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Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update



WHITE PAPER

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Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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The Bipartisan Policy Center staff produced this white paper in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank Henry Claypool and Tim Westmoreland for their contributions to this white paper.

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Table of Contents

5 OVERVIEW

**7 BACKGROUND ON
DUAL-ELIGIBLE INDIVIDUALS**

**11 INTEGRATION OF MEDICARE AND MEDICAID
COVERAGE AND FINANCING**

18 CONCLUSION

Glossary of Terms

Activities of Daily Living (ADLs)

Assistant Secretary for Planning and Evaluation (ASPE)

Center for Medicare and Medicaid Innovation (CMMI)

Centers for Disease Control and Prevention (CDC)

Centers for Medicare and Medicaid Services (CMS)

Children's Health Insurance Program (CHIP)

Calendar Year (CY)

Dual-Eligible Special Needs Plan (D-SNP)

Fee-for-service (FFS)

Financial Alignment Initiative (FAI)

Fully-Integrated Dual-Eligible Special Needs Plan (FIDE-SNP)

Highly-Integrated Dual-Eligible Special Needs Plan (HIDE-SNP)

Long-Term Services and Supports (LTSS)

Managed Long-Term Services and Supports (MLTSS)

Medicaid and CHIP Payment and Access Commission (MACPAC)

Medicare Advantage (MA)

Medicare Payment and Advisory Commission (MedPAC)

Medicare-Medicaid Coordination Office (MMCO)

Medicare-Medicaid Plan (MMP)

Program of All-Inclusive Care for the Elderly (PACE)

U.S. Department of Health and Human Services (HHS)

Overview

The Bipartisan Policy Center is continuing its efforts to improve quality of care through the integration of Medicare and Medicaid services for individuals who are eligible for both programs.ⁱ These Medicare-Medicaid beneficiaries, commonly known as “dual-eligible individuals,” must navigate two separate programs with different benefits and eligibility requirements. For most individuals, this would be daunting, but for dual-eligible individuals and their families, who are often dealing with chronic conditions and functional limitations, these challenges can be overwhelming.

In August of 2019, BPC began work on policy recommendations to improve care for dual-eligible individuals. In recent months however, the COVID-19 outbreak has become an immediate threat to this vulnerable population. According to the Centers for Disease Control and Prevention (CDC), older adults, especially those above age 65, and individuals of any age with serious underlying medical conditions, such as lung disease, heart conditions, and those undergoing cancer treatment, are at a higher risk of experiencing severe cases of COVID-19.¹ Additionally, individuals living in nursing homes or long-term care facilities are at increased risk of exposure to the virus. Because many dual-eligible individuals fall into one or more of the CDC’s high-risk categories, we believe it is necessary to broaden the scope of the project to include recommendations to limit exposure to COVID-19 for this population. While not directly addressed in this white paper, we hope to include recommendations based on stakeholder feedback in our final report.

In recent years, policymakers have sought to better integrate Medicare and Medicaid services for the estimated 12.2 million dual-eligible individuals.^{ii 2} When done well, clinical health, behavioral health,

i Previous reports from the Bipartisan Policy Center that address dual-eligible individuals include: *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, September 2016. *A Policy Roadmap for Individuals with Complex Care Needs*, Jan 2018. *Next Steps in Chronic Care: Expanding Innovative Medicare Benefits*, Jul 2019.

ii For the purposes of this paper, when we use the term “integration” we are referring to alignment of Medicare and Medicaid program administrative requirements, financing, benefits, and care delivery. Integration may also mean that Medicare and Medicaid services are coordinated and are provided seamlessly to an eligible individual through a single point of contact.

social services, and LTSS are coordinated and provided seamlessly to an eligible individual. Integration efforts have included establishing the Medicare-Medicaid Coordination Office (MMCO) to coordinate programs within the Centers for Medicare & Medicaid Services (CMS), permanent authorization of Medicare Advantage plans designed to serve dual-eligible individuals, facilitating integration by states, and establishing demonstration programs. Many stakeholders, however, believe that more should be done to integrate care.

