REPORT

Dually Eligible: Coordinating Across Medicaid and Medicare

NATIONAL CONFERENCE OF STATE LEGISLATURES

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The more than 11 million Americans enrolled in both Medicaid and Medicare—referred to as dually eligible or “duals”—meet the criteria for each program, including age or disability status for both programs and income requirements for Medicaid.

Dually eligible beneficiaries also account for a disproportionate share of spending in both programs. This is often due to enrollees having multiple chronic conditions, disabilities and complex needs, including social support needs and functional limitations. For example, of all dual-eligible older adults, one-third are diagnosed with dementia—and 58% have some cognitive or mental impairment.

Medicaid is a federal-state partnership, with coverage and eligibility requirements varying by state, whereas Medicare is administered solely at the federal level. Typically, Medicare is the primary payer for acute care services (e.g., hospital or primary care). Medicaid covers Medicare premiums and cost-sharing and offers services that Medicare does not, such as long-term services and supports (LTSS). A large portion of dually eligible individuals need access to Medicaid LTSS provided in nursing facilities or community-based settings.

Medicare and Medicaid are governed by different statutes and regulations and were designed to operate as separate programs. The resulting lack of coordination between the programs can create barriers to access for dually eligible individuals, leading to poor health outcomes and unnecessary costs. For example, with Medicare being the primary payer for hospital stays and Medicaid covering LTSS, it can be challenging for beneficiaries to successfully transition from hospital stays back into their communities.

To improve health outcomes and increase cost effectiveness, the Centers for Medicare & Medicaid Services and states are using a variety of strategies to fully integrate financing and care coordination for dually eligible beneficiaries. This brief describes various integration models, with state examples, outlines current status of implementation and discusses opportunities for states to build on current models.
Integrating Payment and Delivery: State–Federal Initiatives

FINANCIAL ALIGNMENT INITIATIVE

The Financial Alignment Initiative (FAI) demonstration offered by CMS is one strategy states have used to improve outcomes for dually eligible beneficiaries. The FAI model seeks to test various financing alignment strategies for reducing unnecessary emergency room visits, hospitalizations and long-term stays in nursing facilities and post-acute care facilities with the overall goal of fully integrating services and funding streams. There are 11 states currently participating in the FAI demonstration using capitated managed care models, fee-for-service models or some combination.

Most Medicaid beneficiaries are enrolled in some type of managed care organization. States are increasingly using managed care models to better coordinate services for dually eligible beneficiaries. Nine of the 11 states currently participating in the FAI use capitated managed care models with participation of 38 health plans, referred to as Medicare-Medicaid Plans (MMPs). This capitated model provides a per member, per month reimbursement and includes a three-way contract between CMS, states and the MMPs, with funding provided by both Medicare and Medicaid.

STATE EXAMPLES

- **California**: Implemented in 2014, California’s FAI demonstration uses a capitated model of service delivery to provide comprehensive, coordinated care for dually eligible beneficiaries. The primary goal of the demonstration is to fully integrate three California Medicaid programs serving older adults and people with disabilities: the In-Home Supportive Services program, the Multipurpose Senior Services Program and the Community-Based Adult Services program. Another key goal is to improve coordination of medical care, LTSS and behavioral health services. The demonstration was authorized in 2012 with the passage of SB 1008.

  Initial CMS evaluation results indicated there were no significant increases or decreases in Medicare spending partially due to low levels of enrollment (Medicaid costs were not included in the analysis). A second CMS evaluation in 2021 found increased costs to Medicare, however the analysis may not fully account for all factors impacting Medicare costs, plus low enrollment numbers could also have limited potential savings and efficiencies.

  While cost savings were not realized in 2021, the evaluation identified improvements in care coordination, with an increased number of beneficiaries indicating there was coordination between their various providers. Other survey findings indicated beneficiaries with complex needs had more involvement with care coordinators, and those with fewer needs indicated receiving check-in calls or knew where to direct questions.

- **South Carolina**: South Carolina’s FAI demonstration goals are to fully integrate medical, behavioral health and LTSS and to develop a person-centered care model. A January 2022 CMS evaluation reported improved care coordination due to a majority of beneficiaries receiving sufficient information from their MMP, and their primary care providers being better informed of services provided by specialists. Additionally, a 2017 evaluation found that South Carolina was above the demonstration national average in providing comprehensive health assessments and developing individualized care plans.

  These improvements to care coordination likely played a role in decreasing the probability of inpatient hospitalizations and post-acute skilled nursing facility admissions while increasing monthly primary care visits. Evaluation results indicated increases in long-term nursing facility stays, due in part to challenges in accessing home- and community-based services. Cost analysis found increases in Medicaid spending and no indication of significant increases or decreases in Medicare spending.
DUAL ELIGIBLE SPECIAL NEEDS PLANS

Dual eligible special needs plans (D-SNPs) are specialized Medicare Advantage plans (a Medicare-approved plan offered by a private company) that integrate Medicare and Medicaid services and provide care coordination across the programs. D-SNPs are capitated managed care plans using many of the same integration strategies as the FAI MMPs. Many of the states not participating in FAI use D-SNPs to facilitate integration. Unlike FAI, D-SNPs are permanently authorized by federal statute, and some states, including Virginia, New York and California, have transitioned or plan to transition enrollees from FAI MMPs to D-SNPs.

States with Dual Eligible Special Needs Plans

As of February 2022, D-SNPs were operating in 45 states and the District of Columbia with about 3.8 million dually eligible enrollees. Other types of special needs plans include:

- **Fully integrated dual eligible special needs plan (FIDE SNP)**, which fully integrates care under a single managed care organization.
- **Highly integrated dual eligible special needs plan (HIDE SNP)**, which provides enhanced integration compared to typical D-SNPs.
- **D-SNPs affiliated with managed care organizations providing long-term services and supports (MLTSS plans).**

Experts suggest states can require D-SNPs to cover Medicare cost-sharing normally paid by the state and to require D-SNPs to submit service claim information to provide better alignment and simplify administration at the provider level. D-SNPs are required to submit encounter data separately for Medicare and Medicaid, which is currently a barrier to full financial alignment.

D-SNPs must also have a **model of care approved by the National Committee for Quality Assurance outlining the health plan’s approach to care coordination and delivery of services for dually eligible beneficiaries.** For care coordination standards, D-SNPs, like MMPs described above, must provide comprehensive health assessments and develop and implement a care plan with an interdisciplinary team. However, states must choose to enact separate requirements to integrate Medicaid and long-term services and supports, as the model of care requirements only apply to Medicare.
STATE EXAMPLES

- **Tennessee:** Since 2013, Tennessee has provided integrated services for dually eligible individuals through D-SNPs affiliated with MLTSS plans. Tennessee requires all Medicaid MLTSS plans to contract with D-SNPs. There is no similar requirement for D-SNPs, resulting in some D-SNPs not contracting with an MLTSS plan. When a dually eligible beneficiary is enrolled in two unaffiliated health plans, Tennessee requires data sharing and care coordination activities between the D-SNP and MLTSS plan. The health plans indicated developing data sharing systems was costly and complicated, but implementation led to improved care coordination.

CMS allows for auto-enrollment in Medicare Advantage plans in limited circumstances. Tennessee uses the auto-enrollment process to maintain enrollment levels with a low disenrollment rate to improve care coordination and support financial sustainability for D-SNPs and affiliated MLTSS plans.

- **Indiana:** The American Rescue Plan Act includes a federal funding opportunity for states to improve services and integration for dually eligible individuals. Indiana plans to leverage this opportunity to improve data sharing between the state and D-SNPs by incorporating reported D-SNP Medicare information into the state's data warehouse. Indiana is also planning to require D-SNPs to submit Medicare Consumer Assessment of Healthcare Providers and Systems data measuring patient experience to help improve quality of care.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

The Program of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to older adults. Dually eligible beneficiaries make up the majority of PACE participants. PACE includes dental and hospital care, social services, prescription drugs, transportation and other assistance. PACE organizations use interdisciplinary teams to provide person-centered planning and service delivery. The teams include primary care physicians, home care providers, nurses, dietitians and other professionals. There are currently PACE programs in 30 states serving over 50,000 individuals.

**States with Programs of All-Inclusive Care for the Elderly**

Source: Integrated Care Resource Center, March 2022
PACE uses a capitated reimbursement model with fully integrated financing and is provider-based rather than insurer-based, like MMPs and D-SNPs. PACE organizations provide fully integrated services offering all Medicare and Medicaid benefits, including LTSS. Evidence indicates outcomes from PACE have been largely positive, with good beneficiary satisfaction and reduction in institutional care, resulting in cost savings to both Medicare and Medicaid.

States looking to expand or implement PACE programs have a variety of strategies to consider. Establishing new PACE sites can take a considerable amount of time and resources, with most sites taking over a year to fully open. States can work with existing PACE sites to reduce the up-front costs and implementation time of expanding services into new areas.

States can also add benefits beyond federal requirements and target services to specific locations of the state. For example, Louisiana selected PACE organizations to improve services for individuals with serious mental illness, and Maryland chose organizations to specifically improve access in rural areas. Other recent state activity to support PACE programs includes Pennsylvania’s HB 754 (2019), which increased income eligibility levels for individuals participating in the prescription assistance program, and Colorado’s SB 22-203 (2022) to improve state-level oversight of PACE organizations.

Opportunities for States to Further Integration Efforts

State integration strategies to improve outcomes for dually eligible beneficiaries have shown some promising results as well as mixed outcomes indicating a need to further develop and enhance integration models.

Many of the cost and quality evaluations need more analysis and may not fully capture positive outcomes. To provide more information, states could consider quality measures related to health disparity information, including race and ethnicity data, to better understand disparities. Additionally, states could include quality-of-life outcomes or develop measures specific to certain populations or settings. For example, to better measure outcomes for individuals needing long-term services and supports, Ohio tracked efforts to serve more individuals in community-based settings rather than institutions. Through the FAI demonstration, Ohio was successful in shifting more individuals to community-based settings, and early results indicated Medicaid savings of approximately $30 million per year.

Challenges accessing community-based services, as noted above in South Carolina’s FAI demonstration, have led to difficulties in fully integrating services. State policymakers have options for increasing access to community-based services, which support personal choice and prove to be more cost-effective than institutional care. For example, policymakers can eliminate or raise enrollment limits in home and community-based services waivers and use models that fully integrate managed long-term care plans with D-SNPs.

Currently these integrated programs have fairly limited reach, with only 1 million dually eligible beneficiaries enrolled in integrated models. To increase or maintain enrollment in integrated programs, states can request D-SNPs to request approval from CMS to automatically enroll dually eligible beneficiaries. Using auto-enrollment, Tennessee has maintained enrollment levels, and Ohio enrolled 70% of dually eligible beneficiaries in an integrated model. States may also require MLTSS plans and other Medicaid managed care organizations to contract with D-SNPs to fully integrate and streamline enrollment.

Integrated models are not available in all areas of the country, limiting participation in these programs. Working with federal partners, states can choose to seek additional federal support to increase access to integrated services. For example, states could request that CMS modify regulations to allow states to share in D-SNP Medicare savings or modify PACE regulations to streamline applications for new and expanding PACE sites. States could also work with the federal government to develop grant opportunities for opening new PACE sites, funding additional staff for health plans and Medicaid agencies, or other administrative improvements.

Conclusion

To improve delivery of services and reduce unnecessary costs, state and the federal policymakers continue to prioritize the integration of Medicare and Medicaid services. The FAI demonstrations assisted some states in developing a foundation to fully integrate services and provided lessons for other states to consider in their integration efforts. Collaboration between states and federal partners can build on these foundations to continue progress toward a full integration of services for dually eligibility beneficiaries.
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