

# The Dual Eligible Population in Massachusetts: ISSUE BRIEF

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The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, MassHealth. MMPI’s mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

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# INTRODUCTION

Across the United States, over 12 million low-income seniors and individuals with disabilities receive health care coverage through both their state Medicaid program and Medicare; these are known as dual eligible individuals. Dual eligible individuals often have some of the most complex care needs: Many require physical and behavioral health care (including treatment for mental health and substance use disorders), and also long-term services and supports (LTSS) like home health aide and personal care services to help them with their daily care needs and routines. Because dual eligible individuals have health care coverage through two distinct payers—Medicaid and Medicare—their care is often fragmented and uncoordinated, which can result in worse health outcomes and higher health care costs.

In Massachusetts, of the 1.8 million people<sup>1</sup> enrolled in MassHealth, the state’s Medicaid program, one in five (or 312,000 people)<sup>2</sup> are dually eligible. Massachusetts has long recognized the challenges in coordinating care for this population with complex needs, and it has been a pioneer in implementing integrated care programs that cover comprehensive Medicare and MassHealth benefits through a single program administered by MassHealth. These programs are One Care, the Program of All-Inclusive Care for the Elderly (PACE), and Senior Care Options (SCO).<sup>3</sup> However, the vast majority of dual eligible individuals in Massachusetts are not enrolled in integrated care programs and instead are covered by MassHealth fee-for-service (FFS). MassHealth is developing a new round of reforms, known as the Duals Demonstration 2.0 (or “Duals Demo 2.0”), to increase enrollment in One Care and SCO, enhance the quality of care received by dual eligible individuals, and reduce costs associated with their care.

Given the complex care needs of the dual eligible population and the dynamic state policy environment in which they receive services, the Blue Cross Blue Shield of Massachusetts Foundation commissioned Manatt Health and the Center for Health Care Strategies (CHCS) to develop this educational “primer” to build a common and improved understanding of dual eligible individuals in Massachusetts. This primer illustrates the diversity of dual eligible individuals’ clinical and functional needs, service utilization, and spending patterns, and it describes the program options that are available to meet their needs, with a particular focus on MassHealth’s integrated care programs. The primer also describes the changes proposed for One Care and SCO under the Duals Demo 2.0. To prepare the primer, Manatt Health conducted extensive research regarding the current coverage landscape for dual eligible individuals in Massachusetts and key objectives of the Duals Demo 2.0; conducted a quantitative analysis to understand enrollment, demographics, and spending trends among dual eligible individuals; and in partnership with CHCS developed profiles of dual eligible individuals enrolled in integrated care and FFS delivery systems, based on interviews with a diverse group of dual eligible individuals and their families across Massachusetts.

The primer consists of four components:

- **This issue brief**, which provides an overview of the characteristics of dual eligible members in Massachusetts and the costs associated with their care, as well as of the coverage landscape for the state’s dual eligible individuals and key objectives of the Duals Demo 2.0;
- **An in-depth comparative analysis** of the integrated care programs available to dual eligible members in Massachusetts;

## What Are Long-Term Services and Supports (LTSS)?

LTSS consist of a wide variety of services and supports that help people with disabilities of all ages meet their daily needs for personal assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

- **A data chart pack**, which offers a detailed analysis of enrollment, demographics, and spending trends among dual eligible individuals in Massachusetts; and
- **A set of five profiles** of dual eligible members.

The purpose of the comprehensive primer is to help policymakers and other interested stakeholders in Massachusetts better understand the characteristics and needs of the dual eligible population, the programs that currently serve them in Massachusetts, and upcoming reforms to improve care integration and quality for dual eligible MassHealth members.

The goal of this issue brief in particular is to provide a qualitative and quantitative overview of the dual eligible population in Massachusetts, to describe at a high-level the various health care coverage options for dual eligible members, and to describe the proposed changes in the state’s Duals Demo 2.0.

*Many of the key terms included in this issue brief are defined in the glossary in Appendix I.*

## WHO ARE DUAL ELIGIBLE INDIVIDUALS AND WHY ARE THEY UNIQUE?

Over 12 million Americans—including 312,000 Massachusetts residents—are simultaneously enrolled in Medicare and Medicaid.<sup>4</sup> These low-income, often high-need dual eligible members include people who are:

- Age 65 and older (“seniors”); and
- Children and non-elderly adults who have qualifying physical disabilities, intellectual and developmental disabilities (I/DDs), or traumatic brain injuries.<sup>5</sup>

**Demographics:** Nationally, most dual eligible members qualify for Medicaid on the basis of income, and Medicare on the basis of disability. As such, dual eligible members nationally skew younger than individuals qualifying for Medicare alone. In Massachusetts, the split between older and younger dual eligible individuals is almost even:<sup>6</sup> Slightly under half (148,000) are non-elderly adults with disabilities (including a few thousand children); and slightly over half (164,000) are seniors.

