to dramatically improve care delivery and control rising health care costs for millions of dual eligible Americans:

- Increase state options for integrating care by eliminating barriers that impede the success of SNPs and developing new alternatives where capitated managed care may not be feasible;
- Overcome financial misalignments so that multiple stakeholders are able to share in potential gains from the successful integration of care; and
- Create ways for consumers to drive the growth of integrated models that meet their needs and expectations.

¹ J. Holahan, D. M. Miller, and D. Rousseau. “Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005.” Kaiser Commission on Medicaid and the Uninsured, February 2009.

² The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted in July 2008; As of July 2009, a number of legislative proposals were circulating in both the House and Senate.

Integrated Care Overview

While Medicare and Medicaid generally cover different populations, there are more than eight million people who are eligible for both programs. Dual eligible beneficiaries represent the most chronically ill segments of both the Medicare and Medicaid population, requiring a complex array of services from a variety of providers. Although Medicare covers basic health care services, including physician and hospital care, dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover necessary long-term supports and services. Dual eligibles are, by definition, low-income: 60 percent of duals live below the poverty level, with as many as 94 percent living below 200 percent of poverty.³ In comparison to the general Medicare population, dual eligibles are also three times more likely to be disabled, and have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease.⁴ While dual eligibles represent just 18 percent of Medicaid enrollees and 16 percent of Medicare enrollees, they account for 46 percent of total Medicaid expenditures and 25 percent of total Medicare expenditures.^{5,6} In 2005, the total cost to Medicare and Medicaid for care provided to dual eligibles was roughly \$215 billion.⁷

Because Medicare and Medicaid are each governed by their own policies and procedures, dual eligibles are forced to navigate a system with two sets of providers, benefits, and even enrollment cards. All too often, this fragmentation results in unnecessary, duplicative, or missed services. Integrating Medicare and Medicaid services (including medical and long-term supports and services) can help ensure that dual eligible beneficiaries receive the right care in the right setting, rather than receiving care driven by conflicting state and federal rules and misaligned payment systems. For dual eligible beneficiaries, integrated care potentially offers one seamless set of benefits and providers, higher quality of care, and less confusion (Figure 1). For state and federal policymakers, integrated care can potentially reduce fragmentation, increase flexibility in the types of services that can be provided to beneficiaries, enhance budget predictability, and control the costs of caring for this population.

Every state's Medicaid program is designed to meet unique demands, and to fit state and local (or regional) provider capacity, practice patterns, and demographics. One size does not fit all, posing a challenge for national health plans that attempt to implement a standard package of benefits and program design within multiple states. While efforts to integrate all Medicare and Medicaid services (including long-term supports and services) for dual eligibles may need to vary by state and target population(s), in general, integrated care models should including the following components:

- **Strong patient-centered primary care base**, i.e., an accountable care home;
- **Multidisciplinary care team** that is structured to address the full range of a beneficiary's needs (medical, behavioral, social);
- **Comprehensive provider network** that meets the needs of the target population and supports the care coordination model;

³ *Report to Congress: New Approaches in Medicare*. Medicare Payment Advisory Commission. June 2004.
http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf

⁴ Ibid.

⁵ J. Holahan, D. M. Miller, and D. Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005." Kaiser Commission on Medicaid and the Uninsured, February 2009.

⁶ *Healthcare Spending and the Medicare Program, A Data Book*. Medicare Payment Advisory Commission. June 2008.
http://www.medpac.gov/documents/Jun08DataBook_Entire_report.pdf

⁷ CHCS estimate based on *Healthcare Spending and the Medicare Program, A Data Book*, Medicare Payment Advisory Commission, June 2007; and J. Holahan, et al., op. cit.

- **Robust data-sharing and communications systems** that guarantee continuous access to services and promote coordination of care across settings;
- **Consumer protections** that ensure access to longstanding community providers and involve consumers in program design/ governance; and
- **Financial alignment** that addresses fragmented systems of care through blended funding and/or shared gains and risks of providing services.

