BRIEF | NOVEMBER 2017

CHCS Center for Health Care Strategies, Inc.

# Advancing Medicare and Medicaid Integration: Key Program Features and Factors Driving State Investment

*By Alexandra Kruse, Stephanie Gibbs, Leah Smith, Center for Health Care Strategies*

**IN BRIEF**

State policymakers and their federal and health plan partners are increasingly seeking opportunities to improve Medicare and Medicaid program integration for dually eligible beneficiaries as a way to reduce fragmentation and improve care. Based on the experiences of 10 states in pioneering integrated care programs, this brief — developed with support from The Commonwealth Fund and The SCAN Foundation — describes key features of effective program design and operation. These include: (1) strong partnerships with engaged stakeholders; (2) transparency and responsiveness; (3) comprehensive care delivery; (4) integrated financing, risk-adjustment, and rate sufficiency; and (5) sufficient resources for oversight and monitoring. In addition, based on takeaways from these 10 state pioneers, this brief presents top factors driving state investment in integrated care programs, including state capacity and environment as well as state ability to access Medicare savings if integrated care lowers overall costs.

In recent years, more and more states have made significant progress in integrating care for the more than 11 million dually eligible individuals who receive services from both Medicare and Medicaid, two otherwise uncoordinated systems of care with different eligibility criteria, benefits, provider networks, and enrollment processes. For these individuals, care is often fragmented across a wide array of medical, behavioral health, and long-term services and supports (LTSS) providers. In addition, dually eligible beneficiaries tend to have high medical, social, and functional needs. Those under 65 also tend to have higher levels of behavioral health conditions requiring specialized support and services to address their needs. All of these services need to be coordinated effectively to improve care for this population. In the past, only a few states had implemented concerted efforts to provide more coordinated, less fragmented care for this population; however, recent enhancements in state authority to contract with specialized Medicare plans serving dually eligible beneficiaries as well as new federal funding provided unprecedented opportunity to advance this work.

The passage of the Affordable Care Act and subsequent creation of the Centers for Medicare & Medicaid Services' (CMS) Medicare-Medicaid Coordination Office (MMCO) in 2010, and the launch of the Financial Alignment Initiative in 2011 spurred rapid federal and state investments in integrated care programs. States have launched and refined demonstrations that are testing both capitated and managed fee-for-service models of payment and care delivery.[1] In addition, states are strategically contracting with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), using their congressionally authorized D-SNP contracting authority to increase the level of integration that health plans have to achieve for the dually eligible population.[2] At the same time, states are increasingly requiring alignment of Medicaid managed long-term services and supports (MLTSS) and

*Made possible with support from The Commonwealth Fund and The SCAN Foundation.*

D-SNP contractors so dually eligible beneficiaries are able to enroll in an integrated product operated by the same insurer.[3,4]

Preliminary findings from the Financial Alignment Initiative demonstrations,[5,6] and an evaluation of the D-SNP based Minnesota Senior Health Options program,[7] suggest positive outcomes for key areas (e.g., beneficiary satisfaction and access to home- and community-based services [HCBS]), but more time and analyses are necessary to understand the full impact of integration efforts. In the meantime, states at the forefront of this work are taking stock of what they have learned. Among them are 10 states — Arizona, Illinois, Massachusetts, Minnesota, New Jersey, Ohio, Rhode Island, South Carolina, Tennessee, and Virginia — that are part of *Implementing New Systems of Integration for Dually Eligible Enrollees* (INSIDE), a learning collaborative supported by The Commonwealth Fund and The SCAN Foundation and led by the Center for Health Care Strategies (CHCS).[8]

Through discussions supported by INSIDE, CHCS worked with these 10 states to identify key features of effective integrated care program design and operation. The resulting list of key features includes both existing items that contribute to program effectiveness for these states, as well as desired elements based on program experience. This brief describes these key features as well as state and federal factors influencing state investment in integrated care. The key features provide a framework to guide states considering options for integrating care, regardless of the integration model selected.

