

## Options for Integrating Care for Dual Eligible Beneficiaries

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National and state policymakers are becoming ever-more aware of the imperative to fix the non-system of care for the millions of vulnerable Americans eligible for both Medicaid and Medicare, over 80 percent of whom remain in uncoordinated fee-for-service (FFS) care. Many federal and state officials as well as those in the stakeholder community have become engaged in a lively and creative discussion of options for integrating care for the nearly 9 million duals, whose care is now costing \$250 billion annually—approaching half of all Medicaid expenditures and a quarter of Medicare outlays.

Options for integration can be grouped into four broad categories: (1) Special Needs Plans (SNPs); (2) Program for All-Inclusive Care for the Elderly (PACE); (3) Shared Savings Models; and (4) States as Integrated Care Entities. A more important starting point, however, is to agree on the main goals and key elements of integration that any one of these options would have to achieve in order to be acceptable to all stakeholders, particularly dual eligible beneficiaries and their families. The goals should be clear: to provide beneficiaries with the right care at the right time in the right places; and to give states and other stakeholders the flexibility they need to design and test accountable models of integrated care. The options to be developed must include the following core elements:<sup>1</sup>

- Strong patient-centered care based in accountable primary care homes;
- Multi-disciplinary care teams that coordinate the full range of medical, behavioral, and long-term supports and services (LTSS) needs;
- Comprehensive provider network capable of meeting that full range of needs;
- Enhanced use of home- and community-based long-term care services
- Robust data sharing and information systems to promote care coordination;
- Strong consumer protections that ensure access to longstanding providers and involve consumers in program design; and
- Financial alignment that impels integration of care.

Each of the four options detailed herein can be constructed to achieve these goals and fully embrace these key elements. However, their applicability will vary across states and regions within states, depending upon the penetration of managed care, the sophistication of integrated health systems, the state's capacity, and its engagement of consumer and provider stakeholders. The options are not mutually exclusive. For example, a state could contract with SNPs and also offer PACE. In addition, the degree to which a program is statewide varies, and the only option in use today on a statewide basis is SNPs. In some larger states, it is probable that no one option will fit all sizes of communities. For example, in a state as large and varied as California, it will make more sense to pursue the broadest option that could accommodate different strategies built upon a common base and set of expectations.

CHCS developed this analysis with support from The SCAN Foundation, which is seeking to advance realistic policy options to establish and finance a comprehensive continuum of care for seniors.

<sup>1</sup> Elements listed are based on integrated care work that CHCS has done with multiple states, plans, the Centers for Medicare and Medicaid Services, and other stakeholders. The list is not necessarily meant to be exhaustive, but rather to represent core elements from the perspective of beneficiaries in integrated programs.

## OPTION 1: Special Needs Plans (SNPs)

The Medicare Modernization Act of 2003 (MMA) gave CMS the authority to designate certain Medicare Advantage plans as SNPs. As SNPs, these plans can target one of three high-need populations: (1) dual eligibles; (2) beneficiaries requiring an institutional level of care; and (3) beneficiaries with chronic conditions. Enrollment in a SNP does not automatically translate into integrated care for dual eligibles, however. The 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.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) facilitated greater SNP integration by: (1) requiring new plans or those that are expanding into new service areas to contract with state Medicaid agencies; and (2) establishing new standards in the provision of care, including: evidence-based models of care; interdisciplinary care teams; and individual care plan identifying goals, objectives, measurable outcomes, and specific benefits.

States can contract with SNPs to cover a variety of Medicaid services. The options below are listed in the order of the contracting complexity and degree of integration likely to be involved, with the least complex/comprehensive Medicaid coverage listed first.

- **Data-Sharing:** An arrangement is made for data/information exchange to allow parties involved in the care of dual eligibles (e.g., Medicaid agencies, health plans, providers, pharmacies, care managers, etc.) to receive necessary information related to that care. State Example: Maryland
- **Medicare Cost-Share Only:** States enter into contracts/agreements with SNPs to provide for the Medicare premiums and beneficiary cost sharing that Medicaid is required or chooses to pay for dual eligibles and others enrolled in Medicare Savings Program (MSP). State Examples: Texas, Maryland
- **Medicare Cost-Share and Medicaid Wraparound Services:** In addition to providing plans with a monthly capitation rate that covers Medicare cost-sharing responsibilities, states also contract with SNPs to provide Medicaid acute care services not covered or only partially covered by Medicare (e.g., vision, dental, hearing, durable medical equipment, transportation, care coordination, etc). State Examples: New York (Medicaid Advantage), Minnesota (Special Needs Basic Care)
- **Medicaid Acute and Long-Term Supports and Services:** States enter into contracts or other agreements with SNPs for the provision of the full array of Medicare and Medicaid acute and long-term supports and services. State Examples: Arizona, Minnesota (Minnesota Senior Health Options), New Mexico, New York (Medicaid Advantage Plus), Texas (STAR+PLUS), Washington

### Considerations

- Presence of managed care infrastructure
- MIPPA requirement that dual eligible SNPs contract with state Medicaid agencies
- Ability/willingness to contract for more than cost sharing and wrap-around services (e.g., LTSS)
- SNP experience/capacity to provide LTSS
- May require new/updated waivers
- Impact of potential Medicare Advantage rate cuts on SNP viability
- Likelihood of SNP extension beyond current authorization through 2011

### Pros

- Allows states to choose the locus and level of integration that meets their needs and goals
- Capitated models provide states greater budget predictability (although consideration needs to be given to the degree of financial risk)
- Allows for some streamlining of administrative processes (e.g., enrollment, marketing, quality measures and reports, etc.)
- SNPs are required to have a multi-disciplinary care team that works together to develop individual care plans for beneficiaries

### Cons

- Medicare and Medicaid funding is not truly blended
- Plans must comply with rules of two different purchasers — i.e., different state and federal requirements about oversight of plans
- If contract is not for full integration, consumers would continue to navigate two separate systems (e.g., enrollment, provider networks, evidence of benefits, marketing materials, etc.)
- SNP model is not viable for all states (e.g., those without operating SNPs; those without Medicaid managed care; and those which may want to operate through an existing primary care case management infrastructure in which the state serves as the managed care entity) and/or in all areas of a state (e.g., rural areas)
- States are unlikely to share in any savings on the acute care side that may result from service integration

## OPTION 2: Program for All-Inclusive Care for the Elderly (PACE)

PACE serves individuals who are age 55 or older, certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. PACE provides eligible beneficiaries with all needed Medicare and Medicaid medical and supportive services.

PACE regulations provide for one set of requirements regarding eligibility, application procedures, administrative requirements, services, payment, participant rights, quality assurance, and marketing requirements. These regulations allow a PACE organization to enter into a PACE program agreement with the Centers for Medicare and Medicaid Services (CMS) and the state Medicaid agency for the operation of a PACE program. A PACE organization may be an entity of a city, county, state, or tribal government or a private 501(c)(3) not-for-profit entity.

### Considerations

- Significant upfront capital is needed to establish a PACE entity
- It is resource intensive for the state to administer for a relatively small population
- Regulatory/statutory change may be needed to address some of the barriers that have slowed the growth of PACE in the past (e.g., removing the age and level of care requirements for beneficiary participation; reducing geographic limitations)
- Impact of potential Medicare Advantage rate cuts on PACE rates

### Pros

- Fully integrates Medicare and Medicaid funding streams
- One set of comprehensive PACE services including non-medical supports designed to keep beneficiaries in their homes
- One set of administrative processes
- Established set of comprehensive quality measures that monitors/ensures consumer outcomes/satisfaction
- Allows states to serve as the PACE organization
- States have authority to provide PACE through their Medicaid state plans

### Cons

- Inability for state to share in the savings that may result from integration
- PACE organizations have limited scope in terms of their provider network so enrollees may be required to change providers in order to participate in PACE
- Current age and level of care requirements may hinder widescale adoption of PACE

## OPTION 3: Shared Savings Model

The focus of this model is on aligning incentives and eliminating cost shifting between Medicare and Medicaid. Broadly speaking, physician groups, integrated health systems, or regional coalitions join together and create a tailored alternative payment system to support integration of services for dual eligible beneficiaries on a FFS 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).

North Carolina's Medicare Health Care Quality (MHCO) Demonstration (aka 646 demo) is the best example of this option. Using North Carolina's Medicaid primary care case management (PCCM) infrastructure, North Carolina Community Care Networks (NC-CCN), a non-profit organization, will:

1. Assign beneficiaries to a primary care provider (PCP);
2. Provide community-based care coordination services to beneficiaries and providers;
3. Expand the case management information system to include duals as well as Medicare only beneficiaries; and
4. Implement a performance, reporting, and incentive program for participating providers.

CMS and NC-CCN will share in any Medicare savings that exceed an agreed-upon threshold. At least 50% of the shared savings payments will be contingent upon satisfaction of a set of performance measures in key areas (e.g., management of diabetes, heart failure, etc.).\*

### Considerations

- Infrastructure/capacity (e.g., NC took considerable time/resources)
- Presence and/or establishment of non-profit entity to administer
- Strength of primary care network
- Overlap between Medicare and Medicaid providers
- Ratio of Medicaid to Medicare payment rates
- Extent to which LTSS are integrated (potential to impact/further enhance savings generated by reductions in Medicare acute care utilization)
- Likelihood of this demonstration authority being extended by CMS to other states

### Pros

- Eliminates disincentive for Medicaid to provide care management for its duals
- Better coordination of care for beneficiaries than in FFS
- Could be incremental step toward taking on more risk/blending of funds

### Cons

- Maintains existing FFS system, which does not reinforce purchasing for value and improved outcomes (e.g., quality over quantity)
- Medicare and Medicaid funding is not fully blended, resulting in less flexibility for providers to tailor the benefits than with a global capitated payment
- While there is limited risk for the state, there is also limited opportunity for the state to accrue savings
- Requires upfront funding to support care management functions
- Must be designed anew for every set of purchaser/payer/provider circumstances

\*"New Medicare Quality Demonstrations in North Carolina, Indiana to Address Quality Improvement Efforts," Centers for Medicare and Medicaid Services press release, issued January 27, 2010. Available at: [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp).

## OPTION 4: State as Integrated Entity

This emerging model would provide 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. The Medicaid program would receive an agreed-upon amount of Medicare funding for participating dually eligible beneficiaries and would assume responsibility for the Medicare benefit. In the operational sense, this model parallels the role of states in administering their Medicaid programs in that they coordinate payment, coverage, and benefits for all acute, behavioral, pharmacy, and long-term care benefits for all Medicaid beneficiaries.

As they do in Medicaid, states could either manage the integrated benefit themselves or establish contracts or other arrangements with health plans or administrative entities (on a risk or non-risk basis) to do so. Responsibilities would include: network development and selection; provider payment and performance review; financial administration; provision of enrollee protections; care management functions; health information collection and use; and compliance with other safeguards.

This model allows a state the option to: (1) leverage current SNP and PACE programs; (2) expand these programs; and/or (3) develop new managed care entity capacities.

### Considerations

- State capacity/infrastructure
- Provider payment rates
- Provider network capacity
- Likelihood of securing CMS approval as no state has yet received approval to receive the Medicare funding and act as the integrated entity
- Methodology to establish Medicare payments to state
- Availability of “good” linked data to inform rate setting, care opportunities, etc.

### Pros

- Complete blending of Medicare and Medicaid funding streams
- More of potential savings could accrue to the state
- State can reinvest savings from better coordinated, more cost-effective care to strengthen the overall system (e.g., rate increases, expansion of community-based services, etc.)
- Establishes care homes for all duals
- Better coordination of care for beneficiaries than in FFS
- Provides states with the flexibility to develop a platform for pursuing/overseeing a menu of options depending on state specific circumstances (e.g., existing infrastructure, urban/rural issues, etc.)
- Increased accountability – performance, quality improvement, etc.
- Should provide more uniform, integrated set of rules for plans to follow

### Cons

- State bears Medicare risk
- Potential impacts of a voluntary program (e.g., rate uncertainty, adverse selection, etc.) are heightened because the state bears full Medicare risk
- Potential health plan, provider and consumer resistance to losing direct relationship with Medicare

## APPENDIX A: States with Fully Integrated Care Programs for Dual Eligibles<sup>1, 2</sup>

State	Program Name	Population	Integration Model		Benefits				Geography		Medicaid Enrollment		
			Special Needs Plan (SNP)	Alternative	Medicare Acute	Medicaid Acute	LTC*	BH*	Pilot	Statewide	Mandatory	Voluntary	
Arizona	Arizona Long Term Care Services (ALTCs)	Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes dual eligibles.	Currently contracts/contractors not required to be SNPs		✓	✓	✓	✓		✓	✓		
Colorado	In Development	All dual eligibles.	Contracts planned		IN DEVELOPMENT							✓	
	In Development	All dual eligibles.		✓	IN DEVELOPMENT							✓	
Maryland	In Development	Dual eligibles and Medicaid-only beneficiaries needing LTC services.	Contracts planned		✓	✓	✓		IN DEVELOPMENT				
Massachusetts	Senior Care Options	Dual eligibles and Medicaid-only beneficiaries age 65 and older.	Currently contracts/contractors required to be SNPs		✓	✓	✓	✓		✓	Statewide procurement, but limited provider regions		✓
	In Development	Dual eligibles ages 22-64; may expand age range.		✓	✓	✓	✓	✓		✓		IN DEVELOPMENT	
Michigan	In Development	Dual eligibles and Medicaid-only beneficiaries with nursing home level of care.		✓	✓	✓	✓		✓		✓		
Minnesota	Minnesota Senior Health Options (MSHO)	Dual eligibles and Medicaid-only beneficiaries age 65 and older.	Currently contracts/contractors required to be SNPs		✓	✓	✓	✓		✓			✓
	Minnesota Disability Health Options (MnDHO)	Dual eligibles and Medicaid-only beneficiaries with physical disabilities, ages 18-65.	Currently contracts/contractors required to be SNPs		✓	✓	✓	✓		✓	Limited regions		✓
	Special Needs Basic Care (SNBC)	Dual eligibles and Medicaid-only beneficiaries with disabilities.	Currently contracts/contractors required to be SNPs		✓	✓		✓		✓	Limited regions (may expand statewide)		✓

<sup>1</sup> CHCS defines fully integrated care as programs that include the full range of Medicare and Medicaid primary, acute, and long-term supports and services.

<sup>2</sup> This matrix includes a selection of state activities for integrating care effective March 2010; it is not an exhaustive list.

## States with Fully Integrated Care Programs for Dual Eligibles (continued)

State	Program Name	Population	Integration Model		Benefits				Geography		Medicaid Enrollment	
			Special Needs Plans (SNPs)	Alternative Model	Medicare Acute	Medicaid Acute	LTC	BH	Pilot	Statewide	Mandatory	Voluntary
New Mexico	Coordination of Long-Term Services (CoLTS)	All dual eligibles; Medicaid-only beneficiaries who receive certain waiver services or reside in a nursing facility.	Currently contracts/contractors required to be SNPs		✓	✓	✓			✓	✓	
New York	Medicaid Advantage	Dual eligibles age 18 and older.	Currently contracts/contractors required to be MA* or SNPs		✓	✓		✓		✓		✓
	Medicaid Advantage Plus	Dual eligibles age 18 and older who have a nursing home level of care.	Currently contracts/contractors required to be MA or SNPs		✓	✓	✓	✓		✓		✓
Pennsylvania	Integrated Care Option	Dual eligibles age 60 and older.	Contracts planned/contractors will be required to be SNPs		✓	✓	✓		✓			✓
Texas	STAR+PLUS	Medicaid beneficiaries who receive SSI* and/or qualify for certain waiver services. Includes dual eligibles.	Currently contracts/contractors will be required to be SNPs as of 2010		✓	✓	✓	✓ Limited		✓ Limited regions	✓	✓ Children receiving SSI
Vermont	In Development	All dual eligibles.		✓	✓	✓	✓	✓	✓			✓
Wisconsin	Partnership Program	All dual eligibles; Medicaid-only beneficiaries who receive a nursing home level of care.	Currently contracts/contractors required to be SNPs		✓	✓	✓	✓ Mental Health		✓ Limited regions (may expand statewide)		✓
Washington	Washington Medicaid Integration Partnership (WMIP)	Dual eligibles and Medicaid only beneficiaries ages 21 and older.	Currently contracts/contractors not required to be SNPs		✓	✓	✓	✓	✓			✓

### \*Legend

LTC	Long-Term Care Services
BH	Behavioral Health Services
MA	Medicare Advantage
SSI	Supplemental Security Income

## Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is working with states, health plans, and federal policymakers to develop and support programs that integrate care for adults who are dually eligible. For additional resources on integrating care for duals, visit [www.chcs.org](http://www.chcs.org).

*This analysis was supported by a grant from The SCAN Foundation, based in Long Beach, California. The SCAN Foundation is an independent foundation dedicated to advancing the development of a sustainable continuum of quality care for seniors that integrates medical treatment and human services in the settings most appropriate to their needs and with the greatest likelihood of a healthy, independent life. The SCAN Foundation supports programs that stimulate public engagement, develop realistic public policy and financing options, and disseminate promising care models and technologies.*