Figure 1: A Day in the Life of a Dual Eligible

Mattie is a 77-year-old woman eligible for both Medicare and Medicaid.⁸ She has longstanding diabetes and hypertension, and has had several strokes, resulting in weakness on her left side. She needs care from many providers: a personal care attendant whose assistance allows her to live alone at home, a licensed social worker who helps address her depression, and a variety of specialists to whom she has trouble getting to because of her mobility problems. The below chart compares Mattie’s health insurance benefits in an integrated system versus unintegrated care.

Mattie’s Health Insurance Coverage	
WITHOUT INTEGRATED CARE	INTEGRATED CARE
✘ Three ID cards: Medicare, Medicaid, and prescription drugs	✓ One ID card
✘ Three different sets of benefits	✓ One set of comprehensive benefits: primary, acute, prescription drug, and long-term care supports and services
✘ Multiple providers who rarely communicate	✓ Single and coordinated care team
✘ Health care decisions uncoordinated and not made from the patient-centered perspective	✓ Health care decisions based on Mattie’s needs and preferences
✘ Serious consideration for nursing home placement; Medicare/ Medicaid only pays for very limited home health aide services	✓ Availability of flexible, non-medical benefits that help Mattie stay in her home

⁸ Case study from Robert J. Master, MD, Commonwealth Care Alliance, Massachusetts.

Current Vehicles for Integrating Care: Special Needs Plans

Efforts have been made to better integrate Medicare and Medicaid for dual eligible beneficiaries almost from the time the programs were fully implemented (e.g., National Long-Term Care Channeling demonstration, On Lok/Program of All-Inclusive Care for the Elderly [PACE], social HMOs, etc.). With the passage of the MMA, a new vehicle emerged through which states could integrate Medicare and Medicaid for dual eligible beneficiaries. In addition to a new prescription drug benefit for Medicare beneficiaries, the MMA includes a provision that allows Medicare Advantage health plans to be designated as SNPs. The MMA established SNP authority through 2008, with subsequent legislation extending the authority through 2010.⁹

As SNPs, health plans are able to target enrollment to three categories of high-need populations: (1) dual eligibles; (2) beneficiaries requiring an institutional level of care; and (3) beneficiaries with chronic conditions. By limiting enrollment to one of these populations, SNPs are better able to tailor benefits. The potential for coordination of benefits for dual eligibles across both Medicare and Medicaid creates a unique opportunity for a specialty health plan.¹⁰ As of April 2009, 698 SNPs were approved, over half of which are targeted solely to dual eligibles.¹¹

Enrollment in a SNP does not automatically translate to integrated care for dual eligibles, however. Rather, the true value of SNPs for dual eligibles lies in the potential relationships between these health plans and state Medicaid agencies. Through these relationships, states and SNPs can offer the full array of Medicare, Medicaid, and supplemental benefits within a single plan so that beneficiaries have one benefit package and one set of providers to obtain the care they need. However, there is considerable variation in the comprehensiveness of SNP contracts among states that currently have them. Only about half of all states currently contracting with SNPs to integrate care for dual eligibles address the full range of Medicaid and Medicare services. In these state-SNP arrangements, dual eligibles are able to enroll in one health plan (which operates as both a SNP and a Medicaid health plan) to receive the full range of Medicare and Medicaid services. Consumers enrolled in these programs can benefit from a comprehensive care plan, coordinated model of care, and unified set of benefits. This is a key step toward eliminating confusion and helping beneficiaries and their caregivers access necessary services.

⁹ Additional proposed legislation currently being considered by the House would extend the authority through 2013.

¹⁰ C. Milligan and C. Woodcock. *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer*. The Commonwealth Fund, February 2008.

¹¹ *Special Needs Plan Comprehensive Report*, Centers for Medicare and Medicaid Services, April 2009.

<http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp#TopOfPage>.