Integration for dual-eligible individuals is especially challenging, given the heterogeneity of the population and the unique and significant needs of the various sub-populations. Many have multiple chronic conditions and may need assistance with activities of daily living, or ADLs, such as bathing or dressing.³ They may have mental illnesses, cognitive impairments, physical limitations, or a combination of these conditions. While the majority are older Americans, 39% of dual-eligible individuals are under age 65,⁴ and less than 10% are enrolled in programs or care models that integrate Medicare and Medicaid services.⁵

This is the first of two white papers on the integration of care for dual-eligible individuals. The purpose of this paper is to provide necessary background on this population of low-income Medicare beneficiaries. The paper discusses important demographics, eligibility for Medicare and Medicaid, covered services under each program, and the implications of being enrolled in both programs. It also discusses different types of integration of Medicare and Medicaid services, and how state and federal policymakers have worked to make the programs function better for those who are enrolled, what has worked, and what has not. The second white paper provides options for consideration by state and federal policymakers, as well as stakeholders representing consumers, providers, and plans. BPC will issue final recommendations in the summer of 2020 and is seeking comments on the second paper.

Background on Dual-Eligible Individuals

To understand challenges associated with integrating care for dual-eligible individuals, it is helpful to review key characteristics of the population, the pathways to becoming a dual-eligible individual, how the programs are administered, and what services are covered by both programs. The following is designed to provide the necessary background on these issues.

Medicare Eligibility and Benefits

In 2018, approximately 85% of the nearly 60 million Medicare beneficiaries qualified for Medicare on the basis of age.⁶ The remaining 15% were eligible based on disability.⁷ For those with disabilities, Medicare eligibility is triggered for individuals who qualify for Social Security Disability Income payments for a permanent disability for at least 24 months.⁸ Individuals may also qualify for Medicare coverage based on a diagnosis of End-Stage Renal Disease.⁹ These individuals qualify for Medicare irrespective of their age, but make up only about one percent of the Medicare population.¹⁰

Medicare covers clinical health services such as inpatient hospitalization, professional office visits, outpatient surgical procedures, and in certain circumstances, home health care, skilled nursing facility care, rehabilitation services and other services. Medicare is divided into four parts, with different financing and cost-sharing requirements:¹¹

- Medicare Part A is financed through employer and employee payroll taxes and generally covers inpatient services and limited stays at skilled nursing facilities.¹²
- Medicare Part B – for which individuals pay a monthly premium that covers the majority of Part B costs – covers professional services furnished by physicians and other non-physician practitioners, hospital outpatient facility and ambulatory surgical center services, certain home health services, dialysis services, and clinical-laboratory services.¹³
- Medicare Part C is Medicare’s managed care program, known as Medicare Advantage, which covers services covered under Parts A, B, and may also cover Part D services, as outlined below.

- Medicare Part D covers prescription drugs and is offered through Medicare Advantage health plans or as a stand-alone plan for those who choose to remain in Medicare fee-for-service.¹⁴

Total Medicare spending for calendar year 2018 was \$741 billion for all beneficiaries.¹⁵ Net spending, when taking into account beneficiary premiums and cost-sharing, was \$605 billion in 2018.¹⁶

Medicaid Eligibility and Benefits

Medicaid is a joint federal-state program that provided health care coverage to an estimated 86.7 million low-income individuals in FY 2018.¹⁷ Medicaid serves low-income children and their parents, pregnant women, people with disabilities, and individuals age 65 and older.¹⁸ In the 37 states, including the District of Columbia, that have expanded Medicaid eligibility under the Affordable Care Act, other low-income adults with incomes up to 138% of the federal poverty level are also covered.¹⁹ Total Medicaid spending was \$621 billion in FY 2018 for all beneficiaries.²⁰

Medicare beneficiaries qualify for Medicaid if they have low incomes and are aged, blind, or have a disabling condition. For dual-eligible individuals who receive full benefits, the Medicaid program covers clinical health services that are not covered by Medicare, as well as non-clinical services, such as targeted case-management services and transportation to medical appointments. States must cover certain mandatory benefits under Medicaid, while other services are optional. Medicaid covers long-term services and supports (LTSS), which include services to address beneficiaries' deficits in ADLs in either an institutional setting for nursing facility residents or through personal-care services and other home and community-based services.²¹