Several themes that emerged in identifying features of integrated programs parallel prior research into successful programs for complex populations. For example, models that demonstrate success for high-need, high-cost populations include similar qualities such as: targeting of interventions for different populations; dedicated leadership commitment; the pivotal role of the care coordinator in driving outcomes; and active engagement of individuals and their families.[9] Another study identified characteristics of successful models serving complex patients in interdisciplinary primary care settings including: targeting the right patients and assessing risks and needs; using evidence-based care planning and patient monitoring; promoting communication among patients, family, and providers; facilitating transitions and community resource referrals; and delivering care that aligns with patient preferences.[10] It is helpful to understand these parallels given the significant role that providers play in supporting dually eligible beneficiaries in new integrated care management models.

## An Overview of Effective Integrated Program Design and Operation

INSIDE states have experience with a range of integration models (Exhibit 1). Six states — Illinois, Massachusetts, Ohio, Rhode Island, South Carolina, and Virginia — developed capitated Financial Alignment Initiative demonstrations. Minnesota has an alternative D-SNP based administrative alignment demonstration built on its capitated Minnesota Senior Health Options program.[11] Five states — Arizona, Massachusetts, New Jersey, Tennessee, and Virginia — have integrated D-SNP/MLTSS programs.[12] Additionally, there are Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) operating in three INSIDE states — Arizona, Massachusetts, and New Jersey.[13]

**Exhibit 1. Overview of INSIDE State Programs**

| State | Integration Model | Program Launch | Aligned Enrollment[a] | Target Population |
|---|---|---|---|---|
| Arizona | D-SNP | 2004 | 69,693[b] | All full benefit duals |
| Illinois | Capitated Financial Alignment Initiative (FAI) | March 2014 | 52,285 | Age ≥ 21 |
| Massachusetts | Capitated FAI and D-SNP | March 2004 (D-SNP) October 2013 (FAI) | 65,365[c] | Age ≥ 65 (D-SNP) and 21-64 (FAI) |
| Minnesota | D-SNP | 1997[d] | 40,499[e] | All full benefit duals |
| New Jersey | D-SNP | January 2012 | 26,142[f] | All full benefit duals |
| Ohio | Capitated FAI | May 2014 | 78,285 | Age ≥ 18 |
| Rhode Island | Capitated FAI | July 2016 | 14,451 | Age ≥ 21 |
| South Carolina | Capitated FAI | February 2015 | 5,241 | Age ≥ 65 |
| Tennessee | D-SNP | January 2013 | 38,718 | All full benefit duals |
| Virginia[g] | Capitated FAI transitioned to D-SNP | April 2014 (FAI) August 2017 (D-SNP) | 23,763 (FAI) | Age ≥ 21 |

[a] FAI enrollment is as of November 2017. Time points for D-SNP enrollment vary by state, but all are as of Fall 2017.

[b] Arizona's aligned enrollment of 69,693 includes 9,874 FIDE SNP enrollees, 53,829 aligned D-SNP/MLTSS enrollees, and 990 Mercy Maricopa Integrated Care enrollees.

[c] Massachusetts' aligned enrollment of 65,446 includes 18,513 Financial Alignment Initiative demonstration enrollees and 46,852 Senior Care Options FIDE SNP enrollees.

[d] Minnesota's program launch date corresponds to the start of its Minnesota Senior Health Options program in 1997 under a past Medicare-Medicaid alignment waiver that later transitioned to a D-SNP-based program in 2004.

[e] Minnesota's aligned enrollment of 40,499 includes 38,370 Minnesota Senior Health Options enrollees and 2,129 Special Needs Basic Care enrollees.

[f] All of New Jersey's aligned enrollment is in FIDE SNPs.

[g] Virginia began a transition from a capitated Financial Alignment Initiative demonstration to an aligned D-SNP/MLTSS program on August 1, 2017 that will be fully implemented statewide by January 1, 2018.

The following section outlines the five features (Exhibit 2) that rose to the surface across these 10 states, regardless of their program model, as key to the effective design and operation of integrated care programs.