Examples of State Integrated Care Programs

New York Medicaid Advantage: Medicare and Medicaid Acute Care

New York Medicaid Advantage allows dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits (excluding long-term care services). To participate in the program, health plans must be designated as a Medicare Advantage plan. These plans must offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product (which covers benefits not covered by Medicare and beneficiary cost-sharing.) Highlights include:

- Coordination to accomplish simultaneous enrollment in both the SNP and Medicaid; and
- Streamlined review by and reporting to CMS and the New York State Department of Health for items such as marketing materials and quality requirements.

New York also requires that participating plans include Medicare Advantage bid data as part of the state's bid template used to establish Medicaid rates. This provides the state with a full picture of the Medicare and Medicaid services being provided to dual eligibles. The data can be used to identify duplicative and overlapping services, as well as better ways to coordinate Medicare and Medicaid benefits and funding. Currently about 4,000 beneficiaries are enrolled in New York's Medicaid Advantage program. The state also operates a similar program, called Medicaid Advantage Plus, that includes long-term supports and services.

Minnesota Senior Health Options: Medicare and Medicaid Acute and Long-Term Supports and Services

Minnesota Senior Health Options (MSHO) is a voluntary, statewide program for seniors that provides Medicare and Medicaid acute and long-term supports and services through capitation arrangements with nine SNPs in 83 counties. The state also operates a comparable program in one metro area for persons with disabilities (Minnesota Disability Health Options). MSHO has been in operation since 1997 (first as a Medicare-Medicaid demonstration), making Minnesota one of the first states to operate a fully integrated program for dual eligibles. Today, over 35,000 duals receive care through this program. Highlights include:

- Integrated marketing and enrollee information materials, including member handbook, evidence of coverage, enrollment card, and provider directory for all current and potential enrollees; and
- Case management services designed to integrate the delivery of all Medicare and Medicaid services.

Despite increasing interest in SNPs as vehicles for integration, as noted above, only a handful of states currently operate fully integrated programs. Thus, of the approximately 1.5 million dual eligibles in the country who receive care via Medicare Advantage plans (including SNPs), less than 120,000 receive care through programs that fully integrate Medicare and Medicaid services. This may be due, in part, to a lack of administrative support or competing state priorities, but may also be because of skepticism from many state and federal policymakers as to what makes SNPs, many of which are large insurance companies, uniquely qualified to provide care for high-needs populations.

However, several small, non-profit entities have successfully demonstrated how SNPs can indeed be “special.” These “Model SNPs” generally have regional roots, which enable them to tailor care packages to beneficiaries’ needs rather than relying on one-size-fits-all approaches.¹² They also have a predisposition to use Medicare and Medicaid capitation payments flexibly to create medical/behavioral/long-term care homes for beneficiaries. Finally, they are more likely to reinvest the savings from avoiding unnecessary hospitalizations and institutionalizations to strengthen community-based services.

¹² For a “Model SNP” example, see the Commonwealth Care Alliance in Boston, a not-for-profit care delivery system launched in 2003; visit <http://www.commonwealthcare.org/index.html> for a program overview.

Key features of Model SNPs include:

- Consumer input on governance and care design, as well as involvement of community organizations;
- Multidisciplinary care team aligning care providers, including family members, nurses, psychiatric social workers, physicians, etc. — to address the full range of a beneficiary’s needs (medical, behavioral, social);
- Care planning that addresses psycho-social and medical factors, high-risk screenings and assessments, comprehensive care coordination, and continuity of care across all settings; and
- Competency in working with the heterogeneous subpopulations that make up duals (e.g., frail elders living in the community, people with disabilities, and those who are institutionalized, etc.).

In order to ensure that all SNPs adopt the features of Model SNPs, policymakers are considering a number of proposals that establish additional requirements for SNPs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was an important first step in facilitating SNP integration by: (1) requiring new plans or those that are expanding into new service areas to have relationships with state Medicaid agencies; and (2) establishing new standards in the provision of care (see sidebar for summary of relevant SNP provisions included in the MIPPA).