Dual-Eligible Individuals

While most dual-eligible individuals are over age 65, there are 39% under age 65.²² About half of dual-eligible individuals first qualify for Medicare based on disability and about half qualify when they turn age 65.²³ The proportion of all individuals who qualify for Medicare based on disability and who are also eligible for Medicaid has grown from 44.3% in 2006 to 52.3% in 2018, according to the Medicare-Medicaid Coordination Office (MMCO) at the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services, or CMS.²⁴

Dual-eligible individuals tend to have poorer health and functional status than those eligible for Medicare only. According to the MMCO, 41% have at least one mental health diagnosis, 49% receive LTSS and 60% have multiple

chronic conditions.²⁵ The average dual-eligible individual receiving full Medicare and Medicaid benefits has six chronic conditions, while all other Medicare beneficiaries average only four.²⁶ Depression and Alzheimer's disease or related dementia were among the most prevalent conditions for full-benefit dual-eligible individuals.²⁷ As a result, those with multiple chronic conditions typically have higher utilization of services, such as emergency room visits, hospitalizations, and eventual need for LTSS. Accordingly, the HHS Office of the Assistant Secretary for Planning and Evaluation, or ASPE, has found that dual-eligible status was the most powerful predictor of poor Medicare outcomes among social risk factors.²⁸

Dual-eligible individuals are also more likely to have greater limitations in ADLs than non-dual eligible individuals.²⁹ In 2016, 26% of dual-eligible individuals had limitations in one to two ADLs, compared to 18% of non-dual eligible individuals and 28% had limitations in three to six ADLs, compared to 9% of non-dual-eligible individuals.³⁰ As a result, dual-eligible individuals are among the most medically complex individuals and often have wide-ranging health care needs that require additional services and supports.³¹

Eligibility and Benefits

While all dual-eligible individuals are eligible for Medicare, their Medicaid benefits vary based on income. Full-benefit dual-eligible individuals are entitled to the full-range of medically-necessary Medicare benefits, as well as medically-necessary benefits covered under the Medicaid state plan. In 2018, full-benefit individuals numbered 8.7 million, or 71% of total dual-eligible individuals.³² Partial-benefit individuals, typically with incomes at or slightly above the federal poverty level, are eligible for all Medicare-covered services, but their Medicaid benefits are limited to the assistance with Medicare premiums, deductibles, and copays through the Medicare Savings Program. They are not eligible for Medicaid-covered services.³³

Many low-income Medicare beneficiaries who qualify as partial-benefit dual-eligible individuals are not enrolled in the Medicare Savings Program.³⁴ The cost of Medicare premiums, deductibles and co-payments may create a barrier to accessing care. In 2018, there were 3.5 million partial-benefit dual-eligible individuals, or 29% of total dual-eligible individuals.³⁵ Between 2006 and 2018, the total number of full-benefit and partial-benefit dual-eligible individuals has grown on average each year by 2.9%.³⁶

For full-benefit dual-eligible beneficiaries, Medicare is the primary payer of acute care and clinical health services. Medicare covers clinical health services such as hospitalization, physician office visits, surgical procedures, and in certain circumstances, skilled home health care, skilled nursing

facility care, and rehabilitation services.³⁷ Medicaid is then responsible for covering Medicare premiums, cost-sharing, long-term care services and certain behavioral health services.