**Exhibit 2. Overview of Key Features of Integrated Program Design and Operation**

| Key Feature | Examples |
|---|---|
| **1. Strong Partnerships and Stakeholder Involvement**<br>The program's design, and ultimately success, is linked to broad stakeholder engagement, which helps states and health plan partners develop and meet program goals while proactively addressing beneficiary and provider needs. | ■ Stakeholder priorities are considered in program design<br>■ Broad stakeholder engagement adds value — including beneficiaries, advocates, federal agencies, state executive and legislative branches, partner agencies, providers, and health plans |
| **2. Transparency and Responsiveness**<br>After launch, the program continues to inform and engage beneficiaries, providers, and other key stakeholders to solicit feedback and demonstrate transparency and responsiveness. | ■ Sustained beneficiary engagement and outreach and targeted strategies to obtain provider "buy-in"<br>■ Sharing of program experience and progress |
| **3. Comprehensive Care Delivery**<br>The program has a comprehensive, but flexible, care management model that coordinates all services while advancing person-centered preferences, encouraging provider involvement, and addressing beneficiaries' unique needs. | ■ Flexible care management program<br>■ Beneficiary-centered and inclusive of providers<br>■ Includes a broad range of services, including physical health, behavioral health, long term services and supports, and social determinants of health |
| **4. Integrated Financing, Risk-Adjustment and Rate Sufficiency**<br>The program has integrated financing that creates incentives for states and health plans to improve care, accounts for the complexity of the population being served, and considers initial investments and unmet beneficiary needs. | ■ Financing aligns incentives to meet program goals<br>■ Risk adjustment addresses complexity and considers investments and unmet needs<br>■ Startup costs are anticipated and provider incentives are built in |
| **5. Sufficient Resources for Oversight and Monitoring**<br>The program has the necessary resources and tools to oversee health plans, monitor program outcomes, and refine program approaches. | ■ Capacity-building investments are made<br>■ Tied to measurable goals and responsive evaluation design |

## 1. Strong Partnerships and Stakeholder Involvement

***The program's design, and ultimately success, is linked to broad stakeholder engagement which helps states and health plan partners develop and meet program goals while proactively addressing beneficiary and provider needs.***

States note that developing strong partnerships early on with a broad group of both internal and external stakeholders was critical to inform program design and early implementation activities. Partnerships between states and health plans, and between federal partners and these parties were essential to INSIDE states developing and overseeing integrated models of care, whether Financial Alignment Initiative demonstrations or D-SNP-based programs. Under the Financial Alignment Initiative, states worked with federal partners to identify and resolve Medicare and Medicaid misalignments, improve administrative coordination, and encourage information sharing. INSIDE states specifically identified active partnership with MMCO as important to the success of their new integrated care models. A number of INSIDE states noted that MMCO support helped to facilitate rapid, joint problem solving across states, federal officials, and plans. INSIDE states see value in continuing and expanding the role of MMCO given the complexity of developing and overseeing integrated programs.

States also found that strong support was needed from their executive and legislative branches, as well as from beneficiary advocates and provider leaders to help make the case and maintain support for integrated care, particularly as stakeholders wait for program results to emerge. INSIDE states found they needed buy-in from state Medicaid leadership and partner-agencies including the aging, disability, and behavioral health authorities that manage the provision of specialized Medicaid benefits including HCBS waivers. Some INSIDE states sought upfront flexibility to restructure agencies or key Medicaid resources to support new program launches, and all prioritized open communication with internal and external agency partners to make these efforts successful.

***States found that strong support was needed from their executive and legislative branches, as well as from beneficiary advocates and provider leaders to help make the case and maintain support for integrated care, particularly as stakeholders wait for program results.***

Robust engagement of a broad group of stakeholders (e.g., beneficiaries, family members, providers, advocacy organizations, state agencies, health plans) was important to gather early input on program design and ensure that program goals address both state and stakeholder priorities. This helped INSIDE states to better understand the specific needs of dually eligible beneficiaries, family caregivers, and the providers who serve them. A number of states developed workgroups to gather feedback on design elements such as: (a) the transition of home- and community-based services to managed care; and (b) benefit design for specific subpopulations including those with significant behavioral health needs. All INSIDE states — those with financial alignment demonstrations and those with aligned D-SNPs/MLTSS plans — use capitated managed care contracts with health plans as a mechanism to implement their programs. As a result, INSIDE states focused considerable time on fostering strong partnerships with their plans to achieve goals such as minimizing provider burden and ensuring enrollees' continuity of care.

Gathering stakeholder input helped INSIDE states to address underlying Medicare-Medicaid integration issues, particularly from the beneficiary and provider perspectives, including coordination of beneficiary assessments and integration of beneficiary and provider materials. States also report that aligning the goals of the integrated program with broader state initiatives during the design phase was important to identify potential synergies and avoid programmatic conflicts. States developing new programs should consider mapping the relationship of their integrated care program to broader efforts that aim to improve access and quality across Medicaid programs or populations. This may help states maximize limited resources, manage budgets and costs, and align their integrated care and LTSS system reforms with other efforts.