Provisions of Medicare Improvements for Patients and Providers Act of 2008

The Medicare Improvements for Patients and Providers Act of 2008 made a number of changes to the Medicare program, including the following enhanced opportunities for SNPs to integrate care.¹³

- **SNP Authority**
 - » Extends one more year (through plan year 2010—set to expire January 1, 2011).
 - » Lifts moratorium placed on CMS approval of SNPs, but sets new criteria for approval of SNPs targeted to dual eligibles (see below).
- **Dual Eligible SNPs**
 - » Plans must provide prospective enrollees with a written statement that describes the benefits and cost-sharing protections under Medicaid and identifies which benefits and cost-sharing protections are covered by the plan.
 - » Plans must have a contract with the state to provide or arrange for the provision of Medicaid benefits in order to enter the market and/or expand to new service areas.
 - Dual eligible SNPs without a contract may not enter the market and/or expand.
 - States, however, are *not* required to contract with SNPs.
- **Quality Provisions**
 - » All SNPs must provide the following care management activities for all members:
 - Evidence-based models of care;
 - Appropriate networks of providers/specialists;
 - Initial/annual assessment of physical, psychosocial, and functional needs; and
 - Individual care plan identifying goals, objectives, measurable outcomes, and specific benefits.
 - » All SNPs must provide data to “measure health outcomes and other measures of quality.”
 - Data will be reported at the plan level and may be based on claims data.

The law also requires the provision of technical assistance resources to work with states on the coordination of care with SNPs (it is assumed that CMS will work with states to determine the best way to provide this technical assistance). All provisions are effective in 2010.

¹³ M. Kennedy. “Medicare Improvements for Patients and Providers Act of 2008: Preliminary Summary of Beneficiary and Plan Provisions.” July 14, 2008. <http://www.communityplans.net/Portals/0/Policy/Medicare/Medicare%20Improvement%20Act%20of%202008.ppt>.

Alternative Models for Integration

As interest in integrated care continues to grow, a variety of options are needed to accommodate the varying delivery system infrastructures, programmatic needs, and political environments of individual states. While some states are already working to integrate care through SNPs, others are still developing the administrative capacity to integrate Medicaid and Medicare benefits. In addition, capitated managed care is not feasible in every state. This is particularly the case in rural areas, where it is often a challenge to get sufficient plan participation and provider networks. Even in states where managed care is present, integrating care via the SNP model may not happen.

Figure 2 identifies potential vehicles for integrating care via new alternative models. Through these options, a state would work alone or with an entity (e.g., a primary care case management vendor, provider group, or administrative services organization) to provide Medicare and Medicaid services (at varying levels of financial risk), including a mechanism for sharing in any resulting savings. While these models vary in complexity and services included, they all provide states with new opportunities to improve care for duals and achieve greater efficiency. Further, through these additional options for integrating care, dual eligible beneficiaries will benefit from having greater choice in how their care is delivered.

Figure 2: Potential Alternative Vehicles for Integrating Care*

Vehicle	Description
Gainsharing Demonstration (e.g., Section 646 of the Medicare Modernization Act)	Physician groups, integrated health systems, or regional coalitions join together and use an alternative payment system to support integration of services for dual eligible beneficiaries on a fee-for-service basis (e.g., provider network receives a per member per month fee for enhanced care management benefits and a portion of the resulting Medicare savings are reinvested in the project or for coverage expansions).
Medicaid Duals Demonstration	State with a well-established infrastructure for health plan/insurer functions (e.g., network development, claims payment, utilization management, etc.) receives Medicare funding and assumes risk for managing the Medicare and Medicaid benefit (directly or via contract/arrangement with an external entity that may or may not be at risk).

*Examples are not meant to serve as an exhaustive list of options.

Gainsharing demonstrations and what is referred to as a Medicaid Duals Demonstration are two relatively new vehicles. Both of these approaches, as described below, could ultimately offer states and/or other organizations a chance for greater participation in the development and implementation of integrated programs.

