Integrated Care Program: Final Evaluation

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Contents

Introduction

States have been concerned for many years about the delivery of services and cost of care for a particularly complex and expensive group of Medicaid beneficiaries—those who are jointly eligible for Medicaid and Medicare. This "dually eligible" population of nearly 7.5 million low-income seniors and persons with disabilities has significant medical and long-term care needs and consumes a disproportionate amount of the total public dollars spent on health care. In 2003, dual eligibles made up only 14% of Medicaid enrollees but accounted for 40% of spending;[1] in 2004, dual eligibles comprised 16% of all enrollees in the federal Medicare program, while accounting for 25% of spending.[2]

The current system of care for dual eligibles is characterized by a lack of coordination in service coverage, delivery systems, administrative requirements, and financing between the two programs. Medicare provides most of the beneficiaries' primary and acute care services and Medicaid covers most of their long-term care services. Consequently, neither program is focused on the beneficiaries' full range of service needs or the overall cost of the services provided.

Policymakers have long recognized that a more integrated system could potentially reduce costs while improving the quality of services received. Capitation offers a way to achieve this integration—by placing a single entity at risk for the delivery of all Medicare and Medicaid services. While states have long been interested in developing integrated managed care models for their dual eligibles, until recently these programs could only operate under federal demonstration authority obtained from the Centers for Medicare and Medicaid Services (CMS). Over the last decade, Minnesota, Wisconsin, and Massachusetts, with support from policymakers and foundations, navigated the waiver process and established dual integration demonstration programs.[3]

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 created opportunities for facilitating state integration efforts with the authorization of a new type of Medicare Advantage plan called a Special Needs Plan (SNP). SNPs are specialized Medicare managed care plans that can restrict enrollment to one of three subsets of Medicare beneficiaries: dual eligibles, institutionalized beneficiaries, or those with severe or disabling chronic conditions. These entities provide states with a vehicle for integration that does not require federal waiver authority—by contracting with SNPs to also provide Medicaid services to dual eligibles.

The MMA legislation stimulated interest in promoting integration among states, the federal government, health plans, and the policy community. In 2005, the Center for Health Care Strategies, Inc. (CHCS) created the *Integrated Care Program (ICP)* to support state efforts to integrate the administration, delivery, and financing of services for dual eligibles (and disabled beneficiaries who are covered only by Medicaid). The two-year initiative was funded by the Robert Wood Johnson Foundation with supplemental support from Evercare and Schaller Anderson, Incorporated.

This report documents activities of the *Integrated Care Program*. Data sources were interviews and program documents. The report describes the *ICP* initiative, reviews federal and state progress during the initiative, discusses key findings, and concludes with future considerations.

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[1] Kaiser Family Foundation, *Dual Eligibles as a Percent of Total Medicaid Enrollees, 2003* and *Dual Eligibles Spending as a Percent of Total Medicaid, 2003*. Available at: http://www.statehealthfacts.org/comparetable.jsp?ind=305&cat=6 and http://www.statehealthfacts.org/comparemaptable.jsp?ind=299&cat=6.

[2] Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, Washington, D.C., June 2007.

[3] These programs were Minnesota Senior Health Options implemented in 1997, Minnesota Disability Health Options in 2001, the Wisconsin Partnership Program in 1999, and Massachusetts Senior Care Options in 2004. For more information see Bishop C., Leutz W., Gurewich D., Ryan M., and Thomas C., *Medicare Special Needs Plans: Lessons from Dual Eligible Demonstrations for CMS, States, Health Plans, and Providers*, March 2007. Available at http://www.cms.hhs.gov/reports/downloads/Bishop0307.pdf.

CHCS Integrated Care Program

The *Integrated Care Program* was launched in December 2005. Five states—Florida, Minnesota, New Mexico, New York, and Washington—were competitively selected to receive $100,000 grants and technical assistance. These states were all working on programs to integrate care, but differed in their experience and their timing for beginning to enroll beneficiaries (see Figure 1). When the initiative began, Minnesota was in the process of transitioning its demonstrations to permanent programs operating under SNP authority[4] and expanding its programs for persons with disabilities. New York and Washington had just begun enrolling beneficiaries in new programs. Florida and New Mexico were designing their programs and securing the necessary authorities to move ahead.

Grantee technical assistance focused on three priority areas: performance measurement, rate setting and risk adjustment, and administrative simplification. CHCS formed and convened workgroups in early 2006 composed of CHCS staff, representatives from the grantee states and from Massachusetts and Wisconsin (who were asked to participate as faculty states), and/or national experts in the respective issue areas. The Performance Measurement Workgroup outlined measures that could be incorporated into state contracts with SNPs. The Rate Setting and Risk Adjustment Workgroup provided guidance to states on rate setting and related program design considerations. Their work is documented in two June 2006 CHCS publications.[5]

Figure 1. Integrated Care Programs in the Five States as of December 2005

	Implementation Date	Dual Enrollment
Florida		
Florida Senior Care	Under development	--
Minnesota		
Minnesota Disability Health Options	2001	319
Minnesota Senior Health Options	1997	11,238
Special Needs Basic Care	Under development	--
New Mexico		
Coordinated Long Term Services	Under development	--
New York		
Medicaid Advantage	2005	611
Medicaid Advantage Plus	Under development	--
Washington		
Medicare-Medicaid Integration Program	2005	41
Washington Medicaid Integration Partnership	2005	120

Source: CHCS Integrated Care Program Final Grant Reports, January and February 2008.

The third area, administrative simplification, emerged as a central focus of the initiative's activities. Administrative simplification sought to improve the coordination between the federal Medicare program and the state-administered Medicaid programs, which are governed by different regulations, policies, and procedures. Efforts in this area were facilitated through a series of meetings attended by CHCS, the states, and CMS, which are described in detail below.

[4] Minnesota's demonstration waivers expired as of December 31, 2007.

[5] See Palmer L., Llanos K., and Bella M., *CHCS Resource Paper, Integrated Care Program: Performance Measures Recommendations*, June 2006 and CHCS Technical Assistance Tool, *Integrated Care Program Design, Rate Setting, and Risk Adjustment: A Checklist for States*, June 2006. Available at http://www.chcs.org.

Federal Progress During the Initiative

At the same time that CHCS' *Integrated Care Program* was getting underway, CMS was exploring ways to use SNPs to improve care for dual eligibles. This section describes CMS' activities and progress in this area, focusing on CMS and the states' collaborative efforts to improve the coordination of Medicare and Medicaid's administrative requirements.

CMS Efforts to Promote Integrated Care

In 2005, CMS senior leadership, including Administrator Mark McClellan, identified dual integration as a high priority for the agency, with responsibility for managing this issue given to the Office of Policy. Soon thereafter, the Office of Policy established the Dual Eligibles Workgroup. This internal workgroup was composed of staff from the Center for Medicaid and State Operations (responsible for Medicaid), the Center for Beneficiary Choices (responsible for Medicare), and the Office of Research, Development, and Information (responsible for the dual eligible demonstrations).