## 2. Transparency and Responsiveness

***After launch, the program continues to inform and engage beneficiaries, providers, and other key stakeholders to solicit feedback and demonstrate transparency and responsiveness.***

After the initial launch, INSIDE states noted the need for continued robust stakeholder engagement strategies to demonstrate program transparency and responsiveness and solicit valued beneficiary and provider feedback. States found it useful to provide updates regarding issues that arose during early implementation and to help ensure a smooth transition for beneficiaries by using stakeholder groups as feedback channels. Efforts to be transparent and responsive encouraged ongoing stakeholder support and helped resolve beneficiary and provider concerns.

***Formal feedback loops have supported states with short-term strategies for refining program requirements to meet program goals and stakeholder expectations, as well as longer-term strategies for demonstrating program success.***

Building on partnerships established early on, INSIDE states also solicited input from stakeholders to develop communication strategies. Some INSIDE states also relied on stakeholder workgroups or other rapid cycle feedback strategies to guide necessary program adjustments. For example, states used beneficiary focus groups, formal surveys, and telephone polling to gather data on early beneficiary experience. They used formal communications channels including workgroups, webinars, and implementation councils to review program feedback data and help address implementation issues. Established formal feedback loops like these have supported states with short-term strategies for refining program requirements to meet program goals and stakeholder expectations, as well as longer-term strategies for demonstrating program success.

INSIDE states also noted the need for targeted post-launch provider engagement strategies. A number of INSIDE states found that provider resistance was greater than they had anticipated. Providers, particularly primary care and LTSS providers, are often trusted sources of information for beneficiaries and influence beneficiary decisions about whether or not to enroll in an integrated care program. States should consider developing ongoing provider engagement strategies that include town halls, provider summits, direct outreach to provider associations, or other in-person and virtual events. These activities can be used to educate providers about the integrated care program and to

gather feedback. Provider feedback can help the state and health plan contractors as they strive to meet program objectives, and it can also uncover opportunities to minimize provider burden, which helps to build buy-in. Other channels to collect provider feedback include: formal surveys; key informant interviews as part of evaluation efforts; provider representation on advisory councils; and program data analytics (e.g., examining complaints and appeals data).

## 3. Comprehensive Care Delivery

***The program has a comprehensive and flexible care management model that coordinates all services while advancing person-centered preferences, encouraging provider involvement, and addressing beneficiaries' unique needs.***

Comprehensive care management and coordinated delivery of Medicare- and Medicaid-covered services to address the needs of all dual eligible populations — including older adults as well as those under 65 — is the cornerstone of an effective integrated care program. INSIDE states are testing comprehensive care management models, and each have their own unique designs, including variation in the level of benefit integration, provider involvement, and requirements for beneficiary engagement and interdisciplinary input.[14] Across INSIDE states, beneficiary needs and desires are at the center of the integrated care planning process. The providers that support each beneficiary are also critical to these models, and although there are important expectations regarding provider involvement, states and integrated health plans are eager to find ways to minimize provider burden related to data sharing and coordination of care.

INSIDE states worked with their stakeholder partners to design and refine their programs' care management models to ensure person-centeredness and promote provider buy-in — while simultaneously making flexibility at health plan or provider levels a hallmark of their approach. INSIDE states agree that care management models should fundamentally provide for care coordination and system navigation needs, but how care is coordinated and the structure of care planning teams and processes varies by state. In some instances this may vary at the beneficiary level when states give health plans the flexibility to adjust processes based on individual needs and preferences.

***States worked with their stakeholder partners to design and refine their programs' care management models to ensure person-centeredness and promote provider buy-in — while simultaneously making flexibility at health plan or provider levels a hallmark of their approach.***

The elements of care management models, identified by INSIDE states as key to meeting beneficiary needs, include: (1) addressing the full continuum of care needs including behavioral health and LTSS, as well as social determinants of health for high-need or vulnerable subpopulations; (2) designing interdisciplinary care teams that encourage beneficiary and provider participation; (3) ensuring that cultural preferences and access to care issues are addressed; (4) evaluating the model and adjusting as necessary in partnership with stakeholders; and (5) providing person-centered, hands-on navigation support to beneficiaries. This person-centered support requires considerable upfront investments by plans or providers for things like comprehensive assessment completion and data sharing capacity. These investments may impact initial cost savings, but they are essential from the perspective of INSIDE states.