Gainsharing Demonstrations

North Carolina's pending 646 demonstration application offers perhaps the best example of what a gainsharing demonstration could entail.¹⁴ The North Carolina Community Care Networks (NCCCN) is pursuing a demonstration to better serve dual eligibles and address the financial misalignments between

¹⁴ For more information on 646 Demonstrations, see Centers for Medicare and Medicaid Services. "Medicare Health Care Quality Demonstration Program Factsheet." http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MMA646_FactSheet.pdf.

Medicare and Medicaid. NCCCN is a non-profit organization made up of 14 regional health care networks, including community physicians, hospitals, health departments, and other community organizations. Under this demonstration, NCCCN will expand current care coordination efforts for the Medicaid population to include the dual eligible and, eventually, the Medicare-only population. Networks will receive a per member per month fee for benefits, including on-the-ground case management, care transitions, and co-location of mental health. Any Medicare savings beyond a set threshold (using comparison counties) will be reinvested in the project for services for non-duals, home-based services, health information technology (HIT), and/or potential coverage expansions. The demonstration, which has been approved by the U.S. Department of Health and Human Services but is currently awaiting final authorization from the Office of Management and Budget, will be implemented in 26 of North Carolina's 100 counties.

While North Carolina's proposed demonstration presents a unique opportunity for integration of Medicaid and Medicare services for dual eligibles outside of the capitated SNP model, the authority under which it is pursuing demonstration status was closed to new applications in 2006. Many states are interested in replicating North Carolina's model; however, it is unclear at this point whether this option will be available to other interested states in the future.

Medicaid Duals Demonstration

This model provides an opportunity to integrate the full range of Medicare and Medicaid benefits (e.g., primary, acute, behavioral health, and long-term supports and services) for dual eligibles beyond the SNP model. Modeled after the Medicare Advantage program but managed by the states (as opposed to the plans), this model would provide a medical home and better coordinated care for duals. Under the demonstration, states with a well-established infrastructure and experience with traditional health plan and/or insurer functions (e.g., claims payment, utilization management, care management, provider networks, etc.) would receive the monthly Medicare premium and assume responsibility for the management of both the Medicare and Medicaid benefit. States could either manage the integrated benefit themselves or establish a contract or other arrangement with a health plan or administrative entity (on a risk or non-risk basis) to do so.

Under this model, states would be responsible for both the Medicaid and Medicare benefit, with the federal government continuing to provide financial support for Medicare services through a risk-adjusted, capitated payment. States and the federal government would continue to share the cost of the Medicaid portion of the benefit. However, by allowing states or the plans they select to manage the full spectrum of services provided to duals, this model offers an opportunity to improve care for the beneficiaries and provide greater budget predictability to both states and CMS.

The type of state most likely to be interested in and/or best equipped for this type of arrangement is one that currently operates a primary care case management (PCCM) program. PCCM programs use primary medical providers to coordinate primary care and incorporate features found in capitated managed care programs, such as care coordination and quality improvement programs. States that operate these non-capitated programs (e.g., Oklahoma, Vermont) essentially function as a health plan and are responsible for activities typically associated with a traditional insurer, including claims payment, utilization management, provider network development, and quality improvement projects, etc. While this could be a promising model for integrating care outside of SNPs, it is unclear at this point whether CMS is interested in allowing such demonstrations.

Challenges to Promoting Integrated Care

Despite continued interest among states, a number of challenges remain that may prevent them from developing and implementing both SNP and alternative models of integrated care. These include: (1) administrative and operational inconsistencies between Medicare and Medicaid; (2) financial misalignments between Medicare and Medicaid that limit states' ability to share in savings associated with these programs; and (3) low enrollment to date. In addition to addressing these challenges, states pursuing integrated care via SNPs should consider working with plans to develop relationships and share information, as well as determining how to develop Model SNPs and bring them to scale.