The Dual Eligibles Workgroup goals were "to remove administrative barriers to implementing SNPs and to generate State awareness of the opportunity to better integrate care for individuals who are dually eligible for both Medicare and Medicaid."[6] The workgroup decided to focus on barriers that could be addressed via administrative changes (rather than those requiring new legislation), and set out to identify and prioritize areas where progress could be made relatively quickly. To help in these efforts, CMS consulted with several organizations including the Reforming States Group, the SNP Alliance, and CHCS. The Reforming States Group provided input on "big picture" items related to dual integration and SNPs. The SNP Alliance provided expertise on operational details from the plan perspective. CHCS, through its grantee and faculty states, provided expertise on operational details from the state perspective.

A close working relationship developed among CMS, CHCS, and the states. Their efforts were facilitated through a series of four, day-long "working sessions" held between April 2006 and February 2007. Dozens of participants attended each meeting, including representatives from the grantee and faculty states, CHCS and its expert advisors, and various entities within CMS. CHCS and the states identified seven major issues to address (see Figure 2). A fifth meeting in November 2007, attended by a smaller number of CMS and CHCS participants, revisited open items and raised possible areas for future collaboration. See Working Session Issue Areas sidebar (page 8-9) for a brief description of the progress made in each issue area.

Figure 2. Major Issues Addressed in the Working Sessions

Issue	Session #1 April 2006	Session #2 August 2006	Session #3 November 2006	Session #4 February 2007
Enrollment	✓	✓		
Marketing	✓	✓	✓	✓
Quality Reporting		✓		
Grievances and Appeals		✓	✓	✓
SNP Subsets	✓	✓	✓	✓
Vehicles to Support Integration		✓	✓	✓
Financing Issues			✓	✓

[6] http://www.cms.hhs.gov/IntegratedCareInt/.

One positive outcome of the Dual Eligibles Workgroup and the working sessions was the new relationships built between the individual participants. CMS Medicare and Medicaid staff, many of whom had not previously worked together, had an opportunity to interact and learn about the operational aspects of each other's programs. State participants not only had a forum to learn from other states (especially those with dual integration demonstration programs) but also to interact with CMS staff, communicating their questions and concerns directly.[7]

These efforts resulted in the development of several resources to help states better understand and coordinate the Medicare and Medicaid requirements for integrated care programs. Many of these resources are available on the *Integrated Care Roadmap*, posted on the CMS website in October 2007. This site provides "one-stop shopping" for information about integrated care. Of particular interest are three "how-to" guides for enrollment, marketing, and quality, developed by CMS with input from a number of groups including CHCS and the states. These guides clarify Medicare and Medicaid rules as well as provide specific examples of how to integrate the requirements of the two programs. A list of pertinent documents developed by CMS or CHCS in each of the issue areas addressed by the working sessions is shown in Figure 3.

Figure 3. Documents Related to the Coordination of Medicare and Medicaid

Issue	*Document(s)*
Enrollment	▪ CMS *Enrollment How-To Guide for SNPs*, July 2006*
Marketing	▪ CMS *Marketing How-To Guide for SNPs*, July 2006* ▪ Combined Annual Notice of Change/Evidence of Coverage form ▪ Integrated Summary of Benefits
Quality Reporting	▪ *CHCS Integrated Care Program: Performance Measures Recommendations*, June 2006** ▪ *CMS Quality How-To Guide for SNPs*, July 2006*
Grievances and Appeals	▪ Model for integrating the Medicare and Medicaid appeals process, October 31, 2007*
SNP Subsets	▪ CMS letter announcing new SNP subset policy for 2008, August 11, 2006*
Vehicles to Support Integration	▪ *Integrated Care Program Design, Rate Setting, and Risk Adjustment: A Checklist for States*, June 2006** ▪ Integrated Medicare and Medicaid State Plan Preprint, August 2008
Financing Issues	▪ *Medicare Advantage Rate Setting and Risk Adjustment: A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefits*, October 2006**

* Available in the *Integrated Care Roadmap* on the CMS website at http://www.cms.hhs.gov/IntegratedCareInt/02_Integrated%20Care%20Roadmap.asp.

** Available in the *Designing Integrated Care Program Online Toolkit* on the CHCS website at http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732.

[7] Both CMS Central Office and Regional Office officials participated in the working sessions. Inclusion of Regional Office staff was important because much of the specifics around integration occurs at the regional level.

Working Session Issue Areas

Below are brief summaries of the seven major issue areas addressed in the working sessions and how they were resolved.

Enrollment
Because enrollment for integrated programs is not generally coordinated between Medicare and Medicaid, beneficiaries often complete two separate processes and two sets of forms to enroll in the same plan for their Medicare and Medicaid coverage. CMS clarified that it is acceptable to use a single enrollment form that combines Medicare and Medicaid requirements. CMS' *Enrollment How-To Guide* explains the programs' requirements and provides a model integrated enrollment form. States were also interested in aligning the effective dates for Medicare and Medicaid enrollment. CMS advised that the Medicare schedule could not be changed and states would need to accommodate it. The *How-To Guide* also contains a mapping exercise that compares these dates in four states with operational integrated programs as examples of workable options that can be used by other states.

Marketing
Under an ideal integrated care model, all of a program's benefits would be described in a single set of marketing materials. Instead, beneficiaries often receive separate materials, which make it difficult for them to understand the advantages of enrolling in the same plan for Medicare and Medicaid. CMS affirmed that plans could use integrated Medicare and Medicaid marketing materials, and that these materials could be approved through a joint review process. Examples of ways to structure a joint review between state Medicaid agencies and CMS Regional Offices (which have primary responsibility for the Medicare review) are given in CMS' *Marketing How-To Guide*. CMS also made some progress in developing "model" integrated documents, including an integrated Summary of Benefits and Evidence of Coverage/Annual Notice of Change. The integrated Summary of Benefits correctly shows that beneficiaries with full dual coverage would not have Medicare cost-sharing obligations.[8]

Quality Reporting
SNPs are required to report the same quality and performance measures used by all Medicare Advantage plans, even though many of these measures are not suitable for plans that serve special needs populations. To address this, CMS is working with the National Committee for Quality Assurance (NCQA) to develop a set of SNP-specific performance measures. Although not a focus of the working sessions, CHCS and the states provided input into these efforts through the work done by the CHCS Performance Measurement Workgroup as well as CHCS' participation in NCQA's Geriatric Measurement Advisory Panel. CMS' *Quality How-To Guide* lays out current reporting requirements for Medicare and Medicaid and provides examples of how they can be integrated under a variety of scenarios.

Grievances and Appeals
The conflicting Medicare and Medicaid grievance and appeals requirements proved difficult to resolve. In general, Medicare has stricter timeframes for appeals, while Medicaid allows for continuation of benefits during appeal for a broader range of services and has broader definitions of medical necessity. In October 2007, CMS proposed an optional model for integrating the Medicare and Medicaid appeals process. Although this model is a viable option, there appear to be existing requirements in some states that may conflict with its implementation. Despite the relatively low volume of grievances and appeals, this area is one in which states are very interested in continuing to work with CMS to find an integrated solution.

[8] The Summary of Benefits is generated from data submitted in the Plan Benefit Package as part of a plan's Medicare bid. Because this information was limited to Medicare benefits, it was inaccurate with respect to dual eligibles' cost-sharing obligations. CMS made it easier to make hard copy changes to the Summary of Benefits to show correct cost-sharing amounts for 2007, and in 2008 made changes to the Plan Benefit Package to electronically produce correct cost-sharing amounts. Despite these changes, the electronic information provided to Medicare beneficiaries is not completely accurate for dual eligibles.