Dual eligible members across the country are more often female and people of color<sup>7</sup> than those who have only Medicare coverage. And, potentially due to their health circumstances and age, they are far less likely to possess a high school diploma. People of color continue to grow as a proportion of the overall “duals” population.<sup>8</sup>

**Health needs:** Compared with their Medicare-only peers, nationally, dual eligible members face more limitations in their activities of daily living, report poorer health statuses, and are more often in institutional

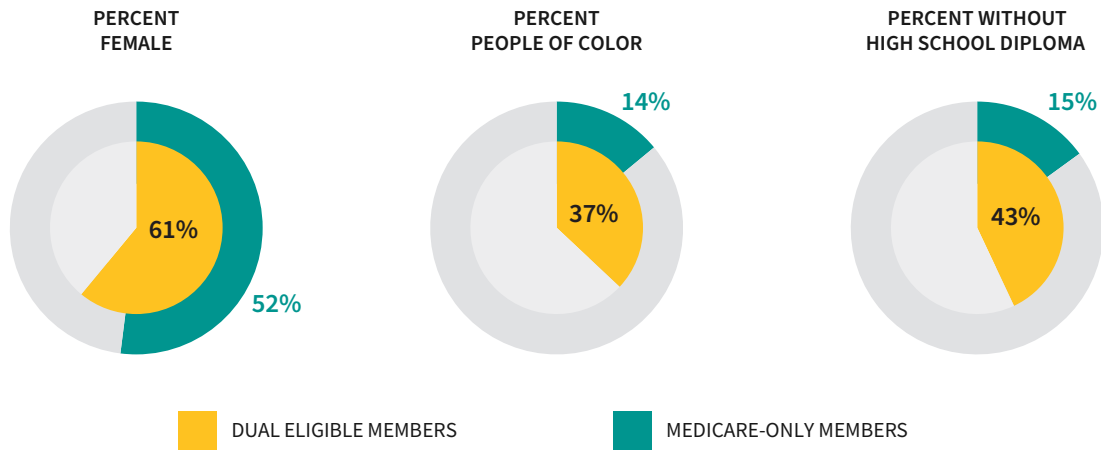


### Dual Eligible Member Spotlight: Olivia

Olivia is a dual eligible young adult enrolled in One Care. Olivia grew up in the foster care system, and at age 27 an illness left her with a permanent disability. Olivia wanted a higher level of care and functional support than she was receiving through her MassHealth FFS coverage. In 2013, Olivia became a member of a MassHealth One Care plan, where she was able to get the coordinated, higher level of care she needed—including a power wheelchair, additional personal care attendant hours to help keep her in her home safely, and help with making her apartment a healthier place to live (for example, One Care paid for a deep clean of her apartment and bedbug treatment). According to Olivia, “They seemed to know what they were doing, and I went from having virtually nothing to having all these people and supports available to me. It was the right intervention at the right time.”

*One Care is described in more detail on page 6 of this issue brief. For more about Olivia’s story, please see the accompanying [Member Profiles](#).*

**FIGURE 1. DUAL ELIGIBLE VS. MEDICARE-ONLY MEMBERS NATIONALLY BY DEMOGRAPHIC CHARACTERISTICS (2018)<sup>12,13</sup>**



care. More than 40 percent of dual eligible members require LTSS, twice the rate of Medicaid-only individuals and over five times the rate of Medicare-only members. Additionally, more than four in 10 dual eligible members have at least one mental health diagnosis and six in 10 face multiple chronic conditions.<sup>9</sup>

**Health care costs:** Dual eligible members’ more complex care needs directly translate into more intensive, complex, and costly care than other populations require. While dual eligible members make up only 18 percent of all members in the MassHealth program, MassHealth’s spending on dual eligible members consumes over a quarter of its programmatic budget (\$4.9 billion).<sup>10</sup> Dual eligible members often require high-touch, high-intensity—and ultimately high-cost—LTSS to support their daily living, such as nursing home care, adult day health care, and home health supports, which make up more than 80 percent of MassHealth’s FFS spending for dual eligible members annually.

MassHealth spent over \$4.9 billion on its dual eligible population during state fiscal year (SFY) 2019, an increase of 4.8 percent since SFY 2017. This rate of increase is higher than overall MassHealth program spending growth, which further highlights the desire—and raises the stakes—for measured program reform.<sup>11</sup>

*For more information about dual eligible members in Massachusetts and nationally, including data on who dual eligible members are (demographics), their health needs, and program enrollment and spending trends, please see the [Data Chart Pack](#).*



**Dual Eligible Member Spotlight: Oliver and Margie**

Oliver and Margie are dual eligible adults over the age of 65; Oliver became eligible for Medicare because of a disability, and Margie qualified when she turned 65. Oliver and Margie also qualified for MassHealth because they were over 65, needed long-term care, and met income eligibility requirements. The couple enrolled in a local PACE organization after hearing about it from their neighbors, and were delighted at the high quality of care they received. Oliver and Margie like living independently and appreciate that they can receive the majority of their support and services under one roof. When asked about his experience with PACE, Oliver says “You won’t find a happier person to be on PACE.”

*PACE is described in more detail on page 6 of this issue brief. For more of Oliver and Margie’s story, please see the accompanying [Member Profiles](#).*

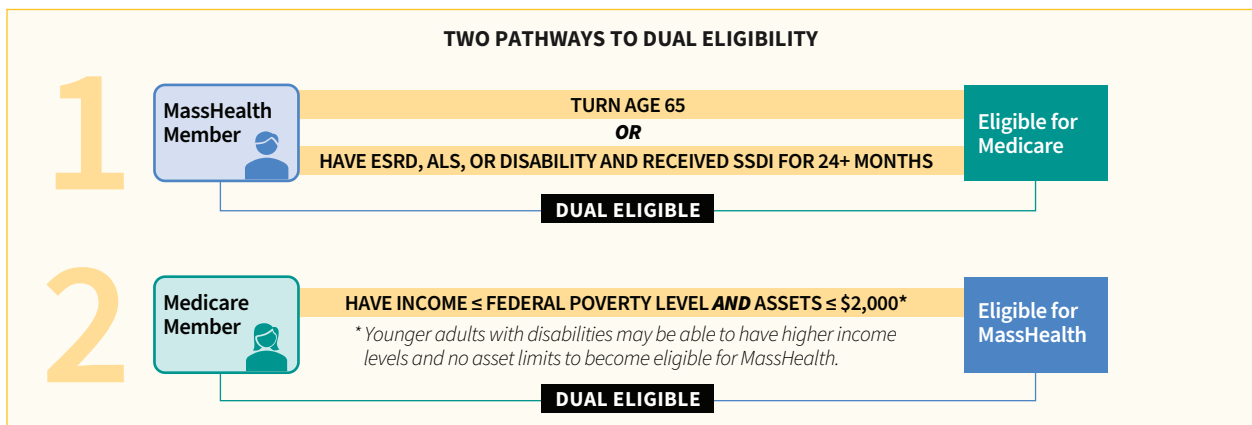
# COVERAGE OPTIONS FOR DUAL ELIGIBLE MASSHEALTH MEMBERS