Administrative/Operational Challenges

The inherent administrative complexities in Medicare and Medicaid rules make it difficult for states and plans to integrate benefits for duals. Specifically, there are conflicts and/or ambiguities in a number of areas, including marketing and enrollment; rate setting and financing; grievances and appeals; and monitoring and reporting. CMS has published several resources to help states address these issues. "How To" guides on enrollment, marketing, and quality provide clarification on Medicare and Medicaid rules and suggest streamlined processes that states and plans can use to fulfill both programs' requirements.¹⁵ While these efforts have made strides in addressing some of the barriers to integration, much work remains to be done.

It is likely that states interested in using alternative options to integrate care will face obstacles to securing the necessary waiver or demonstration authority from CMS. In addition to the investments of time and resources needed to complete the waiver process, stakeholders may need new information systems to ensure real-time exchange of data (including risk assessments, care plans, recent utilization, consumer preferences, etc.) among all those responsible for the care of dual eligibles.

Financial Misalignment

Because Medicare covers the majority of medical care for duals, Medicaid programs that invest resources in improving care for this population (e.g., through enhanced care management) may not see short-term returns on their investments. Rather, financial benefits achieved through reductions in Medicare-covered inpatient or emergency room services flow almost exclusively to the federal government or to SNPs. While state investments may ultimately result in delayed or reduced nursing home utilization, this would be over a much longer timeframe. Thus, there may be inadequate short-term savings to help offset the initial investment by Medicaid. New mechanisms to ensure that both Medicare and the states could share in short- and long-term savings would facilitate more rapid adoption of integrated care models.

Ideally, such gainsharing mechanisms would allow CMS, a state Medicaid agency, and its health plans or PCCM to benefit from the financial savings generated by quality improvement interventions targeted to dual eligibles. A more palatable approach for CMS in the short term may be to allow state Medicaid agencies to count Medicare savings attributable to integrated care programs toward cost effectiveness and/or budget neutrality required for Medicaid waivers. Alternatively, CMS could provide grants, similar to Medicaid Transformation Grants, to support the development of fully integrated programs and assist with upfront costs. These options would alleviate pressure on states operating integrated programs using both SNP and alternative models to show short-term savings. This is particularly critical because, as mentioned earlier, it often takes several years to realize potential savings from reduced use of nursing facility services. All of these options would require approval from CMS.

¹⁵ CMS "How To" guides and other CMS-developed resources can be found in its *Integrated Care Roadmap*: http://www.cms.hhs.gov/IntegratedCareInt/02_Integrated%20Care%20Roadmap.asp.

Outside of CMS, state Medicaid agencies and plans could work together to develop their own approaches for sharing in the savings resulting from their partnership. This would eliminate the need for CMS negotiations while still permitting gainsharing among states and their health plan partners. States could reinvest potential savings into enhanced program benefits, HIT, and possibly even coverage expansions.

Low Enrollment

Although fully integrated care programs can reduce and even eliminate difficulties associated with navigating the traditionally fragmented system of care for dual eligibles, enrollment remains low in the majority of programs that fully integrate care via SNPs. This may be due to a number of reasons, not the least of which is the issue of voluntary enrollment. While states can mandate enrollment into Medicaid programs, Medicare is voluntary due to the “freedom of choice” requirement. As a result, even when integrated programs are available, there is no mechanism to ensure that dual eligibles will receive their Medicare and Medicaid services from a single plan. This has posed a significant challenge for enrollment in integrated programs.

In addition, low enrollment may result from the sometimes complicated processes that hamper beneficiary participation. For example, many programs do not yet have integrated enrollment processes, meaning duals must complete separate forms in order to enroll in one plan for both the Medicare and Medicaid benefit. This can be quite cumbersome for the beneficiary. And while experts and policymakers have discussed the idea of integrated care for years, it is a concept unfamiliar to most dual eligibles and their families. Beneficiaries (and their caregivers) may be reluctant to participate in these new programs/plans for fear that doing so will disrupt their relationships with current providers. This uncertainty could pose similar challenges for states pursuing new alternatives, as well. Better educating consumers and ensuring that all integrated care programs using both SNP and alternative models use a patient-centered approach to care could go a long way toward enhancing consumer demand for programs and increasing future enrollment.