Working Session Issue Areas

SNP Subsets
CMS policy prohibited SNPs from limiting enrollment to subsets within the dual eligible population based on age, disability, or other criteria. This was a problem for states such as Minnesota where there are separate programs for elderly and disabled dual eligibles, each tailored to the specific needs of the beneficiaries served. CHCS, states, and health plans requested CMS to make exceptions for the integrated programs. Efforts included a letter from CHCS on behalf of the *ICP* states explaining the need for changing this policy. In August 2006, CMS announced a new policy beginning in 2008 to permit SNPs to target enrollment to subsets of dual eligibles in coordination with a state's integrated Medicaid program.[9] Once the new policy was established, the sessions focused on how to document the subset arrangement between the state and plan given the timing differences between the Medicare and state contracting cycles.[10]

Vehicles to Support Integration
Several states were interested in developing a document that would formalize the relationships between the federal government, the states, and the plans. They believed that such a document would give them more leverage with the plans. CMS was clear it would not authorize three-way agreements (between the state, CMS, and plans) but was willing to consider other "vehicles" to support integration. The resulting CMS Integrated Medicare and Medicaid State Plan Preprint is a document that can be used at a state's option to house information related to that state's integrated program. By laying out a number of important decisions, the Preprint is perceived to be a useful resource for states new to integration.

Financing
Under the current financing system for integrated programs, plans receive separate capitation payments for Medicare and Medicaid. An issue for the states is that the care coordination that is part of an integrated care program is likely to result in more Medicaid expenditures while the cost savings will likely be achieved through less use of Medicare services (such as inpatient care, emergency room visits, and nursing facility services). This is a problem for states needing to demonstrate cost savings to their state legislatures. One important output of the meetings was a better understanding of Medicare capitation rates by the states.[11] Much of the discussion centered on how the Medicare "rebate" could be used to cover supplemental services that were typically provided by Medicaid, thus saving state funds.[12] CMS affirmed that many types of Medicaid benefits, such as community-based and social support services, could be considered "directly health-related" for dual eligibles and thus covered under the SNP benefit package as supplemental benefits. States also asked if CMS could release copies of their plans' Medicare bids, so that they would have a better understanding of the specific Medicare services being provided. Because the bid data are proprietary CMS cannot release this information. Instead CMS suggested that states request it from the plans as part of the Medicaid contracting process. Some states are also very interested in exploring more fundamental changes to the financing structure, including combining the two separate capitation payments into a single one. CMS, however, was not able to address these types of changes because of statutory limitations.

[9] In 2008, 47 SNPs in six states (California, Idaho, Massachusetts, Minnesota, New York, and Wisconsin) applied for SNP subsets under the new policy. Source: CHCS notes from November 2007 meeting.
[10] CMS' draft Medicare Advantage application for 2008 required plans pursuing a subset to provide a contract between the state and plan by July 2007. This deadline was extended to October 1, and in lieu of a contract, CMS agreed to accept a letter from the state stating an intention to contract with the plan by January 1, 2008.
[11] An important contribution to this understanding was a CHCS Primer that described the Medicare Advantage bid process (also used for SNPs) and discussed approaches to state cost savings. See Verdier J., *Medicare Advantage Rate Setting and Risk Adjustment: A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefits*, October 2006.
[12] Bids submitted by Medicare Advantage plans are compared to a predetermined benchmark. If a plan bids below the benchmark, the difference is split between Medicare, which keeps 25% of the savings, and the plan, which must use the remaining 75% (referred to as a "rebate") to provide "supplemental benefits" or reduce Medicare cost-sharing. Supplemental benefits must be "directly health-related" and not covered by the Medicare fee-for-service program.

Future Issues

By spring 2007, CMS had decided to turn its focus from dual integration to dual eligibles receiving services through Medicare fee-for-service. This shift reflected a change in CMS senior leadership and an interest in supporting the needs of the majority of beneficiaries in the dual eligible population. In addition, there was a sense that a lot of progress had been made in dual integration, especially in the areas prioritized at the outset. As a result, CMS no longer has a structure to facilitate continued staff interaction around Medicare-Medicaid integration. Future progress will need to rely on the relationships developed during this initiative.

CMS' future commitment to addressing dual integration also depends in part on the future viability of SNPs. SNPs were initially authorized through the end of 2008. In December 2007, their authorization was extended through the end of 2009, but the legislation imposed a moratorium on new plans and expansion of service areas.[13] In July 2008, both the authority and moratorium on new plans were extended for an additional year through the end of 2010.[14] The one-year extensions surprised many who had hoped both in 2007 and 2008 that this authority would be extended for a longer period.

[13] The Medicare, Medicaid, and SCHIP Extension Act of 2007.
[14] The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

State Progress During the Initiative

While progress was being made by the states with respect to understanding federal Medicare and Medicaid administrative rules, each state also had to deal with its own set of legislative and regulatory requirements. There were differences among the states in their fiscal environments, the history of their involvement with managed care, and the intensity of support and involvement of their provider and advocacy communities. This section describes the five states' dual eligible populations at the beginning of the *ICP* funding and their progress during the two-year initiative.

Dual Eligibles at Baseline

Almost all Medicaid beneficiaries who are 65 years and older and more than one-third of non-elderly beneficiaries with disabilities are dual eligibles.[15] Medicare covers most of their acute care services (including physician, hospital, and post-hospital nursing home use) and their prescription drugs, which since January 2006 have been covered by Medicare Part D plans. Medicaid is responsible for Medicare cost-sharing and for other services not covered by Medicare, primarily long-term care.[16] Medicaid long-term care services include both institutional and home and community-based services (HCBS), although states differ considerably in the extent to which they offer HCBS through their Medicaid programs.

Figure 4 lays out data on each *ICP* state's dual eligible population as of December 2005, the beginning of the initiative. The percentages of the five state's populations that are dual eligibles vary widely for the 65 and older groups but more narrowly for those under 65 years of age. This is a reflection of differences in the income and health status of the states' populations as well as the differences in the state-specific Medicaid eligibility requirements.

Figure 4. Number and Percentage of State Populations that are Dual Eligibles as of December 2005

	65 and Older		Under 65	
	Number	Percent	Number	Percent
Florida	323,584	11.4	161,167	1.1
Minnesota	52,246	8.6	45,327	1.0
New Mexico	20,843	8.5	12,553	0.8
New York	445,818	17.9	203,109	1.2
Washington	59,471	8.5	48,390	0.9

Note: Numbers reported for Washington are as of June 2005.

Source: CHCS Integrated Care Program Final Grant Reports, January and February 2008.

New York had the largest incidence of dual eligibility for both age groups, with 18% of its 65 and over population and 1.2% of its under 65 population jointly eligible for both programs. Among the 65 and over group, Florida had the next largest incidence (11%) and the other three states (Minnesota, New Mexico, and Washington) had incidences less than half of New York's rate. For the under 65 groups, the percentages ranged from 0.8% in New Mexico to 1.2% in New York.

[15] Kaiser Family Foundation, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*, Washington, D.C., February 2006.
[16] In 2003, long-term care accounted for 66% of Medicaid expenditures, acute care services to supplement Medicare accounted for 15%, Medicare premium payments for 5%, and the remaining 14% covered prescription drugs. Ibid.

States also differed substantially in the percentage of dual eligibles that were receiving Medicaid nursing home and home and community-based care. State differences reflect state-specific Medicaid program rules, including those concerning eligibility, preadmission screening, and service coverage. Figure 5 shows the population percentages reported by the five states to be receiving Medicaid long-term care services by age and site as of December 2005. (Unfortunately, the "non-nursing home" data are limited to dual eligibles receiving services through HCBS waiver programs. This understates community long-term care service use that may be provided through Medicaid or other state programs.) As shown in Figure 5, differences are observed both in the incidence of long-term care use and in the use of HCBS. Once an integrated program is implemented it would be expected that these percentages would change to de-emphasize nursing home care and increase the use of community-based care.

Figure 5. Percentage of Dual Eligibles Receiving Long-Term Care as of December 2005

	In Nursing Homes		In HCBS*	
	65 and over	Under 65	65 and over	Under 65
Florida	13.5	4.0	0.1	0.0
Minnesota	37.0	6.3	30.0	29.9
New Mexico	17.8	2.7	7.5	16.9
New York	17.4	3.5	0.8	15.0
Washington	17.2	2.5	13.2	2.5

* These numbers include only beneficiaries enrolled in home and community-based waiver programs and do not reflect other community long-term care services provided through Medicaid or other state programs.

Note: Numbers reported for Washington are as of June 2005.
Source: CHCS Integrated Care Program Final Grant Reports, January and February 2008.

State Experiences During the Initiative

Over the two years, the five states worked on the development of 10 programs, seven of which were operational as of December 2007. Characteristics for each of these programs are shown in Figure 6. There were three basic types of programs:

(1) Dual eligibles voluntarily enroll in a single managed care organization (typically a SNP) for their Medicare and Medicaid coverage *(programs in Minnesota, New York, and the Washington Medicare-Medicaid Integration Program)*;

(2) Medicaid beneficiaries are required to enroll in a Medicaid managed care plan. Dual eligibles may select the same managed care plan (typically a SNP) for Medicare coverage, remain in the Medicare fee-for-service program, or join another SNP or Medicare Advantage plan *(New Mexico's program)*; and

(3) Medicaid beneficiaries may voluntarily enroll in a Medicaid managed care plan. Dual eligibles may select the same managed care plan (typically a SNP) for Medicare coverage, remain in the Medicare fee-for-service program, or join another SNP or Medicare Advantage plan *(Florida and the Washington Medicaid Integration Partnership)*.

Each state's activities during the initiative are described below. The descriptions are not meant to be exhaustive, but rather to highlight significant achievements and the barriers that present(ed) the most significant challenges. Program descriptions are as of December 2007.

Figure 6: Characteristics of the Programs as of December 2007

	General Information			Eligibility			Enrollment		Benefits		
State and Program Name	**Begin Date**	**Waiver Authority**	**# of Counties**	**Age**	**At-risk of Inst Only**	**Duals Only**	**Mandatory Medicaid**	**# of Plans**	**Acute**	**LTC**	**Behavioral Health**
Florida											
Florida Senior Care	Nov '08 (P)+	1915 (a)/(c) (P)	6	Duals 21+ MCD-only 60+	No	No	No	--	Yes	Yes	Yes
Minnesota											
Minnesota Senior Health Options	1997	1915 (a)/(c)	Statewide 83	65+	No	No	No++	9	Yes	Yes	Yes
Minnesota Disability Health Options–PD	Sep '01	1915 (a)/(c)	7	18-64	No	No	No	1	Yes	Yes	Yes
Minnesota Disability Health Options–DD	Feb '06	1915 (a)/(c)	3	18-64	Yes	No	No	1	Yes	Yes	Yes
Special Needs Basic Care	Jan '08	1915 (a)/(c)	Statewide 83	18-64	No	No	No	7	Yes	No	Yes
New Mexico											
Coordinated Long-Term Services	Aug '08	1915 (b)/(c) (P)	Statewide **	All	Duals No MCD Yes	No	Yes	2 (P)	Yes	Yes	No
New York											
Medicaid Advantage	May '05	1115	33 + 5 NYC boroughs	18+	No	Yes	No	14	Yes	No	Yes
Medicaid Advantage Plus	Oct '07	1915(a)	4 NYC boroughs	18+	Yes	Yes	No	1	Yes	Yes	Yes
Washington											
Medicare-Medicaid Integration Program*	Jun '05	1915 (b)/(c)	2	65+	No	Yes	No	1	Yes	Yes	No
Washington Medicaid Integration Partnership	Jan '05	1915 (a)/(c)	1	21+	No	No	No	1	Yes	Yes	Yes

MCD Medicaid
(P) Projected
* Program terminated as of June 2008.
\+ Program on hold as of September 2008.
** Will be phased-in geographically by county, with statewide implementation within a year.
++ Minnesota seniors are required to enroll in a Medicaid managed care plan but can choose MSHO instead.

Sources: CHCS Integrated Care Program Final Grant Reports, January and February 2008, and communications with the states.

Florida

Of the five states, Florida's experience most clearly demonstrates how difficult it can be to implement a program in a dynamic environment. Since 2002, Florida Medicaid staff have worked through several redesigns of a managed, integrated program for seniors in response to a mandate from Florida's legislature.

Florida Senior Care (FSC) is a voluntary Medicaid managed care program that covers a full-range of Medicaid services, including long-term care. FSC will be available to dual eligibles ages 21 and older and Medicaid-only recipients ages 60 and older in selected counties. Pilots were projected to begin in Central Florida (Orange, Seminole, Osceola, and Brevard counties) in late 2008 and the Miami area (Dade and Monroe counties) in summer 2009. Plans do not need to be SNPs.

The most dramatic setback came in fall 2006, when CMS waivers for Florida Senior Care were received just as Florida's legislature began a six-month recess. The state Medicaid agency was preparing to pilot the program in two parts of the state—one rural area in which enrollment would be mandatory and one urban area with voluntary enrollment—but lacked the necessary legislative authorities to proceed with implementation. When the legislature reconvened, term limits had removed the program's key supporters, and stakeholders, led by AARP, successfully lobbied members to make a number of significant changes. These changes included replacing the mandatory pilot with a voluntary pilot in a more populous urban region, no longer permitting enrollees to be assigned or locked-in to a plan, and switching from competitive plan procurement to an open application process which awards contracts to all qualified providers.

The first pilot was scheduled to begin enrolling beneficiaries in Central Florida in late 2008. However, the program experienced another setback when the legislature did not authorize additional program funding for community-based long-term care. The lack of dedicated waiver funding for HCBS will make it more difficult for plans to offer alternatives to institutional long-term care services. This eliminates an important selling point that could motivate beneficiaries to enroll in the program.

Additionally, in its current structure Florida Senior Care does not fully integrate Medicare and Medicaid services for dual eligibles. The Medicaid agency hopes to have a requirement that plans serving dual eligibles be SNPs and have a streamlined enrollment and marketing process in place when the Miami-area pilot becomes operational in 2009. Given all of these changes to the program's design from what was initially envisioned, it is unclear what specific market niche Florida Senior Care will fill in a state that already has numerous long-term care program alternatives in the pilot areas.[17] (Note: Implementation of Florida Senior Care was placed on hold as of September 2008.)

Minnesota

Minnesota came into the initiative with a mature model for integrating Medicare and Medicaid having operated Minnesota Senior Health Options (MSHO) since 1997 and Minnesota Disability Health Options (MnDHO) since 2001. Among all of the integrated programs, only MSHO has enrolled a large number of dual eligibles, nearly 35,000 as of December 2007. This enrollment is built on the state's long-standing commitment to managed care for its aged population, which has been required to enroll in Medicaid managed care

Minnesota Senior Health Options (MSHO) is a voluntary, statewide program for seniors that provides Medicare and Medicaid acute and long-term services through capitation arrangements with nine SNPs in 83 counties. Its sister program, **Minnesota Disability Health Options** (MnDHO) contracts with one SNP to provide these services to physically-disabled beneficiaries ages 18-64 in the Minneapolis/St. Paul area and to up to 120 developmentally-disabled beneficiaries in a three-county pilot. In January 2008, Minnesota began offering **Special Needs Basic Care** (SNBC), a statewide program for persons with disabilities that is modeled on the other programs but does not include long-term care.

[17] Florida has two Medicaid demonstration projects for elderly beneficiaries who meet nursing home level-of-care criteria, the Frail Elder Program and the Nursing Home Diversion Waiver, in overlapping geographic areas of the state.

since 1983. The largest enrollment increase, approximately 23,000 individuals, came in January 2006 when MSHO plans were permitted to "passively enroll" dual eligibles already enrolled in their Medicaid managed care plans. This was done so that beneficiaries could receive integrated drug coverage in a timely manner under the new Medicare drug benefit.

The use of capitated managed care was not as widespread for Medicaid beneficiaries with disabilities as for other population groups, and Minnesota used its initiative funding to develop a rate setting methodology for programs that serve the disabled. Additionally, throughout the two-year initiative state officials worked closely with the disability community to overcome its resistance to managed care. The introduction of two managed care programs for persons with disabilities reflects the progress made in this area. In addition to a small MnDHO pilot for persons with developmental disabilities introduced in February 2006, Minnesota launched Special Needs Basic Care, a statewide, integrated program for primary and acute care services, in January 2008.

As Minnesota transitioned its demonstration programs to permanent status, the CHCS-facilitated discussions with CMS provided a valuable opportunity to work through operational details of how to retain the programs' integrated practices in the new environment. CMS' change to the SNP subset policy was key to Minnesota being able to make this transition. In general, however, state officials believe they have less flexibility than they did under the demonstration waivers.

New Mexico

New Mexico's **Coordinated Long Term Services** (CLTS) is a capitated Medicaid managed care program with mandatory enrollment for all dual eligibles and for Medicaid-only beneficiaries who receive personal care or elderly and disabled waiver services, or reside in a nursing facility. New Mexico awarded contracts to two SNPs and began implementation in six counties in August 2008. Additional counties will be phased-in over the next year.

New Mexico is unique among the states in that it is proceeding with a mandatory Medicaid program for all dual eligibles and Medicaid-only beneficiaries at-risk of institutionalization. New Mexico has been working toward implementation of its statewide, capitated program called Coordinated Long Term Services (CLTS)[18] since 2004, and began enrolling individuals in August 2008.[19] Interest in such a program evolved out of a need to control the enormous growth of the Personal Care Options program, which provides services to Medicaid clients who meet nursing facility eligibility criteria.[20] Throughout the four-year planning process, New Mexico remained committed to its initial vision for the program despite the additional challenges associated with a mandatory model.

In the early stages of program development, New Mexico selected two national health plans to aid them in designing and implementing the new program. These plans became active partners, working closely with the state to overcome stakeholder resistance and ensure adequate support to move ahead. They have spent considerable time and resources conducting meetings with provider groups and consumers to promote the concept and to work on developing infrastructure.

Because Medicaid enrollment is mandatory, CLTS will provide a strong foundation for Medicare-Medicaid integration. However, how many enrollees will select their Medicaid plan's corresponding SNP for Medicare is unknown. The state is leaving the details of how to incentivize beneficiaries to make this

[18] As of September 2008, the program was renamed to Coordination of Long Term Services.
[19] CLTS will initially be available in Bernalillo, Sandoval, Torrance, Valencia, Santa Fe, and Los Alamos counties. Additional counties will be phased-in quarterly, with the program being statewide within a year at which time it will serve an estimated 38,000 beneficiaries.
[20] The total number of individuals receiving these services had an annual average growth of 76% from 2000 to 2005, and by 2005 accounted for 27% of long-term care expenditures.

selection to the plans, a strategy that has not worked too well in other states. If, however, this can be done successfully, New Mexico will provide an example of an important step forward for dual integration.

New York

New York focused on a number of "big picture" issues over the two years. One accomplishment was incorporating long-term care services into its integrated model. Medicaid Advantage was limited to acute care because of state legislation that allows only "designated" Managed Long Term Care Program (MLTCP) plans to be capitated for long-term care.[21] In October 2007 New York introduced a second program, Medicaid Advantage Plus, which provides acute and long-term care to beneficiaries who meet the nursing home level-of-care criteria through capitated contracts with plans that have both MLTCP and SNP designation.

New York has two programs in which dual eligibles ages 18 and older can voluntarily enroll in one plan for the provision of their Medicare and Medicaid services. **Medicaid Advantage** provides acute care services through contracts with 14 plans in 33 counties and New York City. **Medicaid Advantage Plus** (MAP) provides acute and long-term care services to beneficiaries who meet the state's nursing home level-of-care criteria. MAP plans must be designated as both a SNP and a Managed Long Term Care Plan. As of December 2007, one MAP contract was in place in New York City with additional contracts in process.

New York also focused on trying to increase Medicaid's share of the cost savings from the integrated care programs. One strategy was to require plans to conform to a state-defined Medicare benefit package. This not only saved agency resources by having a standardized wrap-around benefit package, but also reduced costs by having Medicare cover supplemental services (through the rebate) that would otherwise be Medicaid liabilities. An unintended consequence, however, was that the integrated products faced strong competition from "non-integrated" SNP products that used their rebate dollars to offer more attractive supplemental benefits such as health club memberships and pharmacy gift cards.

New York was the first to demonstrate the usefulness of requesting Medicare Advantage bid data from participating plans. New York developed a template that plans must submit as part of their Medicaid Advantage premium proposal, which combines Medicare bid data with Medicaid utilization data. This template provides a full picture of the Medicare and Medicaid services being provided to dual eligibles, and can be used to identify duplicative and overlapping services, and to find better ways to coordinate Medicare and Medicaid benefits and funding.

Program enrollment has been modest and lower than expected, approximately 4,100 as of December 2007. In addition to the competition from other SNP products, Medicaid officials attribute this in part to having voluntary enrollment for both Medicare and Medicaid. One approach under consideration is to mandate Medicaid enrollment for dual eligibles who choose Medicare managed care. At the end of the *ICP* initiative, New York voiced support for a federal requirement that SNPs contract with Medicaid in states that offer integrated Medicaid products.[22]

New York's continuing efforts to improve the programs were negatively impacted by the 2007 SNP legislation. Prior to the SNP moratorium, Medicaid officials had been working with a number of MLTCP plans to receive the SNP-certification necessary to participate in Medicaid Advantage Plus.[23] More

[21] The MLTCP capitates plans to provide long-term care services to nursing-home eligible beneficiaries. As of December 2005, there were 11 MLTCP plans in 17 counties, serving 10,463 dual eligibles.

[22] The MIPPA legislation of 2008 requires dual eligible SNPs to contract with the state Medicaid agency by January 2010 or they will not be able to expand their service areas.

[23] Most MLTCP plans are sponsored by nursing homes or home care agencies that lack the infrastructure to provide Medicare acute services. State legislation passed in 2006 and 2007 made additional MLTC slots available to plans willing to become SNPs, and MLTCP-designation under the new slots was contingent on participating in the fully-capitated Medicaid Advantage Plus or Program for All-Inclusive Care programs.

generally, uncertainty about the future of SNPs has made New York less willing to invest additional resources. Planned discussions with health plans to modify the uniform benefit package for 2009 to make it more marketable and competitive have been postponed while they "wait and see" what happens at the federal level.

Washington

The two voluntary pilots introduced by Washington State in 2005 were the first managed care programs available to the elderly and disabled populations in the state. These programs encountered considerable resistance from stakeholder groups. The county and regional providers (including the Area Agencies on Aging) feared the loss of their client base,[24] other providers were concerned about reimbursement rates, and consumer advocates worried about managed care in general.

The **Washington Medicaid Integration Partnership** (WMIP) is a voluntary Medicaid managed care program that provides the full range of Medicaid services to dual eligibles and Medicaid-only beneficiaries ages 21 years and older. WMIP is limited to one contractor (a SNP) in Snohomish County. From 2005 through early 2008, Washington offered the **Medicare-Medicaid Integration Program** (MMIP), a pilot for dually-eligible seniors in King and Pierce counties who selected to enroll in the participating plan's SNP for their Medicare and Medicaid services.

Over the two years, neither program made much progress enrolling dual eligibles or integrating Medicare and Medicaid. As the state's first comprehensive Medicaid managed care program, the Washington Medicaid Integration Partnership (WMIP) required significant staff resources within the Department of Social and Health Services especially around managing long-term care. The program's contractor, a national plan specializing in Medicaid managed care, was focused largely on developing an infrastructure for Medicaid long-term care. These efforts, in turn, reduced the resources left to work on integrating Medicare and Medicaid. As of December 2007, less than 15% of the nearly 2,900 WMIP enrollees were dual eligibles, of which about half were estimated to be enrolled in the contractor's SNP for Medicare services.[25] Still, WMIP may be a step toward integration if over time the plan and state undertake more efforts to address Medicare-Medicaid integration.

To enroll in the Medicare-Medicaid Integration Program (MMIP), dual eligibles had to select to receive all of their Medicare and Medicaid services from the program's only participating health plan. This program had very low enrollment. As of December 2007, only 225 dual eligibles had selected the program. Despite some joint efforts to try to increase beneficiaries' interest, the plan and the state mutually agreed to terminate the program in early 2008.[26]

Future Issues

A number of factors will play important roles in the *ICP* states' future progress. While support among the states' legislative and executive offices remains strong in some states, interest has waned in others. Legislative turnover, in some cases due to term limits, presents a threat to their continued survival. Integrated care and long-term care in general have steep learning curves, making it a challenge to replace program champions. Without these supporters, the programs are vulnerable to the opposition of well-organized advocates who are resistant to managed care.

[24] County-based providers play a critical role in the state's long-term care infrastructure. Individuals entering the long-term care system are initially assigned to the Area Agency on Aging or state social worker for case management and remain with them as a fee-for-service client unless they enroll in a managed care plan.
[25] Communications with Washington Department of Social and Health Services staff, February 7, 2008.
[26] MMIP was disbanded in June 2008 and the 225 enrollees returned to fee-for-service.

As budgetary pressures increase at the state level, these new programs are potential candidates for reduced funding or elimination. Dedicated waiver funds for the programs are at-risk in several states, even though the desired shift away from institutional services is predicated on the availability of alternative long-term care settings. States may also be cautious about committing resources for new infrastructures in a tight fiscal environment. In many states there appears to be a perception that the programs will not save money for the state and may in fact increase the cost of providing Medicaid services. To address these concerns, more thought needs to be given to ways to structure these programs so that Medicaid cost savings can be maximized.

The programs are also impacted by the same uncertainties faced by CMS with regard to the federal climate for the continuation and expansion of SNPs. They also believe that if progress is to continue, CMS will need to make more of a commitment, specifically by establishing an administrative structure dedicated to the on-going development of integrated programs. This initiative has provided an important forum for the states, but with its conclusion there is concern that CMS may not be fully engaged to move ahead on the issues that have yet to be resolved.

As the initiative came to a close in December 2007, CHCS published *Designing Integrated Care Programs: An Online Toolkit*.[27] This online resource is intended to provide ongoing support for states interested in developing integrated care programs. Other initiatives such as CHCS' *Managed Long-Term Supports and Services Purchasing Institute* provide building blocks for future Medicare-Medicaid integration efforts. In addition, CHCS is conducting a survey of states' current and future interest in contracting with SNPs to deliver integrated care to dual eligibles.

[27] Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=606732.

Key Findings

A fully integrated program for dual eligibles combines the full range of acute and long-term care services covered by Medicare and Medicaid. Supporting states in their efforts to achieve this integration was the ultimate goal of the *Integrated Care Program*. Below we discuss findings in five key areas: ***Program Planning***, ***Plan Participation***, ***Enrollment***, ***Financing***, and ***the Political Environment***.

Program Planning

State planning for a new program requires a number of steps. States need to formulate the design, work with stakeholders, obtain any necessary legislative or CMS authorities, develop an infrastructure for the program such as information technology, and draft policies and procedures.[28] Critical to the process are the initial decisions around a number of key design issues. These include populations to cover, enrollment requirements, scope, service coverage, and plan requirements. Figure 7 outlines details in each of these areas. In making these decisions, it is necessary to be mindful of state legislation or policy constraints that will govern the programs, and determine whether there need to be changes in administrative policy or legislation.

Figure 7. Summary of Critical Program Design Decisions

Population Groups Covered:
- Will the program include seniors and/or persons with disabilities?
- Will the program include only dual eligibles or Medicaid-only beneficiaries as well?
- Will the program target only beneficiaries at-risk of institutionalization?
- How and by whom will preadmission screening be done?

Medicaid Enrollment Requirements:
- Will Medicaid enrollment be mandatory or voluntary?
- Will beneficiaries be auto-assigned to plans and/or locked-in?
- Can beneficiaries enroll while remaining in Medicare fee-for-service?

Program Scope:
- Will the program be statewide or limited to specific geographic areas?
- Will there be a cap on enrollment?

Service Coverage:
- Will the program cover acute, long-term care and/or behavioral health services?
- What supplemental or "unique" services related to integration will be covered?

Plan Requirements:
- Will there be a limit on the number of plans awarded contracts in a geographic area?
- Will plans need to be SNPs?

Integral to the planning process is the involvement of all the stakeholder groups. Two groups—consumer advocates and community long-term care providers—may need attention early in the process. All of the states involved in the *Integrated Care Program* have faced opposition from some consumer advocates and several have had strong concerns voiced by community providers. The strategy that was most effective in promoting support was to engage these groups early in the planning stages and to meet regularly with them throughout the program's implementation. These meetings allow the groups the opportunity to voice their

[28] For a detailed outline of key steps and their sequencing see *Integrated Care Program Development and Procurement Workplan*, available on CHCS' website, www.chcs.org.

concerns and have them addressed in the design of the programs. They also provide a forum for states to continue to reinforce the overall goals of the program and the benefits to dual eligibles.

At each step in the planning process, states need to balance the characteristics of an "optimal" program with what is feasible. Although it may be expedient to make compromises that make it easier to move ahead, it is important to recognize how these decisions will ultimately impact the program's ability to meet its original goals. At the same time, programs that move too slowly may lose their early momentum and support.

Developing these programs has required a considerable investment of time and resources. Most *ICP* states spent at least three years moving from program inception to implementation. Some time is inevitably lost to bureaucratic delays caused by the need to coordinate across different government entities both within the state and between the state and federal government. Coordinating the necessary activities and working to maintain them as high priorities for all concerned is a time consuming and resource intensive effort.

States new to integration may be able to move more quickly if they can build on the resources developed over the course of the *ICP* initiative, including CMS' *Integrated Care Roadmap* and CHCS' *Integrated Care Online Toolkit*. CMS' Integrated Care Roadmap provides easy access to useful information, particularly the models provided in the three "How-To Guides." CHCS' toolkit contains a number of resources that can be used by states to help navigate the process more quickly, including sample contracts, enrollment forms, and rate setting methodologies from the states, as well as technical assistance documents developed as part of the initiative.

Plan Participation

To operate integrated care programs, states need to find entities that are willing to provide Medicaid services, primarily long-term care, to elderly and disabled Medicaid beneficiaries within a capitated amount. For beneficiaries to receive all of their Medicare and Medicaid services from the same managed care plan, these entities must also contract with the Medicare program for the provision of acute care services and some long-term care services under Medicare. SNPs provide a vehicle for facilitating this arrangement.

The number of SNPs has grown rapidly since the MMA legislation was passed in 2003. There were 477 SNPs serving approximately 1.1 million Medicare beneficiaries as of December 2007, with nearly 70% of this enrollment in plans serving the dually eligible.[29] Figure 8 shows the number of dual eligible SNPs and enrollment in the five states in December 2007. It should be noted that the majority of dual eligible SNPs have not contracted with states to provide Medicaid services.

Figure 8. Dual Eligible SNPS and Enrollment as of December 2007

	# of Plans	Enrollment
United States	320	760,561
Florida	56	48,119
Minnesota	13	36,293
New Mexico*	2	1,770
New York	45	56,143
Washington	3	1,727

* New Mexico enrollment numbers include beneficiaries residing in two Texas counties.

Source: CMS Special Needs Plan Comprehensive Report for December 2007, provided by Mathematica Policy Research, Inc. with state identifiers.

Figure 9 lists the contracted plans in each state as of December 2007. The states have not found it difficult to find plans willing to participate. The strength of these plans' commitment to the programs, however, is mixed. In New Mexico they have been active partners in developing the programs and lobbying for community and legislative support. In Florida, they were bystanders to legislative changes that have substantially altered the program. In other states (Washington and New York), they seemed reluctant to invest additional resources to market their

[29] In 2008, the total number of SNPs increased to 770, 440 of which were SNPs for the dually eligible.

product when enrollment did not meet expectations. To the extent the programs can gain momentum, there appears to be a sufficient number of plans willing to provide capitated managed care.

Figure 9. Participating Plans as of December 2007

Florida	Minnesota	New Mexico	New York	Washington
None	**MSHO:** Blue Plus First Plan Blue Health Partners Itasca Medical Care Medica Metropolitan Health Plan PrimeWest Health System South Country Health Alliance **MnDHO:** UCare Minnesota **SNBC***:** Blue Plus First Plan Blue Metropolitan Health Plan PrimeWest Health System South Country Health Alliance	**CLTS*:** AMERIGROUP Evercare	**Medicaid Advantage:** Americhoice Fidelis Group Health Inc. Health Insurance Plan of Greater NY HealthNow New York Liberty Health Advantage Managed Health Inc. MetroPlus Neighborhood Health Providers New York Catholic Health Plan Oxford Health Plans Senior Whole Health Touchstone Health Wellcare **Medicaid Advantage Plus:** Wellcare	**MMIP:** Evercare** **WMIP:** Molina Healthcare

* These plans had a relationship with the State but contracts were not signed until summer 2008.
** Relationship terminated in 2008.
*** These plans had signed contracts to start January 2008.
Source: CHCS Integrated Care Program Final Grant Reports, January and February 2008.

Enrollment

The enrollment process for a beneficiary joining an integrated care program is cumbersome. A dual eligible beneficiary must elect enrollment in a Medicare managed care plan (most often a SNP) and elect enrollment in the same plan's Medicaid managed care offering. Federal legislation requires that every Medicare beneficiary have the "freedom of choice" to stay in traditional Medicare where services are provided on a fee-for-service basis. States may give beneficiaries the option to stay in Medicaid fee-for-service or require them to select a Medicaid managed care plan from which to receive services. States with this requirement are said to have "mandatory" managed care. Mandatory Medicaid managed care does not mean that beneficiaries do not have choices, as beneficiaries can pick from several plans. Mandatory enrollment in Medicaid is desirable for a state because it provides predictability in expenditures and gives the state more control over access and quality.

Among the three *ICP* states with programs operating as of December 2007, only Minnesota had a state requirement for mandatory managed care enrollment.[30] New Mexico was planning a mandatory program. Florida had planned a mandatory pilot in one part of the state but it was derailed by subsequent state legislation. New York discussed the possibility of mandating enrollment in Medicaid Advantage in the future for dual eligibles who enroll in a SNP. Washington understands the desirability of such a program but believes that advocacy opposition is too great to allow the passage of necessary state legislation.

[30] Minnesota's elderly dual eligibles must pick a Medicaid managed care plan, however they can choose to voluntarily enroll in MSHO instead, which includes both Medicare and Medicaid services.

Figure 10 shows the number of beneficiaries that have enrolled in the states' programs as of December 2007. MSHO has 35,000 dual eligibles enrolled and is the only program that has much penetration into its target population (70%). However, this was achieved largely through the one-time passive enrollment of 23,000 beneficiaries. Numbers in MnDHO were much smaller, 515 dual eligibles with physical disabilities (2.8% of those eligible) and 32 dual eligibles with developmental disabilities (the program is capped at 120 beneficiaries). New York's Medicaid Advantage program had 4,130 dual eligibles, a market penetration rate of 1.7%. Washington's MMIP had enrolled only 225 dual eligibles out of a potential 20,000, or 1.1% of the potential population. (This program was terminated in early 2008.) A total of 419 dual eligibles (6.2% of those eligible) elected to participate in WMIP. However, the state reported that only about half receive Medicare services through the plan's SNP.

Figure 10. Program Enrollment as of December 2007

	Dual Eligibles			All
	# Enrolled	# Eligible	Rate	# Enrolled
Minnesota				
Minnesota Senior Health Options	34,872	50,200	69.5%	35,992
Minnesota Disability Health Options-PD	515	18,562	2.8%	888
Minnesota Disability Health Options-DD	32	120**	--	45
New York				
Medicaid Advantage	4,130	248,834	1.7%	4,130
Medicaid Advantage Plus*	10	DNP	DNP	10
Washington				
Medicare Medicaid Integration Program	225	20,037	1.1%	225
Washington Medicaid Integration Partnership	419	6,812	6.2%	2,898

DNP: Data not provided
* Program implemented in October 2007.
** Program is capped at 120 beneficiaries.
Notes: Rates are the number of dual eligibles enrolled divided by the number who meet all eligibility requirements and reside in a geographic area that offers at least one participating plan.
Source: CHCS Integrated Care Program Final Grant Reports, January and February 2008.

There are legitimate reasons why these enrollment numbers are so low. Although policy analysts have talked about these types of programs for a long time, they are new ideas to most dual eligibles and their families. Additionally, the plans participating in many areas were new to the communities, and beneficiaries and their families were likely concerned about how these new plans would affect the use of their current providers. Finally, the plans that were primarily responsible for the marketing of their products may have done a poor job. Small early enrollment numbers fed into these problems.

States are also increasingly recognizing the necessity of mandating Medicaid enrollment as part of the design of these programs. Although there continues to be stakeholder and other advocate concerns about a mandatory program, there is also increased optimism about the states' ability to overcome this opposition.

The work done by this initiative to develop enrollment and marketing materials specific to an integrated Medicare-Medicaid product will be helpful. States now have models for integrated enrollment forms. Integrated marketing materials will make it easier for beneficiaries and their families to recognize the advantages of enrolling in the same plan for Medicare and Medicaid. The final "working session" held

between CMS and CHCS also had an agenda item addressing the possibility of demonstrations mandating Medicare and Medicaid enrollment with an easy opt-out process. While considered unlikely at this time, the item is on the table and exists as a starting point for future discussions.

Financing

Under the integrated care programs, plans that enroll dual eligibles receive two capitated payments—one from CMS for Medicare services and one from the state Medicaid agency for Medicaid services and Medicare cost-sharing. By having the same health plan at risk for the full range of Medicare and Medicaid services, these entities have incentives to provide preventive care, reduce unnecessary care, and deliver services in less costly settings.

While this " plan-level integration" has the potential to reallocate Medicare and Medicaid resources in a way that reduces overall costs, the problem with retaining separate capitation payments for each program is that it perpetuates a fragmented system of funding. Most of the projected cost savings accrue to the federal government from the reduced use of expensive Medicare services (i.e., inpatient stays, emergency room visits and skilled nursing days). State-funded Medicaid services, including care coordination, behavioral health, and HCBS, that may contribute to Medicare savings typically require increased expenditures for Medicaid. States need to find ways to share in these potential Medicare savings.

One approach to state participation in projected cost savings would be to design the Medicare SNP coverage to include some Medicaid cost obligations. These might include Medicare cost-sharing or services typically provided by Medicaid such as care coordination. Although this would solve the problem of generating additional revenue for states it might not be the best use of the potential Medicare savings. If the state wants to encourage enrollment in the SNP, particularly in environments where beneficiaries can elect to stay in fee-for-service Medicare, it might be more useful to apply the potential savings to benefits that would stimulate beneficiary enrollment.

Another approach would be to redesign the program to apportion some of the cost savings to the state. Several of the states plan to request Medicare bid data from SNPs and to use the New York template (described earlier) to help suggest how responsibility for service delivery and sharing of cost reductions could be achieved. CMS will need to be involved in any activity that reallocates the federal and state share of cost savings. So far CMS has been unwilling to engage on this issue. New York has considered working on an agreement directly with the plans, but has put discussions on hold due to uncertainties around SNP reauthorization.

Finding a way to design the programs so the state can accrue costs savings is fundamental to future success. The current allocation will likely result in higher costs for Medicaid, costs which are untenable to state governors and legislators.

Political Environment

In 2005 when the *Integrated Care Program* began, several forces had come together to suggest that the time was right to promote integrated care for dual eligibles. The MMA legislation created SNPs, a new type of capitated Medicare plan. CMS political leadership and senior staff identified dual integration as a high priority issue. A number of health plans saw SNPs as a vehicle to grow their membership. Several states had demonstration projects in place that they wished to make permanent and many other states wanted to join them in pursuing programs that would promote dual eligible integration. Finally, CHCS along with others in the policy community were poised to provide funds and technical assistance to states that wanted

to work on service integration. A favorable economy also contributed to an environment in which everyone was more willing to commit financial and other resources.

Two years later, while SNPs remain a potential vehicle for fostering integrated care for dual eligibles, the federal, state, and business climates are not nearly as favorable, and some flaws in the SNP model have become apparent. On the federal level, there is uncertainty about the future of SNPs whose existence is ensured only through 2010.

States also see a different climate today than in 2005. With state revenues likely to decrease, many are facing challenges in holding onto legislative support for currently-operating community care programs. On the other hand, for states with very big problems (such as the expenditures in New Mexico on the personal care program), a fiscal downturn may provide more momentum for them to move their reforms forward.

At both the federal and state level, a program's implementation can be adversely impacted by personnel turnover. Legislators, presidents, governors, and CMS and Medicaid executive staff can change with election cycles. New people will bring their own priorities, interests, and may be less knowledgeable of this very complex issue. Florida is a good example. In Florida, a combination of changes in the governor and state legislature and the timing of federal approvals and legislative sessions derailed the mandatory pilot program. This suggests the need to engage with senior legislative and executive staff who are less likely to shift with election cycles.

In designing innovative programs there is always a delicate balance between pushing ahead with known imperfections versus waiting until desired improvements can be made. Although it is difficult to identify the appropriate balance, states that have erred on the side of moving ahead have fewer regrets as the window of opportunity can close quickly.

Future Considerations

In a short time, the *Integrated Care Program* has helped states move through bureaucratic logjams that have existed for many years. The initiative has also raised some of the important challenges that must be addressed for this important issue to move forward. The following considerations are based on the authors' experience and findings from the study:

- Future activities should give priority to working with those states that are committed to moving toward a program that mandates that dual eligibles join a capitated plan for their Medicaid acute and long-term care services.

- Ongoing work needs to be done with the disability advocacy community and to a lesser extent the aging advocacy community about the need for and desirability of managing care in an integrated way for dual eligibles. They should be encouraged to articulate their issues and engaged in dialogue about how their issues can be addressed.

- The issue of public funding for dual eligibles needs to be given more attention at forums such as the National Council of State Legislatures and the National Governor's Association. Efforts need to be made to communicate to these important audiences if integrated care programs are to be able to sustain support within their states. Several state legislators and governors could form a working group to devise communication methods to educate and update the respective groups about this complex issue.

- States need technical assistance with respect to working with their advocacy groups, especially the disability and aged groups. Specifically, they need help to better present the benefits of integrated managed care to these important constituent groups. Individuals at the state level who have done this well should be identified and provided support to help them communicate these techniques to program leaders in other states.

- Insurance plans with experience in managed long-term care should be encouraged to share their experiences with national and state consumer groups and with the national and local media so that this form of service delivery for long-term care services can become better understood.

- States need to design their programs to be able to demonstrate access, quality, satisfaction, and cost-effectiveness. This would include working on the issue of how potential Medicare cost-savings are shared between the federal and state governments and how quality, access, and satisfaction are to be measured.

- Efforts should be made to reinstate this issue to a high priority status at CMS. To move this issue forward, CMS will need leadership at the Administrator level, an organizational entity to serve as a focal point, and legislative authority for some experimentation around fully-integrated mandatory Medicare and Medicaid coverage with a choice of managed care plans.