## 4. Integrated Financing, Risk-Adjustment, and Rate Sufficiency

***The program has integrated financing that creates incentives for states and health plans to improve care, accounts for the complexity of the population being served, and considers initial investments and unmet beneficiary needs.***

Integrated care programs need to have the right incentives for the state, and for plans and providers to deliver coordinated, flexible, and potentially lower cost care to dually eligible beneficiaries. When one entity — typically an integrated health plan — is responsible for the provision and coordination of all Medicare and Medicaid benefits, it creates an incentive to deliver care in the right setting at the right time. These incentives can be built into overall program financing and health plan or provider payments. However, states developing integrated programs do not currently have influence over Medicare Advantage payment methodologies regardless of the integration model used.

That said, effectively integrating financing and aligning incentives depends on the extent to which both Medicare and Medicaid payment methodologies account for the complexity of the population being served and whether states and federal partners are able to jointly establish and refine capitated health plan payments. INSIDE states identified thoughtful approaches for risk adjustment, savings targets, and quality incentives, including value-based payment initiatives to incentivize provider performance, as important to both demonstration and D-SNP-based program rate setting. Some of their experiences demonstrate that existing risk adjustment models may not account fully for the complex care needs and higher acute care service utilization that is prevalent among the dually eligible population, although FIDE SNPs can qualify for a small frailty adjustment to rates depending on the acuity of their enrollees. Additionally under the Financial Alignment Initiative, states and federal partners have continued to develop separate Medicare and Medicaid payment methodologies thereby limiting state influence over how rate methodologies are designed and refined.

***Existing risk adjustment models may not account fully for the complex care needs and higher acute care service utilization that is prevalent among the dually eligible population.***

In developing financing models for new integrated programs, INSIDE states found a willingness to adjust benefit and payment structures was sometimes necessary to account for the needs of specific subpopulations that may not have been captured in past Medicare or Medicaid utilization data, including unaddressed behavioral health needs. Additionally, integrated program financing should allow for state and federal flexibility to account for potentially unmet needs that arise when individuals with unmanaged chronic or long-term care needs are assessed and begin to receive services. It is also important to account for the expenses associated with the administrative and infrastructure ramp up, capacity building, and care management requirements of integrated models.

Some INSIDE states had to work with integrated plans and federal partners to ensure that health plan payments aligned with state and federal expectations and supported health plan sustainability. Additionally, as programs mature, integrated payment models should be broadly developed to take a fully integrated approach to rate setting and assessing payment accuracy. To help with, this states would welcome increased transparency related to Medicare Advantage rate development including sharing health plan risk scores and payment information where relevant.

## 5. Sufficient Resources for Oversight and Monitoring

***The program has the necessary resources and tools to oversee health plans, monitor program quality and outcomes, and refine program approaches.***

INSIDE states and their federal and health plan partners developed comprehensive quality oversight and monitoring strategies requiring considerable investment by all parties. From the state perspective, resource needs included not just Medicaid and other state agency staffing, but extended to encompass information systems, technology, and contractor support. State staffing should be sufficient to address strategic planning, day-to-day oversight, and information sharing with internal and external stakeholders. In addition, developing Medicare expertise within the state Medicaid agency is essential for supporting both program design and ongoing monitoring and oversight of the program and health plans.

Early on, INSIDE states found that more time is often needed for early program monitoring than was built into work plans given the complexity of aligning the Medicare and Medicaid programs and benefits for the populations served. When preparing for enrollment, states found that having sufficient time for upfront readiness reviews, including troubleshooting with plans and information technology (IT) partners, and ramping up coordination between federal and state contractors and integrated care plans was critical to ensure new processes were working effectively.

***Developing Medicare expertise within the state Medicaid agency is essential for supporting both program design and ongoing monitoring and oversight of the program and health plans.***

From a quality monitoring perspective, INSIDE states focused not only on whether integrated health plans were meeting contract requirements, but also on how their contracted health plans were addressing the unique needs of their enrollees. Some INSIDE states with well-established integrated care programs found that shifting from a contract compliance to a program outcomes focus supported this goal and encouraged their plans to perform beyond contract expectations.