Forging State-SNP Relationships

To date, relatively few contracts and/or other relationships have been established between states and SNPs. To address this issue, the MIPPA legislation included a requirement that dual eligible SNPs entering the market and/or expanding into new service areas have a contract with a state Medicaid agency in place by 2010. CMS has since incorporated this requirement into the 2009 Medicare Advantage contract.

Another important aspect to improving relationships between states and SNPs is information sharing. The 2008 and 2009 SNP applications required applicants to provide information regarding their model of care.¹⁶ Currently, this information is not made available to states. A number of states, however, have expressed interest in accessing this information because it would allow them to determine whether or not models of care that SNPs are proposing will align with existing or planned state programs.

Additionally, as SNP-specific quality measures are collected in the future, linking model of care characteristics with outcome measures could offer a rich source of information about the effectiveness of various care models. Finally, the MIPPA requires SNPs to develop individual care plans for every enrollee. Sharing this information with states could facilitate SNPs and states working together to design programs tailored to the complex and heterogeneous needs of dual eligible beneficiaries, particularly programs intended for subsets of this population.

¹⁶ The 2008 and 2009 SNP applications asked applicants to provide a model of care, defined as “the applicant’s proposed approach to providing specialized care to the SNP’s targeted population, including a statement of goals and specific processes and outcome objectives for the targeted population to be managed under the SNP, and differentiates how this plan has added value for special needs populations when compared to other MA plans.” <http://www.cms.hhs.gov/medicareadvantageapps/>.

Developing and Bringing Model SNPs to Scale

The Model SNPs introduced earlier in this paper are often provider-sponsored organizations adept at managing care for the frail elderly and people with disabilities, but which have little to no experience as Medicare insurers. By entering the SNP market, many of these organizations have to become insurance companies for the first time. Becoming a SNP is not a simple undertaking. It requires access to capital, significant operational infrastructure, and knowledge of the Medicare world. There are a number of regional and/or community-based entities experienced in providing care to high-risk Medicaid populations, but they often lack the infrastructure and resources to become a Medicare plan. These potential Model SNPs are a direct contrast to some of the large, national health plans that have the resources required to become Medicare health plans, but may lack experience caring for extremely high-need, high-cost populations. Indeed, it may be worth exploring potential partnership opportunities between the smaller “boutique” plans skilled in specialized care management and large insurers that have the resources and infrastructure to take programs to scale.

With over 400 dual eligible SNPs currently in operation,¹⁸ Model SNPs often find it difficult to compete with larger health plans and grow membership. Additionally, significant ongoing resources are needed for these plans to reach scale. Another idea that could be considered to help develop and expand these plans is to create a technical assistance and resource center to: (1) foster knowledge transfer among existing and future Model SNPs; and (2) explore shared infrastructure approaches, revolving loan funds, or reserve funding pools to help Model SNPs go to scale. In addition, since dual eligible SNPs are required to contract with states by 2010, state purchasers could be in a better position to support Model SNPs by requiring elements of these models in integrated care contracts.

Wisconsin Public Franchising Model

The Wisconsin Department of Health Services (DHS) developed a mechanism to help many of its capitated managed long-term care plans expand more rapidly across the state. Its public franchising model would support the development of managed care organizations (MCOs) participating in its Family Care and Partnership Programs. Under this model, the state would provide shared infrastructure and purchasing strategies, as well as technical assistance and training for plans operating within the state. In doing so, the state believes it could achieve economies of scale while having services delivered through community-oriented organizations. This would also accelerate the development and adoption of best practices in areas where the MCOs may be weak or inexperienced. The model consists of the following key elements:¹⁷

