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Starting from Square One: Considerations for States Exploring Medicare-Medicaid Integration

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Starting from Square One: Considerations for States Exploring Medicare-Medicaid Integration

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CHCS Center for Health Care Strategies, Inc.

The ADvancing States **MLTSS Institute** was established in 2016 in order to drive improvements in key MLTSS policy areas, facilitate sharing and learning among states, and provide direct and intensive technical assistance to states and health plans. The work of the Institute will result in expanded agency capacity, greater innovation at the state level, and state/federal engagement on MLTSS policy.

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation, and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

The **Center for Health Care Strategies (CHCS)** is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with states and federal agencies, health plans, providers, and community-based organizations to advance innovative and cost-effective models for organizing, financing, and delivering health care systems, especially those with complex, high-cost needs.

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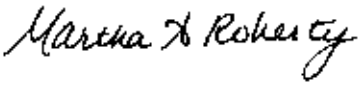
Both the ADvancing States' Board of Directors and the MLTSS Institute Advisory Council identified integrated care as a top priority for research and analysis in 2019. The second issue brief in our series of technical assistance documents around integrated care programs focuses on state considerations for embarking on an integrated care strategy. Paired with our first issue brief outlining the value proposition of integrated care programs for state Medicaid agencies, this brief should help move states forward in pursuing an integrated care program.

Sincerely,



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Introduction

For the past decade, policymakers have sought better integration of Medicare- and Medicaid-covered services and administrative processes for individuals who are eligible for both programs. In a fully integrated care model, all of the Medicare and Medicaid services (i.e., primary and acute care, behavioral health services, and long-term services and supports (LTSS)) that an individual needs are provided by a single accountable entity. While some states are ready to begin moving toward full integration, other states may want to take smaller steps. These states still have many options available that are valuable for dually eligible beneficiaries, particularly when they improve transitions of care and promote care coordination.

In 2008, only three states operated programs that integrated Medicare and Medicaid services, all of which were created through Centers for Medicare & Medicaid Services (CMS) demonstrations.[1,2] Subsequent opportunities, including the demonstrations under the federal Financial Alignment Initiative[3] and requirements for Dual Eligible Special Needs Plans (D-SNPs) to contract with states,[4] along with the expansion of state Medicaid managed care programs to include managed long-term services and supports (MLTSS), prompted more states to create integrated care programs. In addition, emerging data on the value of integration to states and program enrollees show promising findings including: (1) increased use of preventive care and home- and community-based services; (2) decreased use of emergency department and inpatient care; (3) improved beneficiary satisfaction and experience of care; and (4) reduced or slowed cost growth.[5] As of 2020, 22 states have created an integrated care option through demonstrations under the Financial Alignment Initiative or using D-SNPs for all or a subset of their dually eligible populations.[6]

Despite the progress that has been made, about 90 percent of the approximately 12 million dually eligible individuals in the United States are still receiving fragmented, uncoordinated care.[7] Many live in states that have not taken steps toward integration.

A recent ADvancing States issue brief[8] explained the value to states of Medicare-Medicaid integration for dually eligible populations, including:

- Increasing beneficiary satisfaction and quality of care;
- Reducing long-term services and supports utilization and overall costs; and
- Improving Medicaid program administration.

One key challenge facing states newly pursuing integration is that they are not sure where to begin. This brief outlines questions for states that are new to integration to consider as they explore options for better coordinating care delivery for dually eligible populations using either federal demonstration authority or D-SNP based integration models. It is designed to support state officials exploring integration approaches requiring either small or large steps toward integration.

Before deciding on an integration approach, states should be certain that their answers to the questions in this brief support their preferred strategy. States should also ensure that the integration approach will satisfy their policy goal(s), for example:

- Improving health outcomes for dually eligible populations;
- Reducing provider and beneficiary burden;
- Reducing the use of institutional long-term care settings; and/or
- Bending the cost curve for dually eligible individuals.