INSIDE states used early monitoring results and external feedback to make program refinements, including revamping beneficiary materials and adjusting both continuity of care and care management requirements.[15] In the next few years, formal federal evaluations will assess whether Financial Alignment Initiative demonstrations change enrollees' utilization patterns and health outcomes over time. However, several INSIDE states found ways to demonstrate program value and communicate results more quickly using other mechanisms. Strategies for communicating early program results have been particularly important for newly established integrated programs.[16]

## Factors Driving State Investment in Integrated Care

Regardless of the model used, it is clear from the efforts of INSIDE states and their partners that considerable investments are needed to launch and operate integrated care programs. INSIDE states identified several factors that influenced their initial decisions to invest in integrated care and their continued support of these programs. These factors may be driven more by activities at the state-level or at the federal-level and some have more influence over state investment decisions than others (Exhibit 3).

**Exhibit 3. Factors Influencing State Investment in Integrated Care Programs**

| Factor | Description |
|---|---|
| **State-Level Factors** | |
| **Capacity** | Staffing, Medicare expertise, IT resources, partners, and champions |
| **Environment** | History of managed care, appetite for leveraging D-SNP contracting authority, presence of D-SNPs willing to invest in integration, legislative mandates, other Medicaid-related initiatives, stakeholder support |
| **Rebalancing incentives** | Potential to better predict Medicaid LTSS spending and manage costs while rebalancing towards home- and community-based care |
| **Federal-Level Factors** | |
| **Flexibility** | Access to waivers for Medicare program requirements, flexibility in integrating or aligning Medicare and Medicaid administrative processes |
| **Permanency** | Permanency/extension of Financial Alignment Initiative demonstrations, permanent authorization for D-SNPs |
| **Sustainability** | Flexible payment policies and methodologies, enrollment mechanisms to grow or sustain enrollment, and the ability to seamlessly enroll new Medicare beneficiaries |
| **Financial incentives** | Ability to access shared savings and increase transparency in rate setting between the Medicare and Medicaid program when integration lowers costs overall |

### State-Level Factors

The preceding discussion of key features of effective integrated care programs hinted at the key state-level factors influencing investment in these efforts. These include capacity-related factors such as the adequacy of staffing resources, availability of Medicare expertise, IT and data analytic capacity, and the availability of champions and partners both within the Medicaid agency and other state agencies.

Another set of critical state-level factors relate to the state climate. For example, legislative carve-outs of specific benefits or directives to delay implementation of new programs can delay integration

efforts. Alternatively, broad state legislative mandates to reform the delivery of LTSS or to improve care for dually eligible populations can drive the development of growth in these programs.

One very telling climate-related factor is often the launch of an MLTSS program, which provides opportunities to further integration. The majority of Medicaid LTSS users in most states are dually eligible for Medicare, and establishing a managed approach to improving care for those LTSS users that are also eligible for Medicare is an important state policy decision. While challenging and resource-intensive, it can serve as a major step forward toward ultimately integrating Medicare and Medicaid services.

A final state-level factor is the presence of rebalancing incentives. States that have invested in MLTSS can positively impact the rebalancing of their LTSS systems by having an integrated health plan focus on increasing access to Medicaid-covered HCBS and diverting individuals from nursing facility placement. Depending on a state's progress towards rebalancing, it may find the potential for further rebalancing to be a strong influence in deciding whether to develop an integrated program. However, to encourage more states to invest in integrated care, any reductions in beneficiary reliance on Medicare-covered acute care services that result from increased access to HCBS needs to benefit both states and federal partners.

## Federal-Level Factors

A number of federal-level factors may also influence states' decisions to invest in integrated care programs. As INSIDE states look to enhance or maintain their integrated programs, they are eager to have greater flexibility to align Medicare and Medicaid processes, requirements, and oversight for new integration models. While the Financial Alignment Initiative has allowed demonstration states to access Medicare flexibilities and to develop aligned administrative and joint oversight mechanisms, non-demonstration states have generally not had these same opportunities. For example, under the Financial Alignment Initiative beneficiaries routinely receive one set of beneficiary notices and materials that integrate Medicare and Medicaid information. While there are opportunities for D-SNPs to use some integrated materials, D-SNPs generally still provide two sets of unintegrated materials to beneficiaries. INSIDE states note that achieving parity across alignment models and greater state flexibility overall are important steps to advance integrated care more broadly.

