CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE BRIEF | December 2015

Snapshot of Integrated Care Models to Serve Dually Eligible Beneficiaries

By Nancy Archibald and Alexandra Kruse, Center for Health Care Strategies

IN BRIEF

State interest in models to better integrate care for individuals dually eligible for Medicare and Medicaid continues to grow. Integrating care across service settings and funding streams can potentially improve coordination of care, increase alignment of program benefits and administration, improve beneficiary experience of care, and reduce overall costs of care. States are using a variety of approaches to align incentives and reduce fragmentation of care delivery across the Medicare and Medicaid programs.

This brief provides a snapshot of four integration models: (1) Dual Eligible Special Needs Plan-based; (2) Financial Alignment Initiative-based; (3) the Program of All-Inclusive Care for the Elderly; and (4) accountable care organizations and similar entities. It describes the key features, and considerations for using, each model. States exploring options to integrate care for dually eligible populations are encouraged to review these considerations through the lens of their policy/program goals and unique health plan, provider, and consumer landscapes.

Integrating the financing and delivery of services for individuals dually eligible for Medicare and Medicaid offers the potential to improve beneficiary experience, overall quality of care, and cost effectiveness. Spurred by opportunities in the Affordable Care Act, many states are exploring strategies to integrate care for dually eligible enrollees.

This brief, made possible through The Commonwealth Fund and The SCAN Foundation, describes four integrated care models, including implementation considerations for each. It updates a 2010 brief, *Options for Integrating Care for Dual Eligible Beneficiaries*, by Melanie Bella and Lindsay Palmer-Barnette, which was also funded by The SCAN Foundation.[1] While the country has made considerable progress in integrating care in the last five years, there is more to be done. States can use the information in this brief as they continue to explore options for serving dually eligible populations.

Key Elements of Integrated Care

Integrated care models aim to provide all Medicare and Medicaid services (i.e., primary and acute care, behavioral health services, and long-term services and supports (LTSS))[2] and also align administrative policies and procedures, including beneficiary materials and enrollment processes. In addition, integrated care models typically include:

Made possible through support from The Commonwealth Fund and The SCAN Foundation.

- Person-centered, accountable care;[3]
- Multi-disciplinary care teams providing care management and coordination;
- Comprehensive provider networks that meet the needs of the target population;
- Enhanced use of home- and community-based long-term care services;
- Strong consumer protections;
- Robust data-sharing and communication across the range of an individual's providers; and
- Financial alignment that blends Medicare and Medicaid funding.

Integrated Care Models and Considerations for States

Models that integrate Medicare and Medicaid can be grouped in four broad categories: (1) Dual Eligible Special Needs Plan (D-SNP)-based models; (2) Financial Alignment Initiative-based programs such as the capitated and managed fee-for-service model financial alignment demonstrations;[4] (3) the Program for All-Inclusive Care for the Elderly (PACE); and (4) accountable care organizations (ACO) and other similar entities. States are already using the first three types of models; while ACOs for dually eligible individuals, and other similar models, are in development. Following are descriptions of each model and considerations for their use, as well as the key features of D-SNP-based models (including Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)), Financial Alignment Initiative-based models, and PACE. Key features are not included for ACO-based models because they are not yet well-defined.

The Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare & Medicaid Services (CMS) recognizes the potential of all of these models to serve Medicare-Medicaid enrollees. However, the feasibility of individual models will vary across states and regions, depending on the penetration of managed care, the sophistication of integrated health systems, the state's capacity, and the degree of consumer and provider stakeholder engagement and support.

Integrated Care Models

MODEL 1: Dual Eligible Special Needs Plan-Based

D-SNPs are Medicare Advantage plans that provide a coordinated Medicare and Medicaid benefit package and offer a higher level of integration than regular Medicare Advantage plans or traditional Medicare fee-for-service. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as amended by the Affordable Care Act of 2010, facilitated greater integration of care through D-SNPs by: (1) requiring new D-SNPs or those that are expanding into new service areas to contract with state Medicaid agencies and specifying minimum requirements for these contracts; and (2) establishing new standards in the provision of care by D-SNPs. As of October 2015, 336 D-SNPs were operating in 38 states, the District of Columbia, and Puerto Rico, with a total enrollment of 1,732,200.[5]

States can use Medicaid agency contracts with D-SNPs as a platform to further integrate care for dually eligible beneficiaries. The level of integration within D-SNP-based models depends on state policy and program design, and can range from minimally- to fully-integrated. D-SNP contracts can require coverage for a variety of Medicaid services, and they can also be used to align a state's Medicaid managed care plans, including managed long-term services and supports (MLTSS) plans, with D-SNPs operating in the state by requiring the entities offering Medicaid plans to offer companion D-SNPs covering the same geographic area. States can contract with all or some of the D-SNPs operating in their state.

The potential for D-SNP contracting to fully integrate care depends on the relationships and requirements established between state Medicaid agencies and D-SNPs. MIPPA required that all D-SNP contracts with states include certain minimum requirements,[6] but states can go beyond these minimum MIPPA requirements to further integrate care. States and D-SNPs can develop fully-integrated programs that offer the full array of Medicare, Medicaid, and supplemental benefits within a single plan so that beneficiaries have one benefit package and one set of providers to obtain the care they need.

Following are a range of D-SNP-based contracting options, listed in order from least to most in terms of complexity, degree of integration achieved, and comprehensiveness of Medicaid coverage:

- **D-SNPs Meeting Minimum MIPPA Requirements:** State Medicaid agency D-SNP contracts must address eight minimum MIPPA requirements, including Medicaid benefits covered; D-SNPs' responsibility to either provide or arrange for Medicaid benefits; categories of beneficiary eligibility; the method for verifying eligibility prior to enrollment; adherence to cost-sharing protections; sharing of Medicaid provider information; D-SNP service areas; and the contract length. Under these arrangements, D-SNPs follow Medicare Advantage requirements to coordinate and arrange for the provision of Medicare and Medicaid benefits, but no administrative alignment or benefit integration requirements are included in the state contract with D-SNPs. *State Example*: New Mexico
- **D-SNPs with Medicare Cost-Share and/or Medicaid Wraparound Services:** States enter into contracts with D-SNPs to provide for the Medicare premiums and beneficiary cost sharing that Medicaid is required or chooses to pay for dually eligible beneficiaries and others enrolled in the Medicare Savings Program. In addition to providing plans with a monthly capitation rate that covers Medicare cost-sharing responsibilities, states may also contract with D-SNPs to provide Medicaid acute care services not covered or only partially covered by Medicare (e.g., vision, dental, hearing, durable medical equipment, transportation, care coordination). *State Examples*: Illinois, Minnesota (Special Needs Basic Care)
- **D-SNPs Providing Medicaid Acute and Long-Term Supports and Services:** States enter into contracts or other agreements with D-SNPs for the provision of both Medicare and Medicaid benefits including Medicaid long-term supports and services and/or Medicaid behavioral health services. States that have established a high-degree of benefit integration under these arrangements also pursue administrative alignment of Medicare and Medicaid processes and materials. *State Examples*: Arizona, Minnesota (Minnesota Senior Health Options), New York (Medicaid Advantage Plus), Texas (STAR+PLUS)
- **Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs):** States can require D-SNPs to request designation from CMS as a FIDE SNP. FIDE SNPs are a special type of D-SNP, given additional flexibility by CMS, in states that use D-SNP contracts to achieve a high degree of integration of Medicare and Medicaid services. FIDE SNPs must coordinate and be at risk for coverage of Medicaid LTSS, have procedures in place for administrative alignment of Medicare and Medicaid processes and materials, and may be eligible to receive additional Medicare Advantage payments that reflect the frailty of the beneficiaries they enroll. They can also offer additional supplemental benefits not typically covered by Medicare. *State Examples*: Massachusetts, New Jersey, Wisconsin

Considerations for Use	Pros	Cons
■ Good option for states not participating in CMS' Financial Alignment Initiative. ■ Requires a state Medicaid managed care infrastructure and D-SNPs willing to operate in the state and contract for the level of integration the state desires. ■ D-SNPs need to have the capacity to provide LTSS and/or behavioral health services. ■ MIPPA requires D-SNPs to contract with state Medicaid agencies, but state Medicaid agencies do not have to contract with D-SNPs, so they can select only those plans that meet their needs. ■ Congress has not modified the Social Security Act to permanently authorize D-SNPs, but bipartisan support exists for the program, and D-SNPs are currently authorized through 2018. ■ Medicare Advantage rate cuts and changes to the Stars quality rating system may influence D-SNP entry/exits from market.	■ Allows states to choose the level of integration that meets their needs. ■ Provides states greater budget predictability (although consideration needs to be given to the degree of financial risk). ■ Allows states to align their Medicaid managed care plans with D-SNP contractors. ■ Allows for some streamlining of administrative processes (e.g., enrollment, marketing, member materials, quality measures and reports).	■ Medicare and Medicaid funding is not truly blended. ■ States are unlikely to share in any savings on the acute care side that may result from service integration. ■ If the D-SNP contract is not for full integration, consumers would continue to navigate two separate systems (e.g., enrollment, provider networks, evidence of benefits, marketing materials). ■ States must develop the capacity for oversight of managed care plan activities including Medicare Advantage expertise. ■ Not viable for all states (e.g., those without operating D-SNPs; those without Medicaid managed care; and those that may want to use other care management structures, including health homes, ACOs, or an existing primary care case management infrastructure). ■ May not be able to cover all areas of a state (i.e., rural).

MODEL 2: Financial Alignment Initiative-Based

The Affordable Care Act gave CMS §1115A demonstration authority to test new payment and service delivery models that fully integrate care for dually eligible individuals. In 2011, CMS announced the Financial Alignment Initiative with demonstrations to test: (1) a capitated model; (2) a managed fee-for-service model; and (3) alternative models. As of November 2015, nine states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Texas, South Carolina, and Virginia) have implemented capitated model demonstrations, enrolling approximately 378,640 individuals.[7] Rhode Island plans to launch a capitated model demonstration in 2016. Although MMCO has stated that it will not consider adding additional capitated and managed FFS demonstrations in the Financial Alignment Initiative, states can still learn from these models.

In the ***capitated model***, the state, CMS, and a health plan enter a three-way contract where the plan (known as a Medicare-Medicaid Plan) provides seamless and comprehensive coverage for integrated Medicare and Medicaid services in return for a combined prospective payment. The three-way contract is designed to address the fiscal and programmatic challenges inherent in providing care to dually eligible individuals through the separate Medicare and Medicaid programs. The three-way contract also better aligns program incentives. The capitated model operates under a unified set of rules for enrollment, appeals, auditing, and marketing. Medicare-Medicaid Plans provide all Medicare Part A, B, and D and Medicaid services in return for a capitated payment that blends Medicare and Medicaid funds and provides a new savings opportunity for both the state and CMS. Capitated model demonstrations are jointly administered and monitored by CMS and the states.

Managed fee-for-service, a new model of care, adds strategies onto the existing fee-for-service delivery system to improve care management, improve quality and access, increase accountability, and contain costs. States are responsible for integrating all services (primary, acute, behavioral health, and LTSS) and implementing an infrastructure for care coordination. Under these models, CMS establishes a retrospective performance payment to states based on the amount of Medicare savings achieved for demonstration enrollees. Managed fee-for-service models leverage existing state infrastructure such as primary care case management, Medicaid health homes, accountable care organizations (ACOs), and related programs. Colorado and Washington have implemented managed fee-for service model demonstrations.

Minnesota is the only state with a signed Memorandum of Understanding for an ***alternative model*** demonstration. Its administrative alignment demonstration includes beneficiaries who are already enrolled in its Minnesota Senior Health Options (MSHO) program. The demonstration uses MSHO's D-SNP-based delivery system in which Medicaid managed care plans have contracts with the state as well as contracts with CMS to operate a companion D-SNP. Minnesota's demonstration provides Medicare benefits at least equivalent to the basic benefit levels included in Medicare Parts A, B, and D and Medicaid benefits based on existing managed care plan contracts. The demonstration is focused on improving beneficiary experience in the MSHO program by furthering Medicare and Medicaid administrative alignment.[8]

Considerations for Use	Pros	Cons
▪ MMCO has stated that it will not consider adding additional states to the capitated and managed FFS models of the Financial Alignment Initiative; however, the experiences of states implementing demonstrations will enhance their ability to integrate care even after the end of the demonstration period and offer lessons applicable to states implementing D-SNP- and ACO-based models.	▪ Truly blends Medicare and Medicaid financing. ▪ Gives states the opportunity to access shared savings. ▪ Offers significant opportunities to fully integrate administrative process including marketing, member materials, appeals, and quality measurement. ▪ Facilitates sharing of both Medicare and Medicaid encounter data with states.	▪ Medicare-Medicaid Plans in the demonstrations may still silo responsibilities for dually eligible beneficiaries in different parts of their organizations. ▪ Medicare-Medicaid Plans may not reimburse providers in a way that incentivizes care coordination or effective transitions in care.

MODEL 3: Program for All-Inclusive Care for the Elderly (PACE)

The Program for All-Inclusive Care for the Elderly (PACE) is an integrated care program for older adults who need a nursing home level of care. PACE provider organizations include health systems, hospitals, community-based agencies, long-term care providers, and government entities. Provider organizations receive capitated funding from both Medicare and Medicaid and are responsible for all of their participants' health care needs, including medical and behavioral health care, acute care, LTSS, and prescription medications. Beyond integrated payments and delivery of all Medicare and Medicaid benefits, PACE regulations integrate Medicare and Medicaid administrative processes with regard to: eligibility determinations, application procedures, services, participant rights, quality assurance, and marketing requirements.

Participants can be covered by Medicare-only or Medicaid-only, but the vast majority are dually eligible for Medicare and Medicaid. Because of their financing, PACE providers have the flexibility to offer all the services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service. All PACE programs operate on a similar model – and most participants attend adult day care programs staffed by an interdisciplinary team of health professionals that provides coordinated care. As of September 2015, there were 117 PACE organizations operating in 32 states and enrolling 33,003 individuals.[9]

Considerations for Use	Pros	Cons
■ PACE entities are local, provider-led organizations and may need several years of support from a sponsoring organization before they are financially viable. ■ States may want to weigh the resources needed to administer a PACE contract against the relatively small number of enrollees served. ■ PACE entities can serve rural areas, especially in partnership with non-rural PACE entities in a "hub-and-spoke" model. ■ For-profit PACE entities are now permitted. ■ The PACE Innovation Act of 2015 allows for demonstration programs that expand eligibility to individuals age 21 to 54 and to those who do not require a nursing home level of care.	■ Fully integrates Medicare and Medicaid funding streams. ■ Features one set of administrative processes and comprehensive services designed to keep beneficiaries in their homes. ■ Uses an established set of comprehensive quality measures. ■ Allows states to provide PACE through their Medicaid state plans, and they can serve as the PACE organization.	■ States cannot share in savings that may result from integration. ■ PACE organizations have limited scope in terms of their provider network, so enrollees may be required to change providers in order to participate in PACE.

MODEL 4: Accountable Care Organizations and Similar Entities

Accountable Care Organizations (ACOs) seek to improve quality and lower costs by making providers financially accountable for the health of the population they serve. ACOs achieve these goals using a value-based payment structure, quality improvement measures, and a health information technology infrastructure that facilitates data sharing. To create incentives for value-based rather than volume-based care, ACOs typically use either a shared savings arrangement or a global budget model to pay providers.

Medicare permits two primary types of ACOs: Medicare Shared Saving Program and Pioneer.[10] State Medicaid programs are also beginning to offer ACO programs that, in addition to primary and acute medical care, may also be responsible for behavioral health, LTSS, prescription medications, and even social services. However, to effectively serve Medicare-Medicaid enrollees, ACOs must operate across both the Medicare and Medicaid programs. Medicaid ACOs serving dually eligible individuals are in their infancy, but several states have driven the creation of ACO programs, often building on existing state programs:

- Colorado's ACO model for dually eligible individuals, the Accountable Care Collaborative: Medicare-Medicaid Program, uses the existing infrastructure and resources of its Medicaid-only Accountable Care Collaborative. Dually eligible individuals enroll into Regional Care Collaborative Organizations that coordinate physical, behavioral health, and LTSS needs. This ACO model serves as Colorado's managed fee-for-service financial alignment demonstration.[11]
- Oregon's ACO model includes Medicaid services only; Medicare-Medicaid enrollees are allowed to opt-in to the state's Coordinated Care Organization program.
- Maine's ACO model includes Medicaid services only. Its Accountable Communities may enroll dually eligible individuals, but none have done so to date.
- Washington and Vermont are building models with a shared savings component to support the development of accountable communities of health.

In addition to state-led ACO models for dually eligible individuals, health plans and providers are starting to explore ways to develop ACO programs of their own.

Considerations for Use	Pros	Cons
■ May be difficult to align with managed care-based integration models such as D-SNPs because of differing processes for claims submission, enrollee grievances and appeals, and reporting. ■ Multi-payer ACOs may be best positioned to coordinate care, improve outcomes, and reduce costs. ■ Governance structure may influence the ability of the ACO to improve outcomes and reduce costs with provider-led ACO models having greatest degree of success so far. ■ Need to include a broad range of providers and a comprehensive array of services to meet the diverse needs of dually eligible individuals. ■ To effectively care for Medicare-Medicaid enrollees, ACO need access to Medicare and Medicaid data. ■ Care management functions may duplicate those provided by D-SNPs, financial alignment demonstrations, or other integrated care programs.	■ ACOs can build on existing state infrastructure. ■ ACOs can include shared savings incentives for providers. ■ State-driven ACO models can be designed to minimize duplication and coordinate enrollment with other integrated care programs.	■ Adding Medicare-Medicaid enrollees into a Medicaid-only ACO may not produce state-level savings. ■ If the total cost of care is calculated for only Medicaid services, potential exists for cost-shifting toward Medicare services to achieve Medicaid savings. ■ May not achieve statewide coverage of integrated care if ACOs are the only integrated model used.

Key Features of Established Medicare-Medicaid Integration Models

Feature	Dual Eligible Special Needs Plan-Based		Financial Alignment Initiative-Based	PACE
	D-SNP	FIDE-SNP		
Level of Medicare and Medicaid Benefit Integration	■ Medicare primary and acute services ■ Medicaid benefits at the state's discretion ■ Option to offer supplemental benefits	■ Medicare primary and acute care services ■ Medicaid benefits including LTSS ■ Generally includes Medicaid behavioral health ■ Additional flexibility on supplemental benefits	■ One set of comprehensive Medicare-Medicaid Plan (MMP) benefits ■ Must include or coordinate provision of all Medicaid benefits ■ Option to offer supplemental benefits	■ One set of comprehensive PACE services (Medicare and Medicaid) ■ Must include all Medicaid benefits ■ May provide non-medical supports designed to keep beneficiaries at home
Enrollment[a]	■ When same health plan offers a D-SNP and an MLTSS product, one integrated enrollment form can be used ■ Opportunity to leverage Medicaid mandatory enrollment process to assign to companion D-SNPs	■ One integrated enrollment form and process ■ Opportunity for same accretion and deletion dates for all services ■ Opportunity to leverage Medicaid enrollment process to assign to companion FIDE-SNPs	■ One MMP with fully-integrated enrollment process ■ Initial opt-in enrollment process and waves of passive enrollment	■ Voluntary; no lock-in periods ■ One integrated enrollment form ■ Limited to nursing facility level of care ■ Upon enrollment, beneficiary must agree to go onsite and use PACE center physician
Care Coordination	■ Required to establish a Model of Care (MOC) to address unique needs of dually eligible enrollees ■ Must have a multi-disciplinary approach ■ State can add Medicaid care management requirements	■ Integrated MOC focused on provision of both Medicare and Medicaid benefits ■ Must have a multi-disciplinary approach ■ State adds Medicaid care management requirements	■ State/CMS joint development of MMP care management requirements ■ Required to have a multi-disciplinary care team with format and timing subject to state policy	■ Establishes comprehensive care management requirements ■ Required to have a multi-disciplinary care team with periodic in-person meetings
Assessments	■ Generally separate assessment process for Medicare and Medicaid ■ Health risk assessment (HRA) required for all enrollees	■ Medicare and Medicaid assessment processes are coordinated ■ Potential to develop an integrated assessment process ■ HRA required for all enrollees	■ HRA required for all enrollees, and coordination of Medicare and Medicaid assessment processes ■ Many high-risk enrollees receive a comprehensive, in-person assessment	■ Initial and periodic comprehensive, and in-person assessments required

[a] For Medicare, dually eligible beneficiaries may choose to enroll in D-SNPs, other Medicare Advantage plans, or Medicare fee-for-service (FFS), and states cannot limit month to month changes between Medicare Advantage plans or Medicare FFS. Additionally, PACE sites can only enroll dually eligible beneficiaries who meet nursing facility level of care, however states can choose to include or not include dually eligible beneficiaries in the other models at all levels of care and/or in all settings of care.

Feature	Dual Eligible Special Needs Plan-Based		Financial Alignment Initiative-Based	PACE
	D-SNP	FIDE-SNP		
Quality Improvement	▪ Comprehensive Medicare quality improvement and public reporting requirements with potential to integrate with Medicaid requirements ▪ Can integrate Medicaid Performance Improvement Projects (PIPs) and Medicare Quality Improvement Projects (QIPs)	▪ Strong incentive to integrate Medicare and Medicaid quality improvement activities ▪ States tend to align PIP and QIP topics and/or accept Medicare QIPs ▪ Some states are considering including Medicare quality information in state reporting	▪ Comprehensive Medicare and Medicaid quality requirements ▪ Integrated QIPs ▪ Quality withholds and joint state/CMS oversight	▪ Quality Assessment and Performance Improvement program developed with flexibility to meet PACE organizations' needs that monitors/ensures consumer outcomes/ satisfaction ▪ Joint state/CMS performance oversight
Data for Program Analysis/ Care Coordination	▪ States can get and use Medicare encounter data reported by D-SNPs for program analysis and rate setting ▪ Aligned D-SNP/Medicaid plans can use Medicare service utilization data for real-time care coordination	▪ Same features as D-SNP with greater incentives to use Medicare data for real-time care coordination	▪ MMPs report Medicare and Medicaid encounter data to states and CMS for use in program analysis and rate setting ▪ MMPs are required to use all Medicare and Medicaid service utilization data for real-time care coordination	▪ Potential reporting of Medicare and Medicaid service utilization data ▪ PACE organization can use service utilization data for real-time care coordination
Financial Model and Incentives	▪ Separate Medicare and Medicaid payments can be integrated by plan ▪ Incentives may exist for D-SNP/ Medicaid plan to use least costly services in least restrictive settings ▪ Savings from reduced Medicare service use accrue to plan and Medicare; no mechanism for states to share in Medicare savings ▪ Subject to Stars ratings; potential bonus payments	▪ Separate Medicare and Medicaid payments are integrated by plan ▪ Incentives exist to use least costly services in least restrictive settings ▪ May be eligible for frailty adjustment ▪ Savings from reduced Medicare service use accrue to plan and Medicare; no mechanism for states to share in Medicare savings ▪ Subject to Stars ratings; potential bonus payments	▪ Integrated Medicare and Medicaid payments ▪ Plan savings from reduced Medicare use are shared with the state and CMS ▪ Quality withhold will apply ▪ Stars rating system and bonus payments do not apply (CMS has stated they may develop a quality rating system for MMPs in the future)	▪ Fully integrates Medicare and Medicaid funding streams at PACE center level ▪ May be eligible for frailty adjustment ▪ Savings from reduced Medicare service use accrue to PACE Center; no mechanism for states to share in Medicare savings
Administrative Processes	▪ Administrative processes may be integrated when D-SNP/Medicaid plans are aligned	▪ Required to have integrated administrative processes	▪ One set of administrative processes	▪ One set of administrative processes

Conclusion

The four models described in this brief all have pros and cons that states must weigh as they decide how to move forward with integrating care for dually eligible populations. It is important to note that the integration models described here are not mutually exclusive. A state could simultaneously contract with D-SNPs, offer PACE, and operate an integrated program under the Financial Alignment Initiative. This flexibility is particularly useful in states with large geographic areas or that have wide variations in population density or provider service areas. In some larger states, it is possible that no one integration model will work well across all regions or communities.

Integrated care models continue to evolve. State Medicaid agency authority to enter into D-SNP contracts is relatively new and presents significant opportunities for states to expand D-SNP contracting strategies. Although the PACE program has a more limited geographic reach, recent legislation may allow this model to serve more individuals and may boost interest among sponsoring organizations to develop new PACE sites.[12] States and provider organizations are also experimenting with new ACO models to serve dually eligible individuals. Finally, D-SNP, PACE, and ACO models are likely to be influenced by ongoing lessons from the Financial Alignment Initiative demonstrations, including early outcomes from formal program evaluations. As consumers, providers, health plans, and states begin to see the cumulative benefits of integrated care programs, interest in these models of service delivery will almost certainly grow.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

[1] M. Bella and L. Palmer-Barnette. “Options for Integrating Care for Dual Eligible Beneficiaries.” Center for Health Care Strategies, March 2010.

[2] Integrated care programs may also have the resources to provide additional services not usually covered by Medicare or Medicaid. When specialized LTSS and/or behavioral health services are carved out of integrated care programs states have required that health plans help coordinate these services as part of the care planning process.

[3] The American Geriatrics Society has defined person-centered care as that which elicits an individual’s values and preferences and uses this information to guide all aspects of their health care, supporting their health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires. See: American Geriatrics Society Expert Panel on Person-Centered Care. “Person-Centered Care: A Definition and Essential Elements.” *Journal of the American Geriatrics Society*, December 2, 2015. Available at: http://onlinelibrary.wiley.com/doi/10.1111/jgs.13866/pdf.

[4] States implementing demonstrations under the Financial Alignment Initiative are using Medicare demonstration authorities and a variety of Medicaid waiver authorities depending on the goals and structures of their individual programs.

[5] Centers for Medicare & Medicaid Services. "Special Needs Plan Data" October 2015. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

[6] J. Verdier, A. Kruse, R. Lester, A. Philip, D. Chelminsky. State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options. Integrated Care Resource Center, February 2015. Available at: http://www.chcs.org/media/ICRC-Issues-and-Options-in-Contracting-with-D-SNPs-FINAL.pdf.

[7] Integrated Care Resource Center. "Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, November 2014 to November 2015." November 2015. Available at: http://www.chcs.org/media/ICRC-MMP-Enroll-by-State-November-2015.pdf.

[8] For more details see: Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) And The State of Minnesota Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf.

[9] Integrated Care Resource Center. “PACE Enrollment by State and by Organization, September 2015.” September 2015. Available at: http://www.chcs.org/media/ICRC-PACE-program-enrollment-September-2015.pdf.

[10] The Medicare Shared Savings Program facilitates coordination and cooperation among eligible providers who come together to form an ACO to improve the quality of care for fee-for-service beneficiaries and reduce unnecessary costs. Pioneer model Medicare ACOs are designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. They allow provider groups to move more rapidly from a shared savings payment model to a population-based payment model. For more information see: https://innovation.cms.gov/initiatives/aco/.

[11] As of November 1, 2015, 26,269 individuals were enrolled in Colorado’s ACO-based managed fee-for-service model financial alignment initiaitive. Personal communication with Van Wilson, Project Manager, Medicaid-Medicare Program, Health Programs Office, Department of Health Care Policy and Financing on December 9, 2015.

[12] The PACE Innovation Act of 2015. Public Law 114-85, November 5, 2015. Available at: https://www.congress.gov/114/plaws/publ85/PLAW-114publ85.pdf.