- *Family Care becomes a “brand” in which the particular approach to care is defined, specified, and “owned” by DHS.* Because there is a centrally defined, consistent service to be provided, members can expect to receive the same services and outcomes regardless of the MCO.
- *Family Care is provided by independent MCOs working in a collaborative relationship with DHS.* This involves a complex and collaborative business relationship in which contracts go beyond simple business agreements that specify quality, quantity, and price. Instead the contracts will need to define not only program specification and service delivery requirements, but also business processes, information sharing, etc.
- *DHS provides and facilitates support for the MCOs.* DHS will facilitate shared service opportunities such as HIT, payroll, and facilities management, as well as provide technical assistance in areas such as provider contracting and care management quality. This allows MCOs to focus on their core competency—providing consumer-centered care management—in exchange for state access to real-time financial and care management information.

¹⁷ The Management Group, Inc. *A Public Franchise Model for the Family Care Enterprise Development and Management: Rationale, Model Components, Implementation Options and Resource Requirements*. September 2008.

¹⁸ Special Needs Plan Comprehensive Report, op cit.

Conclusion: Opportunities for Promoting Integrated Care

While there have been a number of attempts to foster more widespread and “scaleable” integration of care for the duals over the years, there is now a more urgent need to find new ways to improve the coordination and cost-effectiveness of care for America’s highest-need, highest-cost population. With the first of the 78 million baby boomers becoming eligible for Medicare in the next five years and medical advances enabling the elderly and those with disabilities to live longer, it is likely that care needs will only intensify and the percentage of public expenditures going toward dual eligibles will continue to grow. Unless long-term care insurance becomes more affordable, many individuals will likely spend-down to Medicaid eligibility and the proportion of duals will increase.

Integrating care across service settings and funding streams has great potential for improving the quality, coordination, and cost-effectiveness of care for the dual eligible population. Despite the early promise of SNPs as a vehicle for integrating care, state Medicaid agencies have struggled to contract with these plans in large part due to federal administrative and financial misalignments. However, the current momentum fueled by the national health reform debate coupled with the growing emphasis on state-SNP connections, creates a window of opportunity for additional states to begin developing relationships with SNPs that truly offer something “special.”

Policymakers can take the following steps to make it easier for states and plans to develop and implement fully integrated programs:

- **Eliminate barriers that prevent integrated care from achieving its potential.** CMS can work with states to further streamline conflicting Medicare and Medicaid policies and procedures in areas such as marketing, quality reporting, and grievances and appeals. One idea being discussed is the creation of an office to coordinate care for dual eligibles within CMS that establishes one place to go for policies, procedures, and tools to support integration.
- **Promote better state-SNP relationships.** Federal agencies (CMS, Administration on Aging, etc.) can promote the SNP option with state leadership (Medicaid agencies, Governors, etc.) and with the Medicare Advantage industry. CMS can facilitate state-SNP relationships by making more information available to the respective parties and by promoting the features that make SNPs “special.”
- **Expand the options for integrating care beyond those currently available to states.** Congress and CMS can provide greater authority for testing innovative alternatives to increase options in states where SNPs are not active and duals are served by the Medicare fee-for-service system.
- **Enable Medicare and Medicaid stakeholders to share savings generated from the integration of services for dual eligibles.** Congress and CMS can establish mechanisms that would enable states, plans, and the federal government to share savings (e.g., from reduced emergency department and inpatient use) generated from integrating primary, acute, behavioral, and long-term supports and services for duals.
- **Create avenues for consumers to declare what they want and/or need from integrated care.** States and SNPs can create vehicles for capturing consumer preferences, raising consumer awareness, and building consumer demand for well-coordinated, patient-centered systems of care.

Policymakers and budget officials in Washington, D.C. and in state capitals across the country are increasingly focusing on improving systems of care for the dual eligible population. The current and impending future, high costs of this growing population is a great motivator. Increasing consumer and advocacy interest and the emergence of motivated plan and provider interest groups are further driving efforts for change. By working with states to come up with creative solutions, federal policymakers can both improve health outcomes and control growth in Medicaid and Medicare costs for dual eligible beneficiaries.