Similarly, states are appreciative of ongoing opportunities to provide comments on Medicare Advantage rules and regulations as well as on policies that could impact integration efforts. They would even like to accelerate discussions with federal partners about how to leverage state tools and approaches to care delivery, rate setting, and oversight. Regardless of the model used, integrated programs benefit from a joint oversight structure that gives the state, the federal government, and health plan partners each a "seat at the table" to address challenges as they arise.

Other federal-level factors include the permanency and sustainability of integration models. Neither the financial alignment demonstrations, nor D-SNPs have been permanently authorized. Some demonstrations have been extended through 2020, but, without rulemaking for permanence, states and plans face an uncertain future. The lack of permanency and predictability of available integration

models may influence states' and integrated health plans' willingness to either continue existing programs or launch new programs.

Efforts to ensure sustainability should also include pathways to identify effective beneficiary enrollment and retention strategies. For example, two INSIDE states — Arizona and Tennessee — use seamless conversion to enroll newly eligible Medicare beneficiaries, whether older adults or individuals with disabilities, into D-SNPs. Additional INSIDE states would like to have this option available as well, because it would increase enrollment into the same plan and improve the value of their integrated care programs. Additionally, INSIDE states participating in the Financial Alignment Initiative used "intelligent assignment" to help preserve beneficiary relationships with providers, thereby improving retention rates for those recently enrolled in integrated care.[17]

The sustainability of integration models is an issue relevant to all INSIDE states, as is the development of more effective beneficiary enrollment and retention strategies. While the financial alignment demonstrations have included mechanisms for passive enrollment of beneficiaries into integrated plans, states invested in D-SNP-based programs are either using or have expressed interest in using the Medicare Advantage seamless conversion process discussed above to enroll newly dually eligible beneficiaries into D-SNPs.[18] While INSIDE states would like to have this option available for their integrated health plans, they are also interested in developing additional mechanisms to encourage the enrollment of dually eligible beneficiaries in more coordinated systems of care.

A final federal-level factor — perhaps with the greatest potential to spur new investments — is whether or not federally driven integration options provide financial incentives to states to share in the Medicare savings that may accrue from better coordinated care. Both states and health plans working to integrate care are eager to share Medicare savings that may be generated when Medicaid benefits like personal care are offered in lieu of more costly Medicare services. The ability to generate savings via an integrated model of care is being tested under the Financial Alignment Initiative, and the factors that influence whether a state demonstration program does or does not generate savings are still being evaluated. INSIDE states operating D-SNP-based models do not have the opportunity to share in savings with the federal government, but where they have placed their integrated health plans at full-risk for all Medicare and Medicaid benefits, they have created plan-level incentives to generate savings.

## Conclusion

States continue to be interested in advancing integrated care for their dually eligible populations. This is evidenced by the work of INSIDE states, the acceleration in development of MLTSS programs, the formation of stakeholder workgroups to better understand the needs of dually eligible populations, and a growing interest among states in expanding Medicare knowledge. The five key features of effective integrated care programs outlined in this brief can inform national- and state-level policy discussions on advancing integrated care:

1. Strong partnerships and stakeholder involvement;
2. Transparency and responsiveness;
3. Comprehensive care delivery;
4. Integrated financing, risk-adjustment and rate sufficiency; and
5. Sufficient resources for oversight and monitoring.

For state policymakers, advocates, health plans, and providers, understanding these key features and the state and federal factors influencing further investment can serve as a guide to shape the design of future integration platforms and options to improve care for dually eligible beneficiaries.

## ENDNOTES

[1] Medicare-Medicaid Coordination Office. "Financial Alignment Initiative." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.

[2] The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, as amended by the Affordable Care Act of 2010, required all D-SNPs to have contracts with states by calendar year 2013, but provided explicitly that states are not required to contract with D-SNPs. More information is available at: Public Law 110-275, Section 164(c)(4) OR 42 CFR §422.107.