## DUAL-ELIGIBILITY PATHWAYS AND RELATED CHALLENGES

Congress created Medicare and Medicaid in 1965 as distinct health insurance programs for different populations. In general, **Medicare**—which is fully funded by the federal government—covers hospital, physician, and prescription drug services, and also short-term use of nursing facility and home health services after discharge from a hospital for people age 65 and older, people with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS), and people with disabilities who have received Social Security Disability Insurance (SSDI) benefits for at least 24 months. **Medicaid**—which is jointly funded by the federal government and individual states—covers comprehensive physical and behavioral health services and LTSS for low-income people, including children, pregnant women, families, seniors, and people with disabilities. When Congress created the Medicare and Medicaid programs, it did not address any potential misalignments in eligibility, enrollment, benefit, or payment rules for people who might be eligible for both programs.

For the dual eligible population, Medicare covers the majority of a member’s core medical services, including physician services, hospital care, and post-acute services, such as short-term use of nursing facility, inpatient rehabilitation, or home health services after an acute hospital stay. Medicare also covers durable medical equipment (such as wheelchairs, hospital beds, and blood sugar monitors), prescription drugs, and some behavioral health services. Medicaid (MassHealth) “wraps” a member’s Medicare benefits by providing LTSS (such as custodial nursing facility care, expanded use of home health services, and personal care services), a broader range of behavioral health services, and also vision, dental, and transportation services. In addition, MassHealth helps to defray dual eligible members’ out-of-pocket costs by covering some Medicare premiums and cost-sharing obligations.<sup>14</sup>

Dual eligible individuals become eligible for both Medicare and MassHealth through either of two pathways. A MassHealth member can “age” into Medicare when they turn 65, or become eligible for Medicare because they have ESRD or ALS or a disability and have received SSDI for at least 24 months. Alternatively, a low-income Medicare member typically becomes eligible for MassHealth when they have financial resources below the program’s eligibility limits (typically income at or below the federal poverty level and assets at or below \$2,000, though younger adults with disabilities may be able to have higher income levels and no asset limits to become eligible for MassHealth). Many Medicare members become dually eligible after they have “spent down” their income and assets to pay for their long-term care needs and have become impoverished. Individuals enrolled in



both programs are eligible to receive full Medicare and MassHealth benefits. Some Medicare members with income levels just above the federal poverty level can qualify for MassHealth-administered Medicare Savings Programs, which do not cover MassHealth benefits but provide financial assistance to members to help with their Medicare cost-sharing obligations, such as Medicare Part A and Part B premiums. Notably, Massachusetts expanded the income and asset limits for these programs in January 2020 to enable more older residents to receive the financial assistance that these programs offer.<sup>15</sup> Those who qualify for Medicare Savings Programs, who are sometimes referred to as “partial duals,” are not the primary focus of this primer.

As more individuals enrolled in both Medicare and Medicaid over time, clinicians, consumers, policymakers, and other stakeholders began to recognize the challenges that dual eligible members experience in understanding their health insurance coverage rules and accessing benefits under the two programs. Most dual eligible members have two insurance cards and must navigate two distinct enrollment processes, provider networks, sets of covered services, and grievance and appeals processes. These misalignments can cause confusion, duplicative or unnecessary services, and suboptimal care and poorer health outcomes.<sup>16</sup> Additionally, because the majority of dual eligible members are in a FFS delivery system, they have little access to the person-centered care coordination or care management support that are typically offered by Medicare or Medicaid managed care programs. Care coordination and care management services include a comprehensive initial assessment of an individual’s health, functional, and social support needs and health goals and preferences; person-centered care plan development; ongoing monitoring and coordination of provider visits and transportation; and medication management, among other supports. These services are vital to understanding and meeting the complex care needs of the dual eligible population.<sup>17</sup> As in all states, the absence of data sharing between Medicare and MassHealth providers for dual eligible members in FFS programs limits providers’ ability to effectively coordinate and manage care of dual eligible members.

**Care Coordination and Care Management Services Include:**

- A comprehensive initial assessment of an individual’s health, functional, and social support needs and health goals and preferences;
- Person-centered care plan development; and
- Ongoing monitoring and coordination of provider visits and transportation; and medication management, among other supports.

These financially disconnected programs also create inefficiencies for payers and providers, and can result in uncoordinated and duplicative services. Additionally, for years, states have been frustrated that Medicaid coverage of behavioral health and LTSS for dual eligible members can result in savings not for the states but for the federal government; for instance, investments in these Medicaid services can reduce unnecessary use of hospital and emergency department services, which are covered by Medicare. States have historically been unable to share in these savings, reducing states’ incentives to invest in expanding or enhancing behavioral health and LTSS for dual eligible members in a way that could improve care and reduce the overall cost of care for this population.