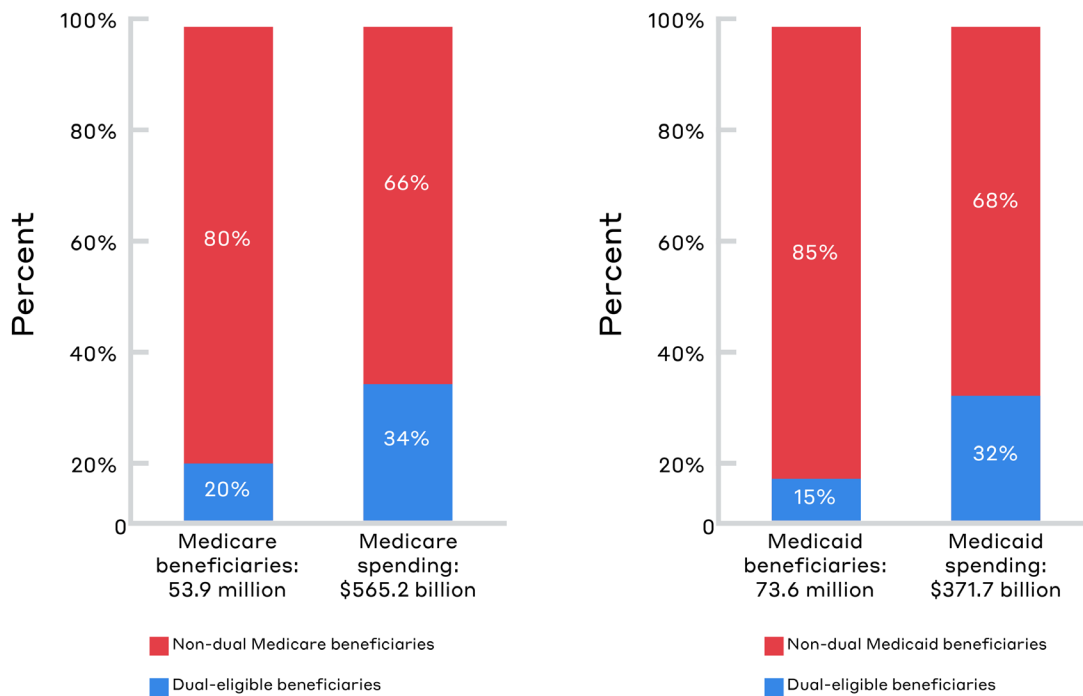
An ASPE report found that 67% of full-benefit dual-eligible individuals qualify for Medicare before also becoming eligible for Medicaid, and 27% qualify for Medicaid first.³⁸ Only about 5% of individuals become simultaneously eligible for both Medicare and Medicaid.³⁹ Of those who qualified for Medicare before Medicaid, 59% qualified for Medicare on the basis of age. For those who already had Medicare, 37% qualified for Medicaid because they met criteria established by the state based on income or another eligibility requirement. For example, states are permitted to provide Medicaid coverage to Medicare beneficiaries with incomes up to 300% of the SSI income limit. Another 22% qualified under Medicaid's Medically Needy spend-down.⁴⁰ Of those who follow the Medicaid-to-Medicare pathway to full-benefit dual-eligible status, 55% qualified for Medicare based on SSI eligibility, and 66% qualified based on disability.⁴¹

Spending

Given the severity of illness and disabilities, per-capita spending on dual-eligible individuals is more than three times higher than for Medicare-only beneficiaries.⁴² The average annual spending per dual-eligible individual in 2013 was approximately \$29,238.⁴³ The average annual spending for those covered only by Medicare came in significantly lower, at \$8,593 per person.⁴⁴

While dual-eligible individuals comprise 20% of the Medicare population, they account for 34% of total Medicare expenditures (see Figure 1).⁴⁵ Similarly, dual-eligible individuals comprise only 15% of the Medicaid population, but account for 32% of total Medicaid expenditures.⁴⁶ Dual-eligible individuals, including partial-benefit dual-eligible individuals, account for only 9.15% of those who have Medicare and/or Medicaid coverage, while their expenditures constitute 33.21% of total expenditures for both programs in 2012.⁴⁷ From 2012 to 2018, total expenditures for both programs have increased by 36%; the disproportionate cost of duals has likely increased accordingly but recent data is unavailable.⁴⁸

Figure 1: Dual-Eligible Beneficiaries as a Share of Medicare & Medicaid Enrollment and Spending, CY 2013