[3] Other integrated care models for dually eligible beneficiaries include the Program of All-Inclusive Care for the Elderly (PACE) and Medicaid Accountable Care Organizations (ACOs). PACE programs are provider-led models operating in 31 states. Medicaid ACOs to serve dually eligible populations are in their very early stages.

[4] N. Archibald and A. Kruse. "Snapshot of Integrated Care Models to Serve Dually Eligible Beneficiaries." Center for Health Care Strategies, December 2015. Available at: http://www.chcs.org/resource/snapshot-integrated-care-models-serve-dually-eligible-beneficiaries/.

[5] A. Ptaszek, A. Chepaitis, A. Greene, et al. "Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative." Center for Medicare and Medicaid Innovation, March 2017. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.

[6] E. Walsh, W. Anderson, A. Greene, et al. "Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees: Preliminary Findings from the Washington MFFS Demonstration." Centers for Medicare & Medicaid Services, January 2016. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf.

[7] RTI researchers found that Minnesota Senior Health Options enrollees, when compared to dually eligible beneficiaries in a Medicaid-only program, were 48 percent less likely to have a hospital stay, 13 percent more likely to receive HCBS, and six percent less likely to have an emergency department visit. See: W. Anderson, Z. Feng, and S. Long. "Minnesota Managed Care Longitudinal Data Analysis." U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation, March 2016. Available at: https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis.

[8] For more information on the INSIDE project, see: http://www.chcs.org/project/implementing-new-systems-of-integration-for-dual-eligibles-inside/.

[9] G. Anderson, J. Ballreich, S. Bleich, C. Boyd, E. DuGoff, B., Leff, and J. Wolff. "Attributes Common to Programs that Successfully Treat High-Need, High-Cost Individuals." *American Journal of Managed Care*, 2015, 21(11), e597-e600.

[10] D. McCarthy, J. Ryan, and S. Klein. "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis." The Commonwealth Fund, October 2015. Available at: http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/care-high-need-high-cost-patients.

[11] Minnesota's demonstration uses a long-standing D-SNP/MLTSS program to test new approaches to improving Medicare-Medicaid alignment and improving beneficiary experience. For details on Minnesota's demonstration 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-CoordinationOffice/FinancialAlignmentInitiative/Downloads/MN.

[12] Virginia began a transition from a capitated Financial Alignment Initiative demonstration to an aligned D-SNP/MLTSS program on August 1, 2017 that will be fully implemented statewide by January 1, 2018.

[13] FIDE SNPs are a special type of D-SNP in states that use D-SNP contracts to achieve a high degree of integration of Medicare and Medicaid services. N. Archibald and A. Kruse. "Snapshot of Integrated Care Models to Serve Dually Eligible Beneficiaries." Center for Health Care Strategies, December 2015. Available at: http://www.chcs.org/resource/snapshot-integrated-care-models-serve-dually-eligible-beneficiaries/.

[14] A. M. Philip and M. Herman Soper. "Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States." Center for Health Care Strategies, January 2016. Available at: https://www.chcs.org/resource/interdisciplinary-care-teams-for-medicare-medicaid-enrollees-considerations-for-states/.

[15] A. Philip, N. Archibald, and M. Soper. *State Insights on Refining Integrated Care for Dually Eligible Beneficiaries.* Center for Health Care Strategies, December 2016. Available at: https://www.chcs.org/resource/state-insights-refining-integrated-care-dually-eligible-beneficiaries/.

[16] A. Kruse and A. Spencer. "Communicating Early Results of Integrated Care Efforts for Dually Eligible Individuals: State Approaches." Center for Health Care Strategies, January 2016. Available at: https://www.chcs.org/resource/communicating-early-results-of-integrated-care-efforts-for-dually-eligible-individuals-state-approaches/.

[17] Intelligent assignment is the process by which individuals being passively enrolled in Financial Alignment Initiative demonstration are assigned to Medicare-Medicaid Plans based on past relationships with providers, including primary care providers, who are currently in the networks of those plans or based on other criteria as determined by the state and federal partners.

[18] In October 2016, following inquiries about how plans are using this mechanism and related beneficiary protections, CMS placed a temporary moratorium on new plan approvals for seamless conversion while it reviews current policies, although already-approved plans may continue. For more information see: CMS. *Seamless Enrollment of Individuals upon Initial Eligibility for Medicare*. (10-21-16 memo). Available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf.