

# IMPROVING CARE AND MANAGING COSTS FOR DUAL ELIGIBLES

HIGHLIGHTS FROM AN NGA ROUNDTABLE



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## EXECUTIVE SUMMARY

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Individuals who are eligible for both Medicare and Medicaid, commonly referred to as dual eligibles, have some of the most complex and costly health care needs of those served by both programs. Dual eligibles represent only 15 percent of Medicaid beneficiaries, but account for 32 percent of program spending. Contributing to the complexity and cost of caring for this population is the fact that they receive services through two distinct programs. Each program has its own set of benefits and employs unique approaches to administration and payment, which can contribute to fragmented care and misaligned incentives for payers and providers.

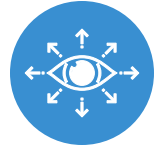
Finding approaches to more effectively and efficiently care for this population can help governors better serve some of their most vulnerable residents and better manage Medicaid costs, which are a significant share of state spending. To advance meaningful solutions, states must effectively partner with the federal government and other critical partners, such as health plans, providers and consumers. Lessons from existing state efforts can offer insights that support the spread and scale of best practices and help advance new and innovative strategies.

To support governors and facilitate cross-state learning, the National Governors Association Center for Best Practices Health Division (NGA Center) hosted a roundtable in December 2018 to discuss challenges and opportunities for states to improve care and manage costs for dual eligibles. The roundtable brought together state and federal officials, national experts, and industry and consumer perspectives. States in attendance included **Arizona, Connecticut, Maryland, Michigan, Minnesota, Montana, New York, Tennessee, Virginia, Washington** and **Wisconsin**.

Drawing on insights from the NGA Center roundtable, this publication provides the following considerations for governors and their staff to improve the quality and efficiency of programs that serve dual eligibles:

▶ **Set a vision and strategy.**

Governors and their senior leaders should establish a clear vision and strategy to improve care for dual eligibles, including establishing guiding principles, building capacity, engaging stakeholders and using data to inform goals and measure progress.



▶ **Learn from other states to identify effective approaches.**

Governors and their staff should review available options to improve care and manage costs for dual eligibles and learn from the experience of other states. Options for states to improve care for dual eligibles outlined in this paper include:

- Exploring federal demonstration opportunities.
- Leveraging managed care for improved alignment and coordination.
- Determining opportunities for provider-led approaches.



▶ **Identify opportunities for change at the federal level.**

Governors and their staff should identify and support actions at the federal level that could significantly advance state efforts to develop better and more sustainable systems of care for dual eligibles. Such actions may include allowing states to receive Medicare funds to fully integrate care, establishing robust shared savings arrangements and creating new financing opportunities.



## BACKGROUND

As governors work to improve the quality and efficiency of health care for their residents, addressing the needs of complex populations can generate significant value. More than 12 million people in the United States are eligible for both Medicare and Medicaid. Commonly referred to as dual eligibles, these individuals qualify for both programs based on some combination of age, financial and functional criteria.<sup>1</sup>

Dual eligibles often have significant health care needs and are among the costliest beneficiaries served by Medicare and Medicaid. In 2013, dual eligibles constituted 15 percent of Medicaid beneficiaries, but accounted for 32 percent of program spending.<sup>2</sup> Contributing to the complexity and high cost of caring for this population is the fact that their services are administered through two separate programs. Medicare and Medicaid each have unique benefits, payment structures, enrollment periods and other program components that can make it difficult to coordinate services and align incentives.<sup>3</sup>

Improving quality of care and reducing costs for dual eligibles are of paramount importance for states. As the nation's primary payer for long-term services and supports (LTSS), Medicaid — not Medicare — covers most of the critical services, such as home care, assisted living and caregiver supports, required by many people with disabilities and older adults. Further, with 10,000 adults turning 65 years of age every day and many people reaching retirement age with little or no savings, more older adults are at risk of “spending down” their assets to qualify for Medicaid when long-term care needs arise.<sup>6</sup> This phenomenon will not only place increasing pressure on states in providing LTSS but will also increase the number of dual eligible beneficiaries who must navigate between Medicare and Medicaid.

States, the federal government, health plans and other key partners have been working for many years to improve outcomes and better manage care for dual eligibles. While strides have been made, there is still opportunity for significant progress.

### The Dual-Eligible Population

Dual eligibles are individuals who are eligible for both Medicare and Medicaid. They fall into two primary eligibility categories: full benefit and partial benefit. Full-benefit dual eligibles qualify for the full array of services that both Medicare and Medicaid offer. Partial-benefit dual eligibles qualify only for Medicare services but receive financial support for Medicare premiums and other cost sharing from Medicaid. The following statistics highlight some of the key demographics of the dual-eligible population:

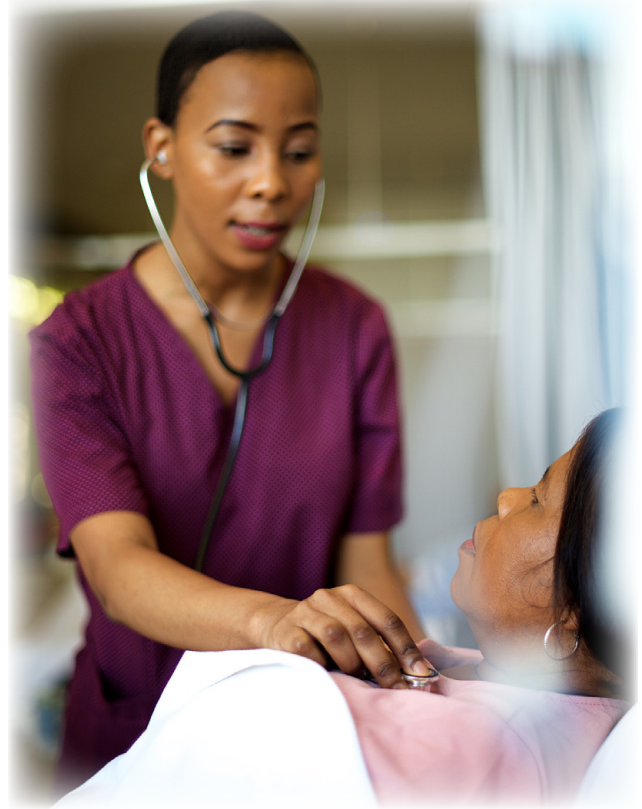
- 15 percent of Medicaid beneficiaries are dual eligibles and account for 33 percent of program spending.
- 20 percent of Medicare beneficiaries are dual eligibles and account for 34 percent of program spending.
- Dual eligibles account for more than \$300 billion in combined state and federal spending.
- 71 percent of dual eligibles qualify for full benefits, while 29 percent receive partial benefits.
- 38 percent of full-benefit dual eligibles have three to six activities of daily living limitations.
- 41 percent of dual eligibles have at least one mental health condition.
- 49 percent of dual eligibles require long-term services and supports.

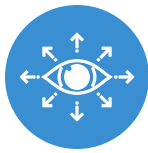
Sources: Centers for Medicare & Medicaid Services, 2019<sup>4</sup>; Medicare Payment Advisory Commission, 2018.<sup>5</sup>



Increased collaboration and learning across states can help scale and spread best practices and foster understanding of common challenges and pitfalls as states explore new approaches. There is also opportunity for new, bold ideas that reshape the way states and the federal government have traditionally served this unique population.

In response to interest from state leaders, the National Governors Association Center for Best Practices Health Division (NGA Center) hosted a roundtable in Washington, D.C., on Dec. 4 – 5, 2018, focused on strategies to advance care for dual eligibles. The meeting — Improving Care and Managing Costs for the Dual-Eligible Population — brought together state and federal officials as well as national experts from diverse organizations to discuss existing state solutions and bold new ideas states can consider in coordination with key partners. States participating in the roundtable included **Arizona, Connecticut, Maryland, Michigan, Minnesota, Montana, New York, Tennessee, Virginia, Washington** and **Wisconsin**.





## SETTING A VISION AND STRATEGY

Setting a vision and strategy is critical for state officials considering new or revamped efforts to better integrate care for dual eligibles. A clear vision that articulates the need for action and desired outcomes can help ensure that those involved in strategy development and implementation have a common understanding of the mission. Using data and bringing key stakeholders into the process early can help refine the vision and

identify achievable objectives. A detailed strategy that brings in key partners also helps identify and address foundational aspects such as staff capacity, financing and data.

Drawing on their own experiences and lessons learned, participants at the NGA Center roundtable discussed steps states should consider as they build their strategy to advance care for dual eligibles. Table 1 lists and describes those steps.

**TABLE 1: STEPS TO BUILD AN EFFECTIVE STRATEGY**

✓	<b>SET A VISION AND IDENTIFY CLEAR POLICY GOALS.</b> Before state officials can identify or implement strategies, they must establish a clear vision for the work and define initial goals and objectives. State officials should answer the questions, “Why are we doing this?” and “What do we hope to achieve?”
✓	<b>MAKE THE CASE AND GAIN BUY-IN FOR CHANGE.</b> Support from the governor, state legislators and other key state leaders is essential to advancing efforts and overcoming competing priorities. State officials should use data, beneficiary experience and other compelling information to communicate the urgency of the issue and gain buy-in among key leaders who can help prioritize the work.
✓	<b>DETERMINE STAFF CAPACITY AND FILL CRITICAL ROLES.</b> Effective implementation of integrated care programs requires significant staff time and expertise in critical areas such as data, Medicare expertise and health plan contracting. States should conduct a gap analysis early in the strategy development process to assess staff capacity and determine the need for additional resources.
✓	<b>IDENTIFY KEY STAKEHOLDERS AND BRING THEM TO THE TABLE.</b> Stakeholders should be involved in the strategy-development process early to inform the design, development and implementation of the state’s vision. States should be strategic in identifying when in the process certain stakeholders may need to be most engaged.
✓	<b>START ON COMMON GROUND BY ESTABLISHING CORE PRINCIPLES.</b> Establishing common principles, or values, to guide the strategy-development process can help set expectations and foster alignment among key stakeholders. Common principles can serve as a guidepost for strategy development and may help refocus the conversation when differences emerge.
✓	<b>LEARN AND BORROW FROM OTHER STATES.</b> State officials can learn from the successes and challenges of their peers when designing and implementing new policies and programs. States should identify and take advantage of resources and shared learning opportunities offered by the Centers for Medicare & Medicaid Services, the NGA Center and other organizations.
✓	<b>USE DATA TO INFORM STATE OBJECTIVES.</b> A data-informed approach to policy development can assist with program design and evaluation. States should review internal data sets to determine objectives and look to external sources (e.g., Medicare) to understand how various strategies or interventions may affect outcomes.
✓	<b>DEVELOP MEASURES TO REINFORCE GOALS AND TRACK PROGRESS.</b> Metrics are essential to determining whether state efforts are achieving desired outcomes. State officials should develop a robust set of metrics that are outcome-based and aligned with the state’s goals and principles. State officials may want to consider including clinical outcome metrics in addition to metrics related to important social factors and beneficiary satisfaction.
✓	<b>ESTABLISH ROBUST PROCESSES FOR DATA COLLECTION AND ANALYSIS.</b> Robust monitoring and evaluation are key to demonstrating success and identifying challenges or missteps that must be addressed. State officials should have a strategy in place to ensure that systems can adequately capture and analyze data regularly, support ongoing oversight and assess whether the state is meeting its goals.



## LEARNING FROM OTHER STATES TO IDENTIFY EFFECTIVE APPROACHES

Understanding approaches other states have taken and lessons learned from those experiences can help governors and their staff identify the strategies that make sense for their state. The following sections review several options available to states and states' recent experiences implementing these strategies in coordination with key partners, including health plans, providers and the Centers for Medicare & Medicaid Services (CMS).

### Exploring Federal Demonstration Opportunities: The Financial Alignment Initiative

One of the most notable efforts to advance integration and coordination of care for dual eligibles in recent years is the Financial Alignment Initiative (FAI). Authorized by the Affordable Care Act and launched by CMS in 2011, the FAI gave states the opportunity to apply for waiver authority to pursue innovative financing and integration approaches for their dual-eligible populations in coordination with the federal government. States could pursue either a fully capitated or managed fee-for-service (FFS) demonstration model. One state, Minnesota, was granted approval to take an alternative approach focused on administrative alignment. Under the fully capitated model, the state enters into a three-way contract with CMS and health plans to form what are referred to as Medicare-Medicaid Plans (MMPs). Under the managed FFS demonstration, a state and CMS enter into an agreement that allows the state to share in any savings that accrue to Medicare as a result of improved quality and lower costs. Notably, the managed FFS and capitated models have different parameters by which a state may share in some percentage of Medicare savings. Ultimately, 37 states submitted letters of intent to apply for the FAI and 13 states were approved for participation.

Evaluation is an important component of the FAI demonstrations. CMS contracted with RTI International (RTI) to evaluate the demonstrations and numerous states have conducted their own analyses. Initial evaluations of the demonstrations

suggest positive outcomes, including increased quality, high enrollee satisfaction and reduced costs. As data illustrate, however, not all states experienced progress in all areas. At the NGA Center roundtable, RTI provided an overview of evaluations that had recently been completed, including initial evaluations of demonstrations in **California, Illinois and Ohio** and secondary reports for **Minnesota and Washington**.

Findings from initial evaluations, as presented by RTI at the NGA Center roundtable, show that care coordination has been a critical component of the FAI demonstrations. As of April 2018, capitated FAI states collectively hired more than 4,600 care coordinators to support the objectives of their demonstrations. Care coordination approaches differed across the FAI states in terms of the type and level of caseload care coordinators and how they engage with clinical and support staff. Coordination between medical and behavioral health services is one aspect of care coordination that is critical to effectively serving the dual-eligible population, though it remains a challenge for some states.



Initial evaluations show varied results across states on key quality indicators, such as emergency department use, skilled nursing facility admissions, thirty-day all-cause readmissions and beneficiary satisfaction. Additionally, these initial evaluations showed variation in terms of savings to Medicare. Washington's managed fee-for-service model is estimated to have saved Medicare \$107 million over the first three years of the demonstration. Illinois and Ohio's capitated demonstrations showed significant reductions in Medicare spending for at least one demonstration period.

Evaluation findings also indicate that beneficiary enrollment has been a challenge for several FAI states. They have had a range of success enrolling eligible beneficiaries, from as low as 4 percent enrollment in one state to nearly 70 percent in another.<sup>7</sup> Across the demonstrations, roughly 29 percent of eligible individuals were enrolled in integrated Medicare-Medicaid plans in 2017. Enrollment has been lower than anticipated in many states, but average enrollment has been stable in the demonstrations since 2015, signaling that states

have at least been able to maintain enrollment levels over time.<sup>8</sup> Additional evaluations and data collected over time will provide greater insight into state demonstrations and potential opportunities and challenges for other states looking to improve alignment and quality of care for dual eligibles.

Since the NGA Center roundtable, new evaluations have been released, including initial evaluations for **Michigan, New York, South Carolina and Texas** and additional evaluations for **Colorado, Massachusetts and Washington**.<sup>9</sup>

Participants at the NGA Center's roundtable noted that although the FAI demonstrations were a good first step, states are seeking longer-term, sustainable solutions and, in some cases, are suffering from demonstration fatigue. In addition, some participants felt that efforts should be designed to benefit more states, including those with significant rural areas or more limited capacity. Participants noted that adjusting demonstration financing models so that more states have the opportunity to share in savings that accrue to Medicare would be

### Spotlight on Washington: Managed Fee-for-Service Financial Alignment Initiative



Washington has operated its Financial Alignment Initiative (FAI) demonstration since 2013. The demonstration uses a managed fee-for-service model in conjunction with Medicaid health homes to better integrate and coordinate care for dual eligibles. Washington used Section 2703 of the Affordable Care Act health home authority for its demonstration, which enabled the state to receive an enhanced federal medical assistance percentage (90 percent) for health home services during the first eight quarters of operation. The demonstration also includes a shared savings arrangement with Medicare.

The demonstration targets high-risk dual eligibles based on expected future costs. Enrollees receive intensive care coordination, including standardized screenings, patient activation measurement and person-centered health goals. Under the model, Washington contracts with lead entities, such as managed care organizations and qualified community-based organizations, such as area agencies on aging, that develop and manage the health home delivery model, including managing networks, making payments, overseeing quality and collecting and analyzing data. Those entities also contract with organizations, such as community health centers, to provide services and coordinate care.

Data integration for care coordinators has also been a core component of the state's efforts and essential to its success. In particular, the integration of Medicaid and Medicare claims and encounter data has helped the state better coordinate services across the two programs. An evaluation found that Washington's FAI demonstration has resulted in \$107.1 million in savings to Medicare — savings that are shared between Washington and the Centers for Medicare & Medicaid Services. Data on savings to Medicaid were not available as of February 2020.



an important improvement to ongoing efforts and sustainability. Sustainable financing mechanisms for care coordination were also cited as important elements going forward.

Since the NGA Center roundtable, CMS has issued guidance on opportunities for states to better integrate care for dual eligibles and build on lessons learned from the FAI. In December 2018, CMS sent a letter to state Medicaid directors describing 10 existing opportunities for states to enhance coordination of care for dual eligibles.<sup>10</sup> Opportunities include integrating through dual eligible special needs plans (D-SNPs), obtaining and using Medicare data and pursuing the Program of All-Inclusive Care for the Elderly (PACE). In April 2019, CMS announced new opportunities for states to test models of integrated care. As outlined by CMS, states currently participating in the FAI may be able to extend their demonstrations, and new states can apply to test the capitated; managed fee-for-service; or new, state-specific integration models.<sup>11</sup> These opportunities signal ongoing commitment from CMS to improve care for dual eligibles in partnership with states.

### Leveraging Managed Care for Improved Alignment and Coordination

Recently, states have increasingly pursued integration of care for dual eligibles through Medicaid managed care organizations (MCOs) and Medicare Advantage (MA) D-SNPs. D-SNPs are specialized MA plans that enroll only dual eligibles and are required to contract with the state to operate. Because the number of states with managed LTSS (MLTSS) programs has increased in recent years, new opportunities have emerged to coordinate with D-SNPs and use managed care as a vehicle for integration. States have generally done this by requiring that Medicaid MCOs offer a companion D-SNP and by encouraging beneficiary enrollment in companion plans so that one health insurer is responsible for providing both Medicare and Medicaid services.

Two examples of states that have effectively used managed care as a lever for integration are **Arizona** and **Tennessee**. Both states require



that Medicaid MCOs have a companion D-SNP and regularly update contracts with D-SNPs to support integration objectives. The states have also implemented processes to help increase enrollment in integrated plans. Participants at the NGA Center's roundtable distinctly noted the importance of encouraging beneficiary enrollment in integrated products. Both Arizona and Tennessee implemented CMS-approved default enrollment processes, which automatically enroll Medicaid MCO members in an aligned D-SNP when they qualify for Medicare.<sup>12</sup> Through this process, in the first two years Arizona successfully enrolled 7,000 new dual-eligible individuals in D-SNPs affiliated with companion Medicaid MCOs and Tennessee saw a 66 percent increase in D-SNP enrollment and a 77 percent increase in enrollment in aligned plans over four years.<sup>13</sup> In addition, to actively support implementation of default enrollment, both states prospectively obtain Medicare enrollment dates from CMS and share that information with Medicaid MCOs. This allows for advance identification of prospective dual eligibles and a more seamless transition when beneficiaries become eligible for Medicare.

Participants at the NGA Center's roundtable discussed several factors that are important for states seeking to improve integration through

managed care. Participants mentioned the importance of effectively using Medicare Improvements for Patients and Providers Act (MIPPA) contracts to improve coordination between Medicare and Medicaid. States such as Minnesota have used their MIPPA contracts to integrate grievances and appeals, enrollee materials and enrollment forms and to streamline and simplify processes for consumers. States can also require D-SNPs to report encounters to the state through their MIPPA contracts, a process that supports coordination of care.

### **Bipartisan Budget Act of 2018**

**Recent changes at the federal level support state efforts to enhance alignment and integration through managed care. The Bipartisan Budget Act of 2018 (BBA 2018) expanded Medicare Advantage (MA) plans' authority to provide supplemental services, such as home delivered meals, transportation and certain personal care benefits, to Medicare beneficiaries who have complex needs. MA plans can target these benefits to specific individuals rather than having to make them available to all beneficiaries. The BBA 2018 also permanently authorized all MA special needs plans (SNPs), including dual eligible SNPs (D-SNPs), institutional SNPs and chronic-condition SNPs, and created new requirements for aligning grievance and appeals processes and other integration standards for D-SNPs.<sup>14</sup>**

Participants also discussed how a lack of such contracts for other MA plans can present challenges for integration efforts. Several states have seen a rise in what are called “D-SNP lookalikes,” or traditional MA plans that market themselves to dual eligibles. Because they are not technically D-SNPs, these plans are not required to hold MIPPA contracts with the state and therefore are not held to the same integration standards. States have expressed concern that such plans are deterring beneficiaries from enrolling in integrated plans tailored to meet their needs. States have also seen an increase in the number of institutional SNPs (I-SNPs), which serve

individuals who meet an institutional level of care and most commonly reside in facilities. I-SNPs are an important addition to some markets, but they are not required to contract with states, which limits accountability and may deter certain beneficiaries from integrated options. CMS is currently looking into the issue of lookalike plans and the implications for beneficiaries.<sup>15,16</sup>

In addition to effective contract management, participants felt that it was critical that states take steps to build internal capacity and staff expertise related to Medicare. Improving coordination across programs requires knowledge of Medicare's benefits, administrative processes and other program components. State attendees noted the importance of having at least one person on staff or under contract who has deep knowledge of the Medicare program.

Finally, participants discussed the challenge of managing multiple health plans. The more plans that hold contracts with the state, the less time states have to work with each plan and conduct effective oversight. In addition, states face issues with plan procurement, which can be disruptive to a state's integration efforts. If a plan — either a Medicaid MCO or Medicare D-SNP — that has been part of an integrated arrangement decides not to rebid, a state may need to do significant work to rebuild integration efforts with new plans. Some states have mitigated this issue by extending the duration of their contracts to help increase stability in the market.

### **Determining Opportunities for Provider-Led Approaches**

In addition to the FAI and managed care, states have pursued better coordination and integration of care for dual eligibles through provider-led initiatives such as PACE, accountable care organizations (ACOs) and health homes.

PACE, which began in the 1970s, was one of the first programs aimed at improving care coordination for dual eligibles, who currently represent 90 percent of PACE enrollees.<sup>17</sup> Currently, PACE programs exist in 31 states, but enrollment has been limited, with only 45,000 enrollees across the country in 2018.<sup>18</sup> The PACE program has demonstrated encouraging



outcomes, including high participant satisfaction, but attendees at the NGA Center's roundtable highlighted challenges with program oversight and more widespread uptake.

Although PACE is a fully capitated program, it operates under different federal rules than Medicaid managed care, making it difficult for managed care states to align oversight across programs. Some participants noted insufficient levers for states to monitor and ensure accountability among PACE programs. Lack of data and limited transparency in some states have made it difficult to set appropriate payment rates and conduct proper oversight. For example, some participants noted concerns about select PACE programs focusing enrollment efforts on healthier individuals, leaving a sicker and costlier population to be managed outside these arrangements.<sup>19</sup> This experience, however, is not uniform across states and may depend on contractual terms and the strength of relationships within a given state. Participants also discussed the limited number of beneficiaries PACE currently serves and whether the model could be effectively scaled. Participants cited some features

of the model, including eligibility requirements (individuals must be over 55 years of age) and its physical site-based approach, that may limit the number of participants.

ACOs are another model of coordination that states and providers have pursued in collaboration with CMS. ACOs are groups of providers that come together to provide more coordinated and higher-quality care to beneficiaries. ACOs have typically been established in commercial and Medicare markets, but some states are employing the model in Medicaid.<sup>20</sup> In 2017, CMS announced a new Medicare-Medicaid ACO model that focused on enhancing quality and lowering costs for dual eligibles, building on the Medicare Shared Savings Program.<sup>21</sup> Although innovative, only one state applied for participation in the model, and the initiative was subsequently terminated. Despite CMS withdrawing the model, participants at the NGA Center's roundtable noted that opportunity still exists for dual-eligible ACOs if they can overcome certain barriers, such as provider readiness. In the future, states may use ACOs to improve care for dual eligibles, however, thus far no state has implemented the model for this population.

Washington's managed FFS FAI demonstration is also an example of a successful provider-led model. As previously noted, the state has used health homes to facilitate coordinated care delivery and integration of services. Additional details on Washington's approach are available on page 6.





## IDENTIFYING OPPORTUNITIES FOR CHANGE AT THE FEDERAL LEVEL

In addition to discussing existing state challenges and opportunities, participants at the NGA Center roundtable contemplated a variety of bold ideas that could potentially spur significant improvements in care for dual eligibles. The opportunities discussed require action by Congress or the administration, such as legislative and regulatory changes or approvals. Specific opportunities discussed at the roundtable included: creating consistent accountability mechanisms for all types of SNP products (D-SNPs, I-SNPs, chronic-condition SNPs) to enhance state oversight; enhancing monitoring of MA plans and new “D-SNP lookalike” products; additional CMS actions to increase and sustain enrollment in integrated products; new ways to keep Medicare beneficiaries with functional limitations healthy for longer periods of time; and new, flexible opportunities that account for specific needs and limitations in rural and frontier areas.

The conversation also included discussion of concepts included in recommendations to Congress and the administration that governors released through NGA Government Relations in spring 2018.<sup>22</sup> The recommendations, outlined below, are

part of a broader set of ideas governors put forward to address health care costs.

As outlined in governors’ recommendations and highlighted during discussion at the NGA Center’s roundtable, providing an enhanced matching rate for state initiatives to integrate care for dual eligibles would help states sustain their programs. States could use the additional funds to reinvest in programs, expand geographic reach or serve more individuals.

Governors also recommended that new opportunities or models expanding integrated care should come with robust shared savings agreements, wherein a state can share in savings that accrue to the Medicare program. The ability for states to receive a significant share of Medicare savings is critical given that state investments in Medicaid services such as care coordination and LTSS often reduce acute care costs, which are typically funded by Medicare.

In addition, governors recommended that consideration be given to allowing states to receive Medicare funding to fully integrate financing and care for dual eligibles. Similar to the way CMS pays

### NGA 2019 Principles for Federal Action to Address Health Care Costs

On May 24, 2019, National Governors Association Government Relations released [2019 Principles for Federal Action to Address Health Care Costs](#), which outlines governors’ recommendations for Congress and the administration to improve value across the health system. Recommendations were provided across four key areas: protecting consumers from surprise medical bills, balancing pharmaceutical access and costs, improving care for dual eligibles and the aging population, and additional strategies to address value across the system.

Specific to dual eligibles, governors recommended that Congress and the administration offer states flexibility and support to provide more efficient and effective care by:

- Providing an enhanced Medicaid matching rate for state initiatives that integrate care for dual eligibles.
- Establishing new opportunities for states serving dual eligibles that include robust shared savings agreements, allowing states to receive Medicare funding to fully integrate financing and care and providing planning and capacity-building grants for new integration strategies.



D-SNPs to administer Medicare services, interested states could receive payment to manage Medicare benefits and enhance integration across programs. As participants at the NGA Center roundtable noted, this approach could help align financial incentives and shared savings across programs and serve as an important option for nonmanaged care states or those with limited managed care market penetration (often highly rural states).

Finally, governors called for new planning and capacity grants for state integration strategies to help jump-start the development of programs to better coordinate care for dual eligibles. Such grants could also assist states by offering new resources to enhance state capacity — whether through new staff capacity, data infrastructure or other investments. All these ideas highlight the importance of shared commitment between states and the federal government to advance care for the dual-eligible population.



## LOOKING FORWARD

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Despite significant efforts over the past few decades to improve care and outcomes for dual-eligible beneficiaries, only about 10 percent of this population are enrolled in arrangements that provide meaningful integration across Medicare and Medicaid.<sup>23</sup> Scaling and increasing enrollment in effective integrated models for the dual-eligible population are critical for governors seeking to improve the lives of older adults and individuals

with disabilities. Improving care for dual eligibles is also imperative to a governor's ability to manage costs in Medicaid, particularly with a growing aging population. As administrators of Medicaid and LTSS, states are distinctly positioned to lead efforts to improve care for dual eligibles and, in partnership with CMS and Congress, can drive best practices and bold new strategies that will significantly improve the quality and efficiency of care for this population.

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