By setting clear and focused policy goals and exploring considerations thoroughly, states can select and implement an integration strategy that is both realistic and achievable.

Questions for States Exploring Medicare-Medicaid Integration

States exploring Medicare-Medicaid integration should begin by considering several factors: (a) the characteristics of the state's dually eligible populations; (b) the landscape of the state's health care environment; (c) stakeholder support; (d) the state's internal capacity and resources; and (e) the degree of integration it seeks to pursue. These issues are explored below as a series of questions for state consideration. Although this brief presents these issues sequentially, they are inter-related, and states may need to address them concurrently.

What Are the Characteristics and Needs of the State's Dually Eligible Beneficiary Population?

Before starting to design an integrated care program, the state will want to have a better understanding of who its dually eligible beneficiaries are, where they live, how they currently receive their Medicare and Medicaid services, and what services they use so that the planned program will have the right elements to best support beneficiaries. This information can also guide internal planning to ensure that the right tools and resources are in place to implement and oversee the program. States should consider the following questions:

- **What do the state's dually eligible populations look like?** Information on the number of dually eligible individuals in the state and their distribution across Medicaid eligibility categories (i.e., full or partial benefit dual eligibility) can provide states a basic sense of the potential scope of an integrated care program. For example, in Utah dually eligible beneficiaries account for just nine percent of the state's Medicaid enrollment, but in Mississippi they are 22 percent.[9] It may also be helpful to know if dually eligible beneficiaries are clustered in certain geographic areas, what proportion is younger and with a disability or age 65 and over, and what their most common diagnoses are. This information is publicly available from CMS, and the Integrated Care Resource Center has published a simple guide to using these data.[10] Also, by analyzing patterns of

Key Questions to Ask about the Dually Eligible Population

- What do the state's dually eligible populations look like?
- How are dually eligible individuals in the state currently covered under Medicare and Medicaid?
- Which Medicaid services are carved in/carved out of Medicaid managed care contracts?
- Does the state allow D-SNPs to provide any Medicaid-covered services?

care, including hospitalizations and Medicaid LTSS use, a state may be able to identify areas where service use patterns could be changed through better coordination of care, such as reducing hospital admissions/readmissions from nursing facilities or increasing transitions to community-based LTSS. Identifying opportunities to change inappropriate utilization through analysis of these data may also help to make the case for integration to a state's governor, legislators, or Medicaid agency leadership.

- **How are dually eligible individuals in the state currently covered under Medicare and Medicaid?** Publicly available data can be used to identify the current service delivery options and the numbers of dually eligible individuals enrolled in original Medicare, regular Medicare Advantage-Prescription Drug (MA-PD) plans, D-SNPs, Chronic Condition Special Needs Plans (C-SNPs), Institutional Special Needs Plans (I-SNPs), and PACE.[11] On the Medicaid side, the state should have data on the number of dually eligible individuals enrolled in various Medicaid delivery system reform efforts (e.g., Medicaid managed care, Medicaid health homes, Medicaid accountable care organizations (ACOs), etc.). By mapping out these arrangements, the state can get a sense of where the opportunities for integration are and where they could be created or expanded. For example, if D-SNPs do not operate in all areas of a state where there is Medicaid managed care, a state could try to persuade plan sponsors to create them.
- **Which Medicaid services are carved in/carved out of Medicaid managed care contracts?** Some states may carve out some Medicaid services, like behavioral health or LTSS, from their managed care contracts. Other managed care entities may have the responsibility for providing these services, or states may just continue to pay for them on a fee-for-service (FFS) basis. In these states, it is more difficult to coordinate and integrate carved-out services for dually eligible individuals because multiple entities are involved.
- **Does the state allow D-SNPs to provide any Medicaid-covered services?** A number of states with D-SNPs arrange for these plans to cover their enrollees' Medicare premiums and cost-sharing. This may reduce burden on beneficiaries and improve their access to care, but coverage of cost-sharing alone does not reduce fragmentation of service delivery that can be addressed when one entity is responsible for providing both Medicare and Medicaid services. As a step in that direction, states may contract with D-SNPs to cover additional Medicaid benefits, including wraparound services, behavioral health services, and LTSS. If state policy and plan capacity enables D-SNPs to cover Medicaid behavioral health or LTSS, D-SNPs may be eligible to achieve a designation by CMS as a Fully Integrated SNP (FIDE SNP) or a Highly Integrated SNP (HIDE SNP), both of which represent a significant advancement in integration.[12]

What is the Landscape of the State's Health Care Environment?

A key element to consider is what potential health care system partners could provide the foundation for integrated care and work with a state to launch a program. Although partners are often Medicare or Medicaid managed care organizations, the presence and involvement of sophisticated providers already involved in caring for dually eligible populations can support efforts as well. Following are several questions to help states assess potential marketplace integration opportunities and barriers.

Key Questions to Ask about the Health Care Landscape

- Does the state have Medicaid managed care?
- What is the state's Medicare Advantage penetration?
- What types of Medicare Advantage plans are available?
- Are Medicare accountable care organizations or other value-based initiatives operating in the state?
- How willing are providers/provider organizations to engage in an integrated care effort?

- **Does the state have Medicaid managed care?** Medicaid comprehensive managed care programs that enroll dually eligible individuals or MLTSS programs are a very useful base to leverage in creating an integrated care program. In states without Medicaid managed care in any or some regions, Medicaid health homes[13] or even primary care case management programs could be used in an integrated care effort.
- **What is the state's Medicare Advantage (MA) penetration?** In 2019, 34 percent of Medicare beneficiaries were enrolled in a MA plan; however, this penetration rate varies widely by state, from one percent in Alaska to 44 percent in Hawaii.[14] Having a higher MA penetration rate indicates a willingness on the part of Medicare beneficiaries, including dually eligible beneficiaries, to enroll in a managed care delivery system. This could support a state's efforts to create an integration model built on a D-SNP platform. To find MA penetration rates, see CMS' monthly report that shows, at the state and county level, the percent of eligible individuals who are enrolled in MA.[15]
- **What types of MA plans are available?** Of the different types of MA plans (e.g., regular MA-PD plans, C-SNPs, D-SNPs, and I-SNPs) enrolling dually eligible individuals, the presence of D-SNPs provides the greatest opportunity for integration. Knowing which regions of the state are served by D-SNPs and their current enrollment is also helpful in planning an integrated care program. CMS publishes monthly data on SNP enrollment by contract number that also includes SNP type and state of operation.[16] Lastly, MA plans generally have a greater presence in urban or more densely populated areas. In rural states or areas, these plans may have more difficulty developing the provider networks and enrolling sufficient participants for an adequate risk pool which they need to operate. States with large rural areas may have limited opportunity to build integrated care efforts using MA plans.
- **Are Medicare ACOs or other value-based initiatives operating in the state?** The Medicare program is currently testing a number of new payment and service delivery models. Most of these models only operate in the Medicare FFS system, so their enrollees/assigned members cannot also enroll in a MA plan. This could limit the number of dually eligible individuals who meet the criteria to enroll in a D-SNP-based integrated care model in certain states. CMS publishes a map showing the location of Medicare Shared Savings Program ACOs and also data on ACO enrollment, including the number of dually eligible individuals enrolled.[17]

- **How willing are providers/provider organizations to engage in an integrated care effort?** Obtaining buy-in from providers is important. Large providers that serve a substantial portion of the state may strongly influence the success of the planned integrated care program. It may be particularly important to engage health systems and large nursing facilities to understand their challenges and motivations. These should be strategically addressed in program design, including aligned incentives that will achieve program goals while also building provider support.

  In addition, the state will need to engage providers of Medicaid-covered services. The history of the state's Medicaid program, including its provider payment rates, Medicaid financing mechanisms, and any efforts to implement Medicaid managed care may affect the willingness of providers to engage in discussions related to the integration of Medicare and Medicaid. Clearly articulating the state's goals for integration along with potential impacts for providers will help build transparency and trust with providers. It's critical to identify opportunities for providers where there is a win-win-win: improved quality outcomes, overall lower costs and potential financial benefits for them.

How much Stakeholder Support for Integration Does the State Have?

A critical element for any state considering an integrated care program is to understand the degree of stakeholder support for such an effort. Taking an initial stakeholder temperature check is a key starting point for designing a stakeholder engagement plan. If support does not already exist, it can be built over time by sharing data, building relationships, and identifying common goals. After assessing the landscape as described above, states should ask the following questions to evaluate the level of support for integration both internal and external to the state Medicaid agency:

Key Questions to Ask about Stakeholder Support

- Is there significant internal support for new programs or efforts?
- Are external stakeholders open to considering and collaborating on the design of an integrated care program?
- How will initial integration efforts be funded and then sustained?

- **Is there significant internal support for new programs or efforts?** Absent a mandate for integration from the state's governor or legislature, having clear buy-in from executive and legislative leadership is critical to set the tone within the Medicaid agency and across other key agency partners such as aging, disability, and behavioral health that manage the provision of specialized Medicaid benefits, including home and community-based services waivers. Helping those other agencies understand the role they will play in the new system is critical. If needed, the flexibility to restructure agency roles or staff and commit key resources to support new integrated care efforts is greatly facilitated by high-level support. In addition, having a dedicated agency-level leader to help state teams define and adhere to specific policy objectives is important. This agency leader can be an internal program champion to communicate the state's vision, address challenges, and balance stakeholder needs throughout periods of program design, early implementation, and ongoing operation.

- **Are external stakeholders open to considering and collaborating on the design of an integrated care program?** Developing early partnerships between the state, its health plans, and key providers, and between the state and the Medicare-Medicaid Coordination Office within CMS can help to identify and resolve questions, improve administrative coordination, and encourage information sharing. In addition, engaging a broad group of stakeholders (e.g., beneficiaries, family members, advocacy organizations, providers and provider organizations) is critical to inform program design and identify issues and challenges during implementation. Convening workgroups or advisory councils is one way that states have successfully engaged stakeholders. Workgroups can provide feedback on program design elements such as how to: (a) transition home and community-based waiver services to managed care; (b) develop a person-centered, care management model that fits the state's particular objectives; and (c) design benefits and payment policies to meet the needs of specific dually eligible subpopulations including those with significant behavioral health needs.
- **How will initial integration efforts be funded and then sustained?** If a state is considering a larger-scale integration effort such as creating a new demonstration or launching a MLTSS program that will align with its D-SNPs, having a clear vision of what existing or new resources will be available to support staff capacity (discussed below) for program development, launch, and day-to-day management is critical. Identifying existing resources or funding that may be supporting FFS operations, but could be transitioned to help oversee an integrated managed care model, is one way that states could support the development and ongoing oversight of these programs. In some cases, new funding streams may be needed to support staffing, information system changes, stakeholder outreach, beneficiary outreach, contractual support (such as for actuaries), and other program design or oversight costs.

  It is worth noting that, if cost savings or slowed cost growth are a goal of integration efforts, it may take several years to see impacts, especially if a state is launching a major systems change effort. This is often the case even if the programs or interventions put into place are effectively impacting other important outcomes such as service use, health outcomes, and beneficiary satisfaction. To sustain integration efforts in the short-term, states should identify a stable source of funding while new programs become established and should not expect immediate cost reductions from implementation.

What Internal Capacity is Available to Support Integration Efforts?

State Medicaid agencies need to build the internal capacity necessary to support integration efforts. Naturally, smaller-scale steps toward integration are less resource-intensive, but bigger steps will require more capacity and dedicated funding (as described in the preceding section). Questions to assess states' internal capacities include:

- **Is the state Medicaid agency implementing other initiatives that are taking up bandwidth?** Many states are implementing multiple Medicaid delivery system reform initiatives at the same time. Adding new Medicare-Medicaid integration activities to this list is sometimes not feasible because competing efforts would require the use of the same staff, the same limited funding pool, and/or the attention and focus of the same agency champions or stakeholders.
- **Is there staff capacity to design and implement the integrated care effort?** Staff capacity includes not just the number of staff (i.e., full-time equivalents or FTEs) needed to support this work, but that staff have the specific knowledge and skills required to oversee an integrated program (e.g., knowledge of Medicare and its interactions with Medicaid, experience with managed care procurements, ability to use data for contract oversight, etc.). While it may be possible to reorganize resources to identify staff with time to devote to procurement and contract oversight efforts, it is generally more difficult to find staff with Medicare knowledge and, when this expertise is available, it can be costly. As such, states will want to identify key staff and available resources to help build Medicare knowledge and capacity.[18]
- **Does the state have the needed data analytic capacity and information technology infrastructure?** Integration efforts are greatly aided by the use of linked Medicare and Medicaid datasets, which can provide valuable insight into the characteristics of dually eligible populations, their service use patterns, and opportunities for better care coordination. While not absolutely critical, the resources to build and analyze data can be very helpful. Additionally, changes to information systems will be needed to accommodate program eligibility and payment guidelines and processes. Similarly, information systems that can connect seamlessly with CMS' information systems as well as those of health plans can greatly support eligibility and enrollment, promote information sharing to improve care transitions, and facilitate program oversight.[19]

Key Questions to Ask about Internal Capacity

- Is the state Medicaid agency implementing other initiatives that are taking up bandwidth?
- Is there staff capacity to design and implement the integrated care effort?
- Does the state have the needed data analytic capacity and information technology infrastructure?
- Does the state have access to a contractor that can serve as a staff extender?

- **Does the state have access to a contractor that can serve as a staff extender?** If states are launching large-scale integration efforts such as a new MLTSS program that will be aligned with integrated health plans, staff extension support via existing or new consulting contracts may be helpful. Even states with some existing staff capacity and available resources could find value in using consulting resources to help conduct readiness reviews, manage ongoing stakeholder engagement, or develop parameters for needed information system changes.

What is the State's Approach to Integration?

Once the state has identified its policy goals, performed an assessment of the state health care landscape, assessed internal capacity, and consulted with stakeholders, the state can determine the scale of integration it wishes to pursue. Some of the state's choices with regard to its integration approach will be contingent upon the opportunities and barriers identified in those earlier phases. However, the decision to pursue a greater degree of Medicare-Medicaid integration does not necessarily mean large-scale systems change. In the context of the other considerations raised in this brief, states should think about: (1) the scale of the effort they are willing/able to undertake; (2) how an incremental approach to integration would impact beneficiaries and providers; (3) strengths of the existing system that should be maintained; and (4) if it is possible to use existing Medicaid platforms to support integration efforts. The answers to these questions will help states set their strategic approach to integration, which can be smaller or larger scale depending on the size or complexity of the anticipated integrated program change.

Key Questions to Ask about the State's Approach to Integration

- Does the state want to start incrementally?
- Does the state want to implement a large-scale reform?

- **Does the state want to approach integration incrementally?** Incremental steps include making small-scale changes, often leveraging existing structures, and requiring less of a heavy lift to improve some aspect(s) of administrative alignment and coordination of care for the dually eligible population. Examples of incremental efforts include:
    - Supporting beneficiary enrollment in Medicare Savings Programs and Extra Help;[20]
    - Promoting beneficiary enrollment into any integrated care models that may already exist in the state (e.g., PACE, aligned D-SNPs and Medicaid managed care plans);
    - Facilitating development of new PACE organizations for older adults;
    - Adding requirements to existing D-SNP contracts that increase integration or alignment;
    - Providing training and resources to Medicaid waiver case managers in order to help them understand and coordinate with Medicare benefits; and

- Aligning D-SNPs with existing Medicaid managed care organizations to the extent that the state enrolls dually eligible beneficiaries in Medicaid managed care.

These incremental approaches may be more attainable for states with: (1) fewer health plans or providers with which they can partner; (2) limited stakeholder support for large-scale change; (3) multiple other initiatives that are taking up bandwidth; or (4) fewer internal staffing resources to oversee a large-scale integration effort.

- **Does the state want to implement a larger-scale reform?** Larger-scale reform could include developing a new integrated care program or expanding current programs to create a fully or partly aligned program that provides a high degree of coordinated care and administrative alignment. The most integrated programs can provide a seamless care experience across both programs to beneficiaries. Examples of platforms or care delivery models that could be considered larger-scale reforms, listed in order from least to most integrated, include:
  - Medicaid health home programs;
  - MLTSS programs that are aligned with D-SNPs;
  - Integrated D-SNP programs (HIDE SNPs or FIDE SNPs); or
  - Demonstrations under the Financial Alignment Initiative or new state-specific demonstration models.

  These reforms may be attainable for states with: (1) health plans experienced in both Medicare and LTSS service delivery; (2) providers experienced with managed care; (3) clear executive/legislative direction to advance integration and/or strong stakeholder support; and (4) internal staff capacity and resources to design, launch, and sustain a new program.

Conclusion

States have made unprecedented progress to advance integration in the last decade, and new federal opportunities and requirements continue to accelerate interest and action among new states. As they explore opportunities for Medicare-Medicaid integration, states should consider: (a) the needs of the population they are serving; (b) opportunities and barriers in the state health care landscape; (c) the degree of stakeholder support for change; (d) their internal capacity and resources; and (e) the policy goals to be achieved. For Medicaid and other key agency partners, the considerations described in this brief are key precursors for designing and implementing new programs and can serve as a guide to shape initial discussions about whether and how to implement a new program or policy.

Endnotes

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[12] FIDE SNPs are a type of D-SNP that covers all of an enrollee's Medicare services as well as Medicaid-covered LTSS (and potentially behavioral health services) to the extent required by state policy through a capitated contract with the state. HIDE SNPs are another type of D-SNP, also providing all Medicare-covered services, and either Medicaid LTSS or behavioral health services consistent with state policy, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP. For more information see: CMS. "Medicare Managed Care Manual, Chapter 16B Special Needs Plans." August 19, 2016. Available at: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf**; and CMS. "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)." January 17, 2020. Available at: **https://www.integratedcareresourcecenter.com/sites/default/files/DSNP%20Integration%20Guidance_HPMS%20Memo_01172020.pdf**

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[18] The Integrated Care Resource Center has a number of webinars and technical assistance tools that provide an introduction to working with Medicare for state staff. See: **https://www.integratedcareresourcecenter.com/resource-library?&field_resource_type%5B0%5D=306&field_resource_type%5B1%5D=307**

[19] The State Data Resource Center provides technical assistance to states to help create and analyze linked Medicare and Medicaid datasets. See: **https://statedataresourcecenter.com/**. Medicaid's Innovation Accelerator Program (IAP) also provides Medicare-Medicaid Data Integration (MMDI) Technical Support. See: **https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/data-analytics/index.html**

[20] The Medicare Savings Programs (MSPs) are Medicaid programs (or categories of Medicaid eligibility) that provide payment for Medicare premiums and/or cost sharing for low-income individuals. MSPs provide important cost savings for low-income dually eligible beneficiaries. Medicare beneficiaries also can qualify for Extra Help with their Medicare prescription drug plan costs. For more information, see: **https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs** and **https://www.ssa.gov/benefits/medicare/prescriptionhelp/**

[21] CMS. "Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare." State Medicaid Director Letter #19-002. April 24, 2019. Available at: **https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd19002.pdf**

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