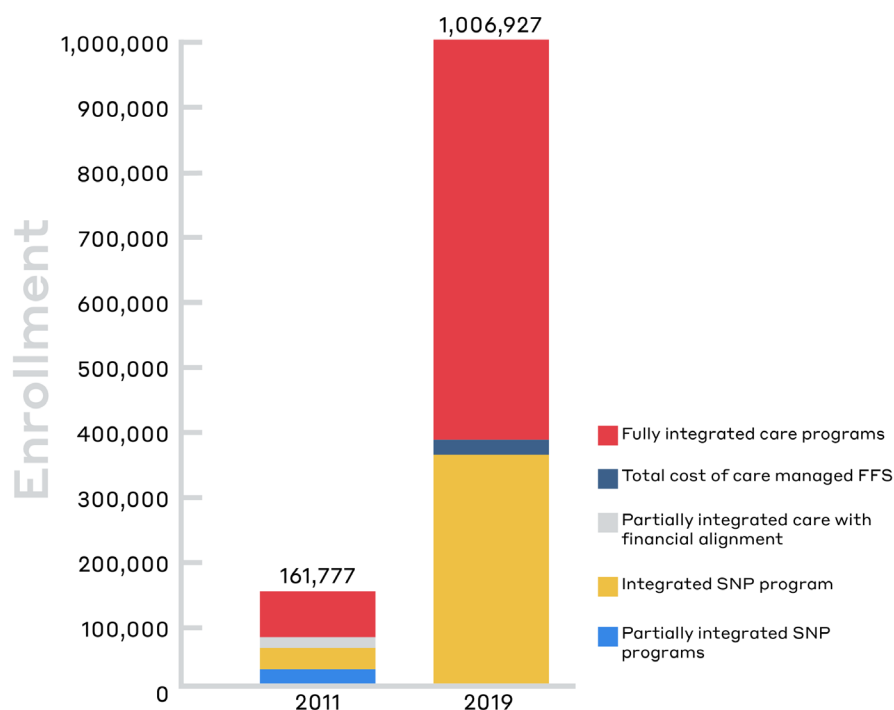
Source: MedPAC, MACPAC, Data book: *Beneficiaries dually eligible for Medicare Medicaid*. Jan 2018

Integration of Medicare and Medicaid Coverage and Financing

Despite the availability of models that integrate Medicare and Medicaid, many dual-eligible individuals are enrolled in separate Medicare and Medicaid managed care plans that do not provide integrated care or care coordination for all services. There are many approaches to integration that include some level of care coordination. Delivery and payment models range from Medicare Advantage D-SNPs that offer all Medicare and Medicaid-covered services, to advanced versions of D-SNPs that meet greater coordination requirements, to PACE. The Center for Medicare and Medicaid Innovation, or CMMI, and MMCO within CMS have also partnered to

allow states to test capitated and managed fee-for-service demonstration models under the FAI that feature a high level of integration. Some models in each category have excelled in providing high-quality integrated care, while others have fallen short, posing a threat to patient health and creating disruptions in long-term beneficiary-provider relationships. While the number of dual-eligible individuals in integrated programs has grown significantly between 2011 and 2019 (see Figure 2), a relatively small percentage, roughly 8.25% according to MMCO, are enrolled in integrated programs.⁴⁹

Figure 2: Total Integrated Care Enrollment by Program Type: 2011 and 2019



Source: Medicare-Medicaid Coordination Office, *FY 2019, Report to Congress*, p. 8ⁱⁱⁱ

iii From the report: [A]nalysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP, Fully Integrated Dual Eligible (FIDE) SNP, and PACE enrollment through July 2019. This category also includes the FIDE SNPs previously noted as “Legacy Medi-Medi Demo Programs” and categorized separately in previous reports. “Total Cost of Care Managed FFS” includes enrollment in the Washington Managed Fee-For-Service demonstration under the Medicare-Medicaid Financial Alignment Initiative. “Integrated SNP Program” enrollment includes programs in which a dually eligible individual receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans; several state programs were reclassified from partially integrated to integrated to align with the integration standards for D-SNPs finalized in the 2020 Medicare Advantage and Part D final rule. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration, for which no 2019 information is included because the initiative had ended. No state data was available in July 2019 for “Partially Integrated SNP Program” enrollment. The 2019 analysis newly includes data from existing integrated care options in Oregon, select D-SNPs in California, and FIDE-SNPs and certain types of D-SNPs in Florida.

In recent years, Congress and CMS have made efforts to advance the integration of Medicare and Medicaid services for dual-eligible individuals by actively encouraging states to adopt more fully integrated programs. There are three main approaches that states can take to integrate Medicare and Medicaid:

- Dual-eligible special needs plans (D-SNPs);
- Program of All-Inclusive Care for the Elderly (PACE); and
- The Financial Alignment Initiative (FAI), a demonstration that integrates coverage and financing.

Dual-Eligible Special Needs Plans

Congress permanently authorized D-SNPs through the Bipartisan Budget Act of 2018.⁵⁰ That law also established new integration standards for D-SNPs and unified Medicare and Medicaid grievance and appeals procedures for certain D-SNPs beginning in contract year 2021.⁵¹

CMS released regulations in April 2019 implementing the new D-SNP requirements.⁵² Under the regulations, D-SNPs must meet the integration criteria beginning CY 2021. Plans must: (1) be a fully integrated dual-eligible special needs plan, called FIDE-SNP, or a highly integrated dual-eligible special needs plan, called HIDE-SNP,^{iv} or (2) notify the state Medicaid agency, or its designee, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual-eligible individuals.⁵³ Beginning CY 2021 through CY 2025, CMS will impose the intermediate sanction of prohibiting new enrollment into a D-SNP if it determines the D-SNP does not meet the new integration standards.⁵⁴

iv The regulation, codified at 42 CFR § 422.2, defines a FIDE-SNP as a type of D-SNP: (1) that provides dual-eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the [SSA] with the applicable State; (2) whose capitated contract with the state Medicaid agency provides coverage, consistent with state policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) that coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) that employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement. The regulation, codified at 42 CFR § 422.2, defines a HIDE-SNP as a type of D-SNP offered by an MA organization that provides coverage, consistent with state policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements— (1) the capitated contract is between the MA organization the Medicaid agency; or (2) the capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.

D-SNPs must have a coordinated Medicare and Medicaid grievances and appeals process beginning CY 2020, while FIDE-SNPs and HIDE-SNPs with exclusively aligned enrollment must implement a unified Medicare and Medicaid grievances and appeals process beginning CY 2021.^{55, v} The unified grievances and appeals process will allow individuals to follow one resolution pathway at the plan level when filing a complaint or contesting an adverse coverage determination for Medicare non-Part D benefits and Medicaid services.⁵⁶

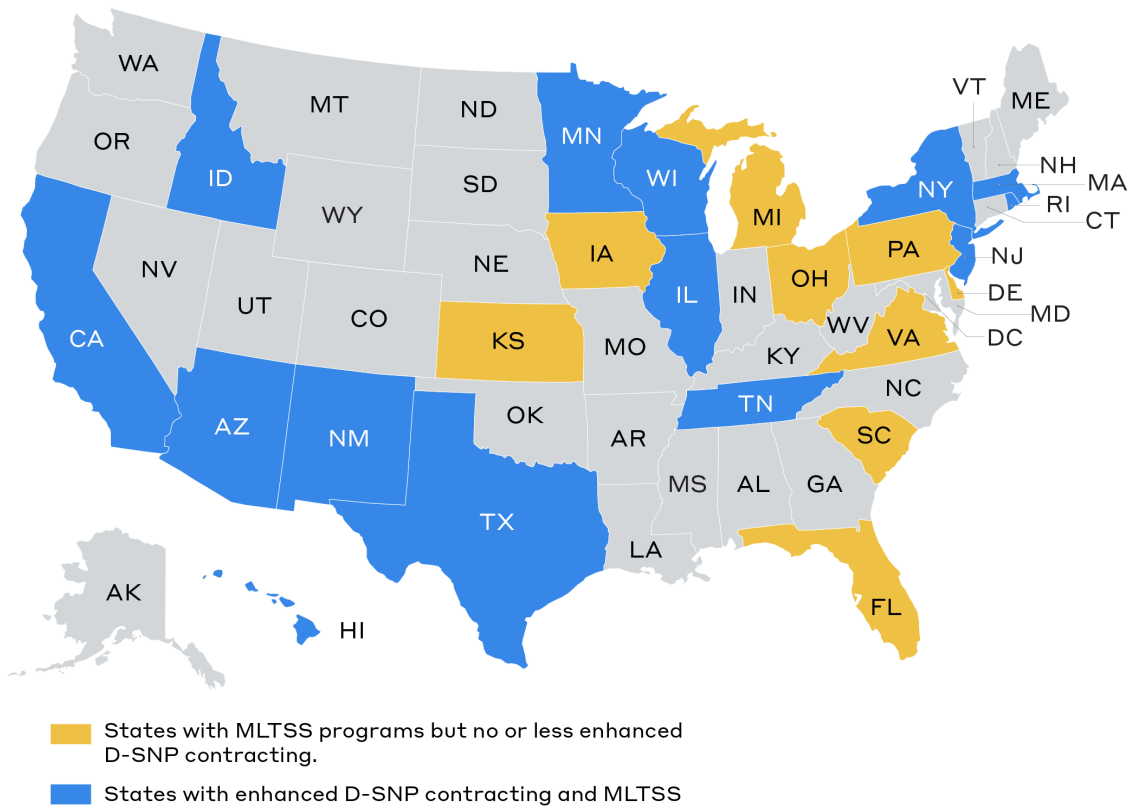
Enrollment in D-SNPs, which have the highest number of participants compared to other integrated plans, varies significantly by state, and includes both rural and urban populations. Texas, Arizona, and New Mexico – states with the largest populations residing in frontier counties – have relatively high D-SNP enrollment.⁵⁷ Yet other rural states such as North Dakota, South Dakota, and Iowa have virtually no dual-eligible individuals enrolled in D-SNPs.⁵⁸ States with significant urban areas, including Florida, California, New York, and Massachusetts, have higher percentages of eligible individuals enrolled in D-SNPs.⁵⁹

Information on health outcome and cost measures for dual-eligible individuals is insufficient in states with low enrollment in integrated care models, making comparisons difficult.⁶⁰ Overall, Medicaid outcomes by state may be skewed by this discrepancy as well. Even states such as Texas, which have robust integrated care models, have numerous counties that lack data, presenting an issue for researchers and policymakers, especially when it comes to examining disparities within counties and states.⁶¹

The Affordable Care Act required D-SNPs to either have contracts with states to provide Medicaid benefits or arrange for them to be provided to dual-eligible enrollees. Fourteen states, highlighted in blue in Figure 3, require D-SNPs to align with Medicaid managed long-term services and supports, or MLTSS, programs. Similarly, other states have developed Medicaid MLTSS programs with the potential to align D-SNP and MLTSS programs.^{62 63}

v Exclusively aligned enrollment occurs when the state limits enrollment into a D-SNP to full-benefit dual-eligible individuals who are also enrolled in a Medicaid MCO that is offered by the D-SNP's MA organization, the D-SNP's parent organization, or by another entity that is owned and controlled by the D-SNP's parent organization.

Figure 3: States with Aligned D-SNPs and Managed Long-Term Services and Supports Programs, 2017



Source: ASPE Report: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Integrating Care through Dual Eligible Special Needs Plans D-SNPs: Opportunities and Challenges*, April 2019, 9.

Financial Alignment Initiative

Under the FAI, states may test any of three integrated care models: (1) a capitated managed care model; (2) a managed FFS model; or (3) a state-specific model.⁶⁴ Under the capitated managed care model, states enter into a single three-way contract with CMS and health plans.⁶⁵ Most states participating in the demonstration chose to implement the capitated managed care option. Plans operating under this contract, known as Medicare-Medicaid Plans, receive a blended capitated rate for all Medicaid and Medicare benefits.⁶⁶ Using this model, a plan provides all Medicare-covered and all or most Medicaid-covered services with a high level of care coordination.⁶⁷ As of December 2019, nine states are participating in the capitated managed care model.^{vi 68}

vi California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas are participating in the capitated managed care model under the financial

In the managed FFS model, CMS and a state enter into an agreement that allows the state to provide coordinated care by building on the existing FFS delivery system.⁶⁹ Specifically, states have built on the Medicaid Health Homes model and Accountable Care Organizations.⁷⁰ Under this model, the state invests in care coordination and receives a retrospective performance payment if certain quality thresholds are met and Medicare achieves target savings levels.⁷¹ Only Washington State and Colorado have implemented this model.⁷² Colorado has ended its demonstration; Washington's demonstration is ongoing.⁷³

The state-specific model allows states to implement innovative models that may include elements of demonstrations under the FAI or other types of delivery system reforms, such as alternative payment methodologies, value-based purchasing, or episode-based bundled payments.⁷⁴ As of December 2019, Minnesota is the only state participating in the state-specific model under the FAI with a focus on administrative alignment.⁷⁵

PACE

PACE is a permanently authorized program that offers comprehensive medical and social services, including those beyond Medicare and Medicaid – if deemed necessary – to those above age 55 who need nursing home-level care. Almost all PACE enrollees are dual-eligible individuals and the care model is centered on adult day care centers with each patient taken care of by an interdisciplinary team.⁷⁶ While PACE represents a high-degree of Medicare-Medicaid integration, it is not widely available and less than 50,000 people are enrolled given the eligibility limitations and start-up costs associated with establishing adult day care centers.

Program Evaluations

Dual-eligible individuals enrolled in integrated models in some areas generally experience some reductions in health care utilization compared to their counterparts not in integrated models, according to a July 2019 MACPAC report – although evaluations of specific integrated models make it difficult to generalize about the effects of integrated care broadly.⁷⁷ According to the report, individuals in integrated models generally experienced decreases in hospitalizations and hospital readmissions.⁷⁸ That is consistent with other studies, which have reported higher beneficiary satisfaction in integrated models than in non-integrated Medicaid FFS arrangements.⁷⁹

At the same time, findings are mixed for use of emergency department services, LTSS, other services, and beneficiary experience related to communicating with health plans and understanding benefits.⁸⁰ Care coordination between Medicare and Medicaid services can be difficult due to lack of access each program has to the other program's data,⁸¹ but recent demonstrations under MMCO and CMMI have emphasized the

alignment initiative. Virginia participated in the capitated managed care model, but ended its demonstration in December 2017.

incorporation of care coordination into integrated models and, as mentioned earlier, CMS has issued new rules for D-SNPs that require further coordination and unification.

Early cost results are also promising but limited. Lower per-person Medicare spending was associated with some integrated care models, but few evaluations have been able to review changes in associated Medicaid spending due to lack of recent Medicaid data.⁸² The new Transformed Medicaid Statistical Information System, or T-MSIS, is expected to provide more information in the near future on Medicaid spending and service use in integrated models.

The MMCO has reported increased access to care coordination within the capitated model demonstrations under its FAI through metrics including increases in completion of health risk assessments and care plans.⁸³ Many of the states participating in FAI faced declines in enrollment that meant participation was lower than expected.⁸⁴ Washington State did see savings, with the caveat that the savings were in Medicare and did not include the effect of the demonstration on Medicaid.⁸⁵

Studies evaluating D-SNPs have demonstrated evidence of reductions in hospitalizations and hospital readmissions. One study compared individuals in California's SCAN plan with Medicare FFS individuals in the state, and found 14% lower rates of preventable hospitalizations and 25% lower rates of hospital readmissions.⁸⁶ Another study found a 54% decrease in hospitalizations and a 24% decrease in hospital readmissions in the Visiting Nurse Service of New York's Choice health plans.⁸⁷ D-SNPs have also been associated with reductions in long-stay and end-of-life care nursing facility entries⁸⁸ and reductions in per-person Medicare spending, such that a 1% increase in D-SNPs penetration was associated with a 0.2% reduction in Medicare spending per beneficiary.⁸⁹

Because traditional fee-for-service providers in Medicare and Medicaid have no reporting requirements, comparing D-SNPs to FFS is not possible. However, D-SNPs consistently performed higher than MA plans. In a study conducted by the Government Accountability Office, D-SNP performed better on process of care and health outcomes with similar utilization compared to traditional Medicare Advantage Plans.⁹⁰ Specifically, they performed better on the majority of process measures and performed better on all outcomes measures.⁹¹

Studies evaluating PACE have demonstrated reductions in inpatient hospital use,^{92, 93, 94} hospitalizations,⁹⁵ and length of stay.⁹⁶ Specifically, PACE participants compared to a matched group in one study experienced reduced hospitalization rates over a two-year period and a shorter length of stay when hospitalized, with an average reduction of 0.6 hospital days per month, even though they had higher levels of hospitalization six months prior.⁹⁷ The Assistant Secretary for Planning and Evaluation did note that limitations of PACE, like the reliance on adult day care centers, have led to slow growth in enrollment and more-scalable and permanent options were necessary for the integration of care.⁹⁸

Conclusion

While the evidence is still outstanding on the potential for long-term savings for demonstration projects that fully integrate care for dual-eligible enrollees, it is clear this population must have a better coordinated and more seamless system of care. Even those without serious medical or functional impairment should not be asked to navigate two separate programs for services without full accountability on the programs for coordination of care. The current bifurcated system should not continue. BPC health care leaders believe states are in the best position to integrate Medicare and Medicaid services and these options encourage states to move forward with integration. Over the long-term, better integration and care coordination will lead to a better enrollee experience, improve quality of care, eliminate inefficiencies, and result in long-term savings.

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