## **EVOLUTION OF INTEGRATED CARE PROGRAMS FOR DUAL ELIGIBLE MASSHEALTH MEMBERS**

Since the 1980s, states have been testing care models for dual eligible individuals that seek to address programmatic and financial inefficiencies across Medicaid and Medicare. Massachusetts has been a leader in this arena, developing voluntary provider-based (PACE) and health-plan based (SCO and One Care) programs for dual eligible members designed to align Medicare and Medicaid services, administrative processes, and financial incentives through a single program.

The remainder of this section provides a brief history and overview of each of the three integrated care programs available to dual eligible members in Massachusetts. *Key features of these programs are described in greater detail in the [Comparative Program Assessment Chart Pack](#).*



**TABLE 1. OVERVIEW OF MASSACHUSETTS' INTEGRATED CARE PROGRAMS**

PROGRAM DESCRIPTION AND QUALIFYING AGE GROUP		GEOGRAPHIC COVERAGE
<b>PACE</b>	PACE organizations provide or coordinate access to comprehensive medical and support services for people <b>age 55 and older</b> who meet the criteria for receiving a nursing facility level of care in their home or community. Most PACE enrollees are dually eligible; however, some are members of either MassHealth or Medicare. Individuals without either MassHealth or Medicare can join PACE at their own expense.	PACE is available in all counties except Barnstable, Berkshire, Dukes, and Nantucket. In Franklin County, PACE is only available in three of 25 towns.
<b>SCO</b>	SCO plans offer members <b>age 65 and older</b> comprehensive Medicare and MassHealth services, as well as additional behavioral health diversionary services, dental and vision care, and community-based supports. Most SCO members are dually eligible; however, some are members of MassHealth but not Medicare.	SCO is available in all counties except Dukes and Nantucket.
<b>ONE CARE</b>	One Care provides dual eligible members <b>ages 21–64</b> at the time of enrollment with comprehensive Medicare and MassHealth services, as well as additional behavioral health diversionary services, dental and vision care, and community support services.	One Care is available in all counties except Dukes and Nantucket.

**PACE** grew out of an innovative care model developed in San Francisco in the 1970s at the On Lok senior health center. PACE provides or coordinates access to comprehensive medical and support services for people age 55 and older who meet a nursing facility level of care in their home or community. Members may receive services at their local PACE center, which is a physical site that offers adult day care services, a health clinic with an on-site physician and nurse practitioner, physical and occupational therapy facilities, and at least one common room for social and recreational activities. Today, there are over 130 PACE programs operating in 31 states. Massachusetts was an early adopter with Neighborhood PACE (formerly East Boston Neighborhood PACE), one of the country's first PACE programs. There are now eight PACE organizations operating 23 PACE centers in all but four of Massachusetts' 14 counties. Most PACE enrollees are dually eligible; however, some are members of either MassHealth or Medicare. Individuals without either MassHealth or Medicare can also join PACE at their own expense.

When Massachusetts launched **SCO** in 2004, it also became one of the first states to design and implement an integrated Medicare and Medicaid managed care program for dual eligible members. Today, members age 65 and older may enroll in one of six SCO plans, which offer members comprehensive Medicare and MassHealth services, as well as behavioral health diversionary services, dental and vision care, transportation, and community-based supports.<sup>18,19</sup> Most SCO enrollees are dually eligible; however, some are members of MassHealth but not Medicare.

In 2013, Massachusetts was one of the first states to implement a demonstration program under the federal Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Initiative (FAI), which authorized states to procure private health plans that align Medicare and Medicaid coverage and financing, including by sharing any program savings.<sup>20</sup> MassHealth used the FAI authority to create the **One Care** program for dual eligible members ages 21–64 (at the time of enrollment). Two One Care plans are currently in operation.<sup>21</sup> Similar to SCO, One Care provides dual eligible members with access to comprehensive services provided by MassHealth and Medicare, as well as behavioral health diversionary services, dental and vision care, transportation, and community support services.<sup>22,23</sup>

**FEDERAL EFFORTS TO ALIGN COVERAGE FOR DUAL ELIGIBLE MEMBERS**

*CMS has supported state efforts to align Medicare and Medicaid for dual eligible members over time in the following ways:*

Late 1980s	2003	2011	2018 & 2019
Launching a <b>PACE</b> demonstration with 10 pilot sites, including one in Massachusetts; and in 1997 making PACE programs a permanent component of Medicare and enabling states to provide PACE services to Medicaid members as a Medicaid state plan option (though individuals need only be enrolled in either Medicare or Medicaid to receive care through PACE).	Creating Medicare Advantage (Medicare managed care) Dual Eligible Special Needs Plans (D-SNPs) for dual eligible members that exclusively enroll and coordinate care for these members. Massachusetts' <b>SCO</b> plans are a type of D-SNP called a fully integrated dual eligible SNP, or FIDE-SNP. FIDE-SNPs contract with states to arrange for or provide Medicaid benefits for dual eligible members under a single managed care plan.	Creating the Financial Alignment Initiative (FAI) demonstration opportunity to enable states to test single Medicare-Medicaid plans (MMPs) that align Medicare and Medicaid financing of care for dual eligible members. Massachusetts' <b>One Care</b> plans are MMPs.	Issuing rules that require D-SNPs to integrate with state Medicaid benefits and promote enrollment in integrated care programs.

# KEY FEATURES OF INTEGRATED CARE PROGRAMS

One Care, PACE, and SCO have a common mission of streamlining and integrating Medicare and Medicaid coverage and service delivery for dual eligible members. These programs have made progress toward these goals (see select findings from One Care, PACE, and SCO evaluations in the “Integrated Care Programs: Select Evaluation Findings” callout box). While they have a common mission, the programs differ on key programmatic features, including eligibility criteria, enrollment mechanisms, provider networks, care management models, and financing models. These features are described briefly here, and are compared in detail within the [Comparative Program Assessment Chart Pack](#) component of the primer. One additional common feature of all integrated care programs, not discussed below, is they do not require copayments; dual eligible members enrolled in FFS pay copayments for medications, while those enrolled in One Care, PACE, and SCO do not.<sup>24</sup>

*Note: The glossary in Appendix I defines several of the key terms and concepts referenced in this section.*

- **Eligibility criteria.** These are a set of financial criteria (e.g., income and assets) and nonfinancial criteria (e.g., age and level of care requirements) that an individual must meet to be eligible to enroll in a given integrated care program. Eligibility criteria for One Care, PACE, and SCO vary, with age and level of care requirements being the main factors. For example, dual eligible individuals age 21–64 (at the time of enrollment) may enroll in One Care; those age 65 and older may enroll in SCO; and dual eligible individuals age 55+ who meet the criteria for receiving a nursing facility level of care may enroll in PACE.
- **Enrollment mechanism.** This is the process by which a dual eligible individual who has met the eligibility criteria applies for and enrolls in an integrated program. One Care, PACE, and SCO are voluntary programs, meaning a dual eligible member has the option to enroll in one of the programs or remain in MassHealth’s FFS program.<sup>25</sup> For One Care, MassHealth also uses an automatic enrollment process called “passive enrollment” for individuals who meet the program’s eligibility criteria. With passive enrollment, individuals do not need to take any action to enroll in the program, and they have the ability to opt out. Passive enrollment, which CMS authorized states to use in the FAI, can help educate dual eligible members about this coverage option and ease the administrative tasks associated with enrollment. However, passive enrollment sometimes results in confusion among members who may not be aware they have been enrolled in a plan.<sup>26</sup> To help prevent confu-

## Integrated Care Programs: Select Evaluation Findings

**PACE:** A national PACE study found that on average, states spend 13% less on caring for their PACE populations than they do on comparable Medicaid populations, and PACE members have a 24% lower hospitalization rate than dual eligible Medicaid members receiving nursing home services.

**SCO:** A recent Massachusetts SCO evaluation found that many SCO enrollees are highly satisfied with their coverage and access to care. Another evaluation showed a positive impact on service utilization and outcomes, with a 12% reduction in the number of nursing facility residency months and a 17% reduction in the risk of death among the SCO study population compared with a control cohort covered by the traditional, separate fee-for-service (FFS) Medicaid and Medicare programs.

**One Care:** One Care evaluations to date have demonstrated that service utilization trends, financial performance, and member experience can differ across plans. One multi-plan study showed a lower probability of long-stay nursing facility use over a given year but an increase in monthly inpatient admissions and readmissions. In a separate study, one of the One Care plans reported a reduction in inpatient admissions and emergency department utilization among members continuously enrolled for 12 months compared with those only enrolled for six months, as well as a reduction in inpatient admissions for members with severe disabilities.

### SOURCES:

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sion, One Care sends passively enrolled members two notices, 60 days and 30 days before their coverage becomes effective. These notices provide information about the benefits they are eligible to receive if they choose to enroll in One Care and give them the option to join a different One Care plan or opt out of the program.<sup>27</sup> PACE and SCO lack a passive enrollment process, which may be contributing to lower than anticipated enrollment rates of dual eligible members into integrated care programs. Approximately 20 percent of dual eligible members in Massachusetts have opted to enroll in One Care, PACE, or SCO. As means of comparison, a recent report found that in 2018 the average participation rate in an integrated care program among dual eligible individuals in 10 FAI demonstration states was 27 percent, with the low end of the range around 3–5 percent and the high end between 67 and 82 percent. The same report also noted that dual eligible members are more likely to enroll in integrated care plans when the process of enrolling is easy; they cited passive enrollment as one of the primary factors associated with enrollment in integrated care plans.<sup>28</sup>

- **Provider network.** This is the set of providers that contract with a health plan to deliver covered services for plan members. Dual eligible members often have long-standing relationships with teams of providers who are keenly aware of the individual’s unique needs and who manage their complex health and functional needs. Maintaining access to these established providers is a critical goal for dual eligible members enrolled in integrated care programs. The One Care program has instituted specific “continuity of care” mechanisms to help ensure a smooth transition between an old and a new plan with different provider networks and to temporarily protect the critical relationships that dual eligible members have developed with established providers for the first 90 days of program enrollment (or until the member’s care plan is complete and the member has agreed to it).<sup>29,30</sup> All three programs enable members to seek urgent and other emergency care with out-of-network providers when necessary.
- **Care management model.** This is a broad set of person-centered, coordinated activities that support an individual’s health, welfare, and daily living goals and help ensure access to necessary services. Effective care management is the cornerstone of integrated care programs that oversee care delivery for the multifaceted needs of dual eligible members. All three integrated care programs offer comprehensive care management services and supports. These include comprehensive initial needs assessments and interdisciplinary care teams that help the plans better understand the complex needs of their members. However, the care management model varies across programs. Additionally, One Care and SCO plans offer dual eligible members the support of a specialized Long-Term Supports (LTS) Coordinator or Geriatric Support Services Coordinator, respectively. Lack of care management is the most defining feature of MassHealth FFS when compared with integrated care program coverage for dual eligible members. Dual eligible members receiving care through MassHealth FFS generally do not receive any of the care management supports afforded to those enrolled in One Care, PACE, or SCO.
- **Financing model.** This is the way in which Medicare and MassHealth develop their rates of payment to integrated care plans, and how plans allocate these funds for services provided to members. Financing models within integrated care programs that serve dual eligible members are particularly complicated, as they seek to combine Medicare and Medicaid dollars in a way that is equitable for both payers, appropriate to meet dual eligible members’ needs, and sufficient to encourage plans to participate in the program and assume risk for this high-cost population. All three integrated care programs have the same baseline Medicare reimbursement mechanism: They rely on risk-adjusted capitated monthly payments from Medicare Part A/B and Medicare Part D (prescription drug coverage) to cover the cost of caring for their dual eligible members. Unlike Medicare, MassHealth reimbursement mechanisms are not uniform across programs. A portion of SCO’s MassHealth capitation rate is risk-adjusted; however, the remaining SCO, PACE, and One Care MassHealth rates are not risk-adjusted. PACE and SCO are unique in that their Medicare risk-adjusted rate includes a “frailty adjuster” that takes into account that they care for a predominantly elderly population. The frailty adjuster leads to higher capitated payments for plans with members who require complex and high-cost care; this factor is not currently applied to One Care rates. In addition, One Care plans benefit from a two-sided risk corridor that provides protection

against potential financial losses if the health care costs of a One Care plan's members substantially exceed the capitated payments. But if a One Care plan's capitated payments were much higher than what the plan actually paid for their members' care, the plan would pay back a portion of their capitation payments to the state and to the federal government. MassHealth also added a two-sided risk corridor to SCO plans in 2020.<sup>31</sup> PACE organizations do not have risk corridors; therefore, they are more exposed to financial risks as a result of caring for high-cost members.

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## THE FUTURE OF CARE DELIVERY FOR DUAL ELIGIBLE MEMBERS IN MASSACHUSETTS: DUALS DEMONSTRATION 2.0

In August 2018, Massachusetts submitted to CMS a [Duals Demonstration 2.0 \(“Duals Demo 2.0”\) Concept Paper](#), which outlines proposed enhancements to the state's One Care and SCO programs under a newly aligned 1115A Demonstration.<sup>32</sup>

Duals Demo 2.0 seeks to build upon the early successes of integrated care programs for dual eligible members and address some of the current misalignments between key features of the state's integrated care programs highlighted in the [Comparative Program Assessment Chart Pack](#).

Through Duals Demo 2.0, Massachusetts is aiming to increase access to integrated care management and improve the quality of care for dual eligible members by better aligning One Care and SCO, and encouraging more dual eligible members who are currently in FFS programs to enroll in integrated care programs. Many of the critical elements of One Care and SCO would remain the same under Duals Demo 2.0: the populations they serve, covered benefits, and eligibility requirements. However, some of the administrative, financial, and programmatic features of One Care and SCO would change in order to adopt best practices of each while better aligning the two programs.

For example, in order to help grow enrollment, Duals Demo 2.0 proposes to apply to the SCO program the passive enrollment currently in place within One Care. In an effort to smooth members' transitions into One Care and SCO, Duals Demo 2.0 proposes maintaining the existing continuity of care mechanisms within One Care, and requests new authority to do the same for SCO. Finally, Duals Demo 2.0 seeks to reform the financing models for One Care and SCO in order to ensure the fiscal sustainability and accountability of each program. Most notably, the state had proposed to change the capitation rate methodology for both programs so that their risk adjustment mechanisms are more similar.<sup>33</sup>

All of the Duals Demo 2.0 proposed flexibilities and program changes noted above are subject to the state's negotiations with CMS, which have been underway since the Duals Demo 2.0 concept paper was submitted in August 2018. The Duals Demo 2.0 was originally expected to be implemented on January 1, 2021, but has been delayed until at least January 1, 2022, due to federal and state efforts to respond to the COVID-19 pandemic.<sup>34</sup> As of the time of publication, no details regarding whether the state's negotiations with CMS have changed anything the state proposed in their Duals Demo 2.0 concept paper have been released.

*Further details about specific Duals Demo 2.0 requests and how they relate to key features of One Care and SCO can be found in the [Comparative Program Assessment Chart Pack](#).*

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## CONCLUSION

This comprehensive primer on the dual eligible population in Massachusetts, including this issue brief, aim to serve as an educational guide to help policymakers and other interested stakeholders in Massachusetts better understand the characteristics and needs of the dual eligible population, the programs currently in place to serve them in Massachusetts, and proposed reforms to enhance and improve care integration and quality for dual eligible members. Massachusetts has made major progress in the past two decades to align Medicare and MassHealth coverage, member care experiences, and financing in a way that:

1. Streamlines access to Medicare and MassHealth services for dual eligible members;
2. Provides necessary care management and coordination support services for these high-need members; and
3. Encourages appropriate and efficient service delivery.

These programs are the foundation for a new set of reforms—Duals Demo 2.0—designed to enhance and further align integrated care program coverage for a growing number of dual eligible members. Continued growth in integrated program enrollment is one of the central goals of Duals Demo 2.0; increased enrollment in these programs that are specifically designed to meet the health care and functional needs of dual eligible members can ensure access to the high-quality and coordinated care that this population deserves.

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## APPENDIX I: GLOSSARY

**Capitated Payments:** Fixed, predetermined monthly payments received by a health plan to cover the cost of care for an individual member. Capitated payments are sometimes “risk adjusted,” or calculated to reflect the level of risk (i.e., health status or acuity) of the plan’s specific members.

**Care Management:** The provision of person-centered, coordinated activities to support members’ care goals and preferences. Activities may include (but are not limited to) providing a comprehensive member assessment; creating a documented care plan; providing a care coordinator or clinical care manager to manage members’ care; designating a care team of providers; and providing team-based care management, including meetings of the care team at least annually and after any major events in the member’s care or changes in health status, or more frequently if indicated.

**Diversionsary Services:** Intensive community-based mental health and substance use disorder services that help support individuals as they transition from a facility to the community setting.

**Frailty Adjuster:** A special rate that is sometimes applied to a plan’s Medicare risk-adjustment rate, which accounts for higher expenditures specifically associated with caring for individuals with complex health needs, and is intended to help those plans cover the higher cost of caring for those members.

**Functional Needs:** Individuals’ basic daily self-care and other routine needs that allow them to live independently in their homes and communities, such as bathing, dressing, eating, cooking, and cleaning.

**Initial Assessment:** A critical enrollment step, in which a plan or coverage organization (e.g., a PACE organization) conducts a detailed assessment to gain an understanding of the new member’s complex clinical, functional, and social support needs, goals, and preferences. Details gathered during the assessment are typically used to inform the development of a member’s person-centered care plan and to organize the member’s interdisciplinary care team or integrated primary care team.

**Interdisciplinary Care Team (One Care and PACE) / Integrated Primary Care Team (SCO):** A team of individuals who are responsible for developing a member’s care plan and coordinating their care. Team members meet regularly to ensure that members’ medical, behavioral health, and social needs are met. These teams are typically composed of a combination of care coordinators, primary care providers, nurses, specialists, peer support/counselors, along with other individuals that members may choose to include (e.g., a personal representative or family member.)

**Long-Term Services and Supports (LTSS):** A wide variety of services and supports that help certain members meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, and also support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities but also in facility-based settings such as nursing facilities.

**Medicare Part A:** Provides coverage for inpatient care in a hospital; skilled nursing facility care; inpatient care in a skilled nursing facility (not custodial or long-term care); hospice care; and home health care.

**Medicare Part B:** Provides coverage for medically necessary and preventive services.

**Medicare Part D:** Provides prescription drug coverage.

**Passive Enrollment:** An enrollment method through which an individual who meets a coverage program's eligibility criteria is automatically enrolled by the state. Individuals do not need to take any action to enroll in a program. They are sent notice of their enrollment by the state prior to being passively enrolled, and they have the option to opt out of coverage.

**Risk Adjustment:** A risk mitigation tool and a way of calculating a plan's capitation rates to reflect the level of risk (i.e., the health status or acuity) of their specific members. Under a risk-adjusted capitation rate, plans will get higher capitation rates for caring for higher-risk members (members with more complex health care needs).

**Self-Selected Enrollment:** An enrollment method by which individuals are not automatically or passively enrolled into a coverage program by the state and they proactively choose to enroll in a coverage program by submitting a formal application and selecting a specific plan.

**Two-Sided Risk Corridor:** A provision of the Affordable Care Act that limits losses and gains incurred by plans beyond an allowable range. Under this system, if a plan's capitation payments were much higher than the amount the plan actually had to pay for their members' care, the plan would pay back a portion of the capitated payments to the state. Similarly, if a plan paid its providers far more for the health care of its members than it received in capitated payments, the plan would receive additional payments to offset its losses.

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## ENDNOTES

- 1 Mass.gov, “MassHealth Snapshot Enrollment Summary of November 2019 Caseload,” available at [www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-november-2019-4/download](http://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-november-2019-4/download).
- 2 CMS Medicare-Medicaid Coordination Office, “People Dually Eligible for Medicare and Medicaid,” March 2020, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf).
- 3 Individuals receiving both Medicare and MassHealth coverage through One Care, PACE, SCO, or the MassHealth fee-for-service (FFS) program are referred to as “dual eligible” members or individuals throughout this primer.
- 4 *Ibid.*
- 5 Although they are not a focus of this report, some low-income Medicare members have income or assets too high to qualify for “full” Medicaid benefits, but they still receive support from MassHealth to pay for their Medicare premiums or cost sharing (these members are sometimes referred to as “partial duals”). In Massachusetts, approximately 7 percent (21,000) of dual eligible members receive only this Medicare “buy-in” support from MassHealth, which is provided through the Medicare Savings Program. Partial duals may be aged or disabled.
- 6 Massachusetts’ relatively even distribution in the number of dual eligible individuals under and over 65 may be attributed to the larger number of eligibility pathways MassHealth offers its non-elderly adults compared with other state Medicaid programs, and its higher income thresholds.
- 7 “People of color” is used collectively to refer to racial and ethnic groups other than non-Hispanic White.
- 8 State-level race and ethnicity data were not available for this report. The national data available is limited.
- 9 MACPAC, “Integrating Care for Dually Eligible Beneficiaries: Background and Context,” June 2020, available at <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-1-Integrating-Care-for-Dually-Eligible-Beneficiaries-Background-and-Context.pdf>.
- 10 Manatt Health analysis of MassHealth data (July 2020) and data from the Massachusetts Budget and Policy Center, available at [www.massbudget.org/browser/subcat.php?id=MassHealth+%28Medicaid%29+%26+Health+Reform#line\\_items](http://www.massbudget.org/browser/subcat.php?id=MassHealth+%28Medicaid%29+%26+Health+Reform#line_items).
- 11 Manatt Health analysis of MassHealth data (July 2020). MassHealth “Duals Demonstration 2.0 Proposal,” One Care Implementation Council with MassHealth and Centers for Medicare & Medicaid Services, June 14, 2018, available at [www.mass.gov/files/documents/2018/06/15/20180614-dual-demo-2.0.pdf](http://www.mass.gov/files/documents/2018/06/15/20180614-dual-demo-2.0.pdf).
- 12 Latest data from 2018; see source notes. National statistics refer to full-benefit dual eligible members. Race and ethnicity data at the national and state levels was limited.
- 13 MACPAC, “Integrating Care for Dually Eligible Beneficiaries: Background and Context,” op. cit. CMS Medicare-Medicaid Coordination Office, “Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2016,” November 2017, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/Eleven-YearEver-EnrolledTrendsReport\\_2006-2016.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/Eleven-YearEver-EnrolledTrendsReport_2006-2016.pdf). Note that there exist significant differences in race and ethnicity reporting among the data sources listed here. All, however, indicate that a higher proportion of nonwhite individuals are dually eligible than are Medicare-only enrollees. MACPAC, “Beneficiaries Dually Eligible for Medicare and Medicaid,” January 2018, available at [www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf](http://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf). Note: 2013 data.
- 14 Medpac.gov, “Report to Congress: Medicare and the Health Care Delivery System, Chapter 9: Managed Care Plans for Dual-Eligible Beneficiaries,” June 2018, available at [http://medpac.gov/docs/default-source/reports/jun18\\_ch9\\_medpacreport\\_sec.pdf](http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf).
- 15 Mass.gov, “Medicare Savings (Buy-In) Programs,” Eligibility Operations Memo 20-30, January 1, 2020, available at [www.mass.gov/doc/eom-20-03-medicare-savings-buy-in-programs-0/download](http://www.mass.gov/doc/eom-20-03-medicare-savings-buy-in-programs-0/download).
- 16 Manatt Health, “Webinar: New Opportunities to Advance Integrated Care for Dual Eligibles,” July 24, 2019, available at [www.manatt.com/insights/webinars/new-opportunities-to-advance-integrated-care-for-d](http://www.manatt.com/insights/webinars/new-opportunities-to-advance-integrated-care-for-d).
- 17 Additional key care-management functionalities may include connecting patients to social and community supports and facilitating dialogue among interdisciplinary care team members.
- 18 Mass.gov, “Enrolling and Receiving Care Under Senior Care Options (SCO),” available at [www.mass.gov/service-details/enrolling-and-receiving-care-under-senior-care-options-sco](http://www.mass.gov/service-details/enrolling-and-receiving-care-under-senior-care-options-sco).
- 19 Mass.gov, “Senior Care Options (SCO) Overview,” available at [www.mass.gov/service-details/senior-care-options-sco-overview](http://www.mass.gov/service-details/senior-care-options-sco-overview).
- 20 CMS, “Massachusetts Capitated Financial Alignment Model Demonstration (One Care),” available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Massachusetts](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Massachusetts).
- 21 MassHealth recently re-procured its One Care plans, but the effective date of new One Care contracts was delayed from January 1, 2021 to January 1, 2022 because of the COVID-19 pandemic.
- 22 Mass.gov, “Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0,” August 20, 2018, available at [www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf](http://www.mass.gov/files/documents/2018/08/24/final-concept-paper-duals-demonstration-2.0-08-22-18.pdf).
- 23 Mass.gov, “One Care Fact Sheets & Other Materials,” available at [www.mass.gov/service-details/one-care-fact-sheets-other-materials](http://www.mass.gov/service-details/one-care-fact-sheets-other-materials).
- 24 Mass.gov, “MassHealth Copayments Frequently Asked Questions,” available at <https://www.mass.gov/service-details/masshealth-copayments-frequently-asked-questions>.
- 25 Medicare members, including dual eligible members, cannot be required to enroll in a Medicare managed care program, including an integrated Medicare and Medicaid program; these individuals have freedom of choice to enroll in a Medicare managed care program or remain in the FFS system.
- 26 Walsh EG (RTI International, prepared for Centers for Medicare & Medicaid Services), “Report On Early Implementation Of Demonstrations Under The Financial Alignment Initiative,” October 2015, available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>.



- 27 According to information provided by MassHealth, rates of opt-outs for passive enrollment in One Care were higher when the program was new and relatively unknown; current rules restrict MassHealth from including any member who opted-out previously in passive enrollment moving forward.
- 28 Mathematica Policy Research, “Report: The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries,” December 2018, available at [www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf](http://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf).
- 29 CMS and MassHealth, “Massachusetts One Care Demonstration: Three Way Model Contract,” March 2019, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MACContract.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MACContract.pdf).
- 30 In addition to maintaining new enrollees’ access to their established providers during the first 90 days of enrollment, One Care plans are also encouraged to contact any out-of-network providers who have established relationships with new enrollees within their first 90 days of membership to provide them with information about becoming credentialed in-network providers. One Care plans also must offer single-case out-of-network agreements to providers under certain circumstances (for more information, please see <https://www.mass.gov/doc/masshealth-implementation-council-network-presentation-02-12-19-0/download>).
- 31 MassHealth added a two-sided risk corridor to SCO in 2020 when it directed integrated care programs to institute temporary rate increases (known as “directed payments”) to better support health care providers impacted by and responding to COVID-19. Risk corridors remain in place in SCO in 2021.
- 32 The Duals Demo 2.0 Concept Paper and proposed demonstration focus on better aligning One Care and SCO; PACE was not included in Duals Demo 2.0. The Commonwealth intends to undertake separate efforts to enhance the PACE program’s financial sustainability, quality measures, and enrollment so it remains a critical part of Massachusetts’ programming for the dual eligible population. Within the Duals Demo 2.0 submission to CMS, Massachusetts noted that it seeks to move One Care and SCO to a newly aligned Section 1115A Medicaid Demonstration waiver, which is a mechanism that states can leverage to test innovative payment and service delivery models for dual eligible individuals.
- 33 MassHealth has already implemented risk adjusted SCO rates, since this change does not need demonstration authority from the federal government.
- 34 The original January 2021 start date of Duals Demo 2.0 was loosely tied to the start date of new contracts for recently reproposed One Care plans. Because of the COVID-19 pandemic, the effective date of these contracts was delayed until January 1, 2022.



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