



A Guide for Advocates: State Demonstrations to Integrate Medicare and Medicaid

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There are currently at least 9 million “dual eligibles”—people who are enrolled in both Medicare and Medicaid. They are often the sickest and most vulnerable patients in the health care system. Among dual eligibles, 66 percent have three or more chronic conditions, and 61 percent have a cognitive or mental impairment.¹ More than half of dual eligibles have incomes that are below the federal poverty level (\$10,890 for an individual or \$14,710 for a couple in 2011). They are also some of the most costly patients to cover: Dual eligibles account for 25 percent of Medicare spending and almost half of Medicaid spending, despite making up less than a quarter of total enrollment in these programs.²

Since neither Medicare nor Medicaid is responsible for coordinating care and benefits, and because of conflicts between the two programs, this population is the least likely to have access to coordinated care. Instead, they find themselves in a highly fragmented system. As a result, dual eligible individuals sometimes encounter problems getting the care that they need in the most appropriate setting, and they often receive duplicative or unnecessary tests and treatments.

Over the years, some initiatives have tried to improve coordination between Medicare and Medicaid, with mixed success. These initiatives include Medicare Advantage Special Needs Plans and the Program of All-Inclusive Care for the Elderly (PACE). The health care law, the Affordable Care Act, provides new opportunities to improve coordination between and integration of Medicare and Medicaid, such as shared savings models and the option for states to serve as integrated care entities. The health care law also established two new offices within the Centers for Medicare and Medicaid Services (CMS) that will each play a major role in carrying out these new opportunities: the Federal Coordinated Health Care Office (FCHCO) and the Center for Medicare and Medicaid Innovation (Innovation Center). (See “The Federal Coordinated Health Care Office” and “The Center for Medicare and Medicaid Innovation” on page 2 for more information.)

This guide explains the requirements for state demonstrations that integrate care for dual eligible individuals, discusses possible models of integration and the issues to consider with each model, and provides guidance to advocates on how to get involved in the planning process.

The Federal Coordinated Health Care Office

Creating the Federal Coordinated Health Care Office (FCHCO), often referred to as the Office of Duals, was a significant step forward in improving how the Medicare and Medicaid programs function for dual eligibles. It is the first time that one entity has been tasked with the responsibility of improving the experience of dual eligible beneficiaries. The Office of Duals has two main responsibilities: (1) making the programs work better for beneficiaries, and (2) improving coordination between the federal government and the states in the administration of each program.³

The Office of Duals plans to achieve these goals by eliminating regulatory conflicts between the two programs and providing tools that will help states and providers develop demonstrations that align Medicare and Medicaid. For example, CMS will begin providing state Medicaid agencies with data on Medicare Parts A, B, and D; this will help states better understand the location and types of health care services that dual eligibles receive. The agency will also provide states with profiles of their dual eligible populations, giving states valuable information, such as the number of dual eligibles in the state and characteristics of the population. These efforts will help CMS and states work toward addressing the problems beneficiaries experience in getting care and benefits, as well as helping beneficiaries understand their benefits and improving their satisfaction and quality of care.

The Office of Duals will work with the Center for Medicare and Medicaid Innovation to test different models of integration and coordination with state Medicaid agencies and providers.

The Center for Medicare and Medicaid Innovation

In order to allow Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to test new and innovative delivery system and payment models in a quick and timely manner, the health care law established the Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center was provided with \$10 billion in funding through 2019 to work with states, health care providers, and other stakeholders to develop, test, and evaluate delivery system and payment models that improve quality while lowering costs. The Innovation Center has also been given the authority to waive certain requirements within Medicare or Medicaid if doing so would make it possible to pursue a promising delivery system or payment model. The Innovation Center will focus on models that improve coordination, quality, and efficiency of care.

The Secretary of Health and Human Services (HHS) has the authority to expand the demonstrations that are funded by the Innovation Center, including expanding them nationwide. To qualify for expansion, demonstrations must reduce spending without reducing quality, or they must improve quality without increasing spending. In addition, the Chief Actuary of CMS must certify that the expansion would reduce spending, or at least not increase spending. Finally, the expansion must not deny or limit coverage under Medicare, Medicaid, or CHIP.

One area that the Innovation Center will focus on is models that integrate Medicare and Medicaid. The Innovation Center will work in conjunction with the Office of Duals to test and evaluate models to coordinate and integrate Medicare and Medicaid.

State Demonstrations to Integrate Care for Dual Eligible Individuals

In December 2010, the Innovation Center, in conjunction with the Office of Duals, issued a Request for Proposals for “State Demonstrations to Integrate Care for Dual Eligible Individuals.”

⁴ These demonstrations will test different delivery system and payment models that integrate care for dual eligibles. In April 2011, CMS announced that the following 15 states received design phase contracts of up to \$1 million each: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.⁵

The demonstrations are broken into two phases: a design phase and an implementation phase. The design phase will last for a period of 18 months. States will have 12 months to develop an implementation proposal, and the Innovation Center and Office of Duals will use the last six months to review proposals and negotiate with states. Demonstration implementation contracts will be awarded at that point. (It is important to note that if a state receives a design phase contract, it is not necessarily guaranteed an implementation contract.) Implementation of the demonstrations will likely begin in the fall or winter of 2012.

Generally, the Innovation Center wants states to use the design phase to develop implementation proposals that cover the full range of health care services (acute care, behavioral health, and long-term supports and services), cover the entire dual eligible population, and be administered statewide. If a state is initially unable to do this, it must explain in its proposal which services, populations, and areas will be included, as well as how it will scale up to include the full range of services and the entire dual eligible population and function statewide. The state may propose a new model, may expand existing pilots within the state, or do some combination of both. The dual eligible population is quite heterogeneous and has a variety of health care needs, and states have varied geographies with different health care system capabilities. These will be important issues to consider and address during the design phase.

Models for Integrating Medicare and Medicaid

There are many different ways to integrate Medicare and Medicaid. States that received design phase contracts have proposed a range of options to integrate these programs, including shared savings models that use primary care medical homes and accountable care organizations (ACOs); managed care, including managed long-term care; or a combination of a few different models. Many states have proposed blending Medicare and Medicaid funding—with the state given both Medicaid and Medicare dollars and the responsibility of administering both programs—as the financing mechanism. These different approaches have different benefits and potential risks for beneficiaries.

■ **Shared Savings and Care Coordination Models**

Shared savings models are intended to align financial incentives for health care providers and encourage them to coordinate care for beneficiaries. The shared savings model generally maintains the existing fee-for-service payment structure, but it sets a target for spending. If costs per patient are below the target, providers can share the savings. Because payment remains fee-for-service, providers are not penalized for going above the target. However, not all shared savings models maintain a fee-for-service payment structure. Some models put providers at risk for any spending above the payment level, but also let them share in any savings that may be realized. This model incentivizes providers to coordinate care, but it raises concerns that providers may limit care inappropriately.

Issues to Consider

- **Adequate Infrastructure:** Care coordination models like primary care medical homes and Accountable Care Organizations (ACOs) rely heavily on adequate provider capacity and infrastructure, particularly primary care providers and health information technology (HIT). States must ensure that this capacity exists or can be built quickly. Dual eligibles in particular need adequate access to providers, including specialists, that accept both Medicare and Medicaid and that are able to appropriately bill for both full and partial dual eligibles.
- **Enrollment:** States will need to determine how they will assign beneficiaries to primary care medical homes or ACOs. The process of assigning beneficiaries to a particular medical home or ACO is referred to as attribution. Generally, in order to maintain freedom of choice of providers, attribution is done based on claims data that indicate whether a beneficiary sees a particular primary care provider who is part of the medical home or ACO. States will need to determine when they will attribute beneficiaries, either at the beginning of the performance period (prospective) or at the end (retrospective). How and when a beneficiary is attributed to a coordinated care model have implications for how and when beneficiaries will be notified that they are part of a medical home or an ACO. Full transparency is key to beneficiary buy-in and engagement.
- **Ensuring Quality:** The fee-for-service payment system in Medicare and Medicaid is generally criticized because it pays providers for each service that is provided, which encourages overutilization and disincentivizes care coordination. In order to overcome the financial motivation to provide unnecessary or duplicative services, states will need to ensure that the potential shared savings are sufficient. Shared savings payments should be tied to minimum quality measurement requirements to ensure that providers deliver high-quality care while also lowering costs. States will need to put in place mechanisms to ensure that providers do not avoid high-risk patients or withhold medically necessary care.

■ **Managed Care Models**

Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) were created with the intent of coordinating care for dual eligible beneficiaries, which was supposed to improve the quality of their care and lower costs. Unfortunately, few D-SNPs have achieved this goal. Managed care does not necessarily mean coordinated care, and, in the case of Medicare Advantage plans, it has not led to cost savings for Medicare. While D-SNPs have contracts with Medicare, few have contracts with state Medicaid agencies (though this is required to change by 2013). As a result, most D-SNPs have not integrated the financing or care delivery for these programs.

Issues to Consider

- **Network Adequacy:** Managed care plans in both Medicare and especially Medicaid have been plagued by inadequate provider networks. Because these plans usually have network requirements, beneficiaries have had to change providers, which interrupts longstanding relationships and treatments. This is particularly disruptive to dual eligibles, who often have multiple, complicated medical conditions. Managed care plans also often use prior authorization and other utilization management techniques that beneficiaries have difficulty navigating, which can limit access to needed care.
- **Enrollment:** CMS has a Medicaid waiver process to permit mandatory enrollment of dual eligibles into Medicaid managed care. However, CMS has only once granted a waiver of the freedom of choice of providers requirement in Medicare—to Arizona. If states pursue mandatory enrollment in managed care plans for the dual eligible population, they should provide an opt-out for beneficiaries for whom managed care is simply not a good option. States will also need to build in protections for transitioning care if a beneficiary must switch providers during the course of treatment.
- **Can Private Plans Truly Manage Medicare and Medicaid?** Administrative requirements for Medicare and Medicaid, along with the generally high cost of care for dual eligibles, have traditionally made covering this population unappealing to plans—unless the plans are provided with significant subsidies. Dual eligibles also have different, more complex needs than other Medicare and Medicaid patients, such as a need for long-term supports and services (LTSS). Few managed care plans have experience with managing long-term supports and services, which requires addressing non-health related matters, such as home modifications.
- **Oversight:** States will also need to implement strong oversight of these plans to ensure that they are providing beneficiaries with the full range of acute care, behavioral health care, and long-term supports and services; have adequate provider networks; and are meeting consumer protection requirements. States will also need to impose quality measurement and reporting requirements. Little evidence exists that plans are providing high-quality services to the managed care population, particularly Medicare Advantage Special Needs Plans, because there has been little quality measurement of these plans.⁶

■ **State as an Integrated Entity Using Blended Funding**

Blending Medicare and Medicaid funding is a new model that would allow states to receive a predetermined amount of Medicare funding in exchange for assuming full responsibility for administering the Medicare benefit. While states have previously sought authority to blend Medicare and Medicaid funding, no state has ever received permission from CMS to do so. However, the health care law, for the first time, allows states to receive Medicare funding. States can now decide to become integrated entities and administer both Medicare and Medicaid benefits themselves. They can also contract with other entities, such as managed care organizations or integrated health care systems, to administer both benefits. Or they can do some combination of both.

Historically, states have had little incentive to coordinate care for dual eligible beneficiaries, because most of the savings accrue to Medicare (through reduced hospitalization, for example), while the expense is borne by Medicaid (through improved long-term supports and services, for example). States that propose to blend Medicare and Medicaid funding and administer both benefits argue that this approach has the potential to result in the fullest integration and coordination of Medicare and Medicaid. Some states said in their initial proposals that they intend to use savings that are generated in Medicare to invest in care coordination and possibly an expanded range of covered services.

Issues to Consider

- **Holding States Accountable:** CMS and states will need to put in place a transparent process of accounting for how states spend these blended funds. It is necessary to ensure strong oversight so that states do not simply supplant Medicaid dollars with Medicare dollars
- **Can States Administer Medicare Benefits?** Although states have a great deal of experience with administering the Medicaid program, they do not have any experience with administering the Medicare program. These programs, while complementary, are quite different. States will need not only a strong understanding of the eligibility, benefits, coverage requirements, and appeals processes of each program, but they will also need to address conflicts in these programs in a way that is most advantageous to beneficiaries. For example, where Medicare and Medicaid have two different coverage standards for providing the same benefit, the state must provide beneficiaries with the more generous benefit. Where Medicare and Medicaid provide different notice and appeal rights, the state must use the standard that is most favorable for beneficiaries. If during the planning process it becomes clear that the state cannot administer the Medicare benefit properly, it may be preferable that the state find an alternative mechanism to sharing Medicare savings without assuming responsibility for administering Medicare.

The Role of Advocates

The Innovation Center requires that states engage stakeholders, including beneficiaries and advocates, when they are designing integration proposals. To be successful in this process, states must also have a good understanding of both Medicaid and Medicare requirements, particularly where the two programs are in conflict. Advocates have an important role to play in the development of these proposals and can be a valuable resource to states as they undergo the design phase of their integration demonstrations. For example, advocates often have experience in helping beneficiaries navigate Medicaid and Medicare and have an understanding of where the two programs conflict. Advocates will also be the strongest voice for beneficiaries, ensuring that state proposals not only lower costs, but that they also meet the needs of the beneficiary population and include adequate beneficiary protections.

Advocates' first step in this process is ensuring that they are at the table when decisions are being made. If a state has received a design phase contract, advocates should contact their state Medicaid agency and find out what the state's process is for including beneficiaries and their advocates in the design phase, and they should follow that process to get involved.

It may be helpful for advocates to develop principles that they would like the state to use as a guide when developing its integration proposal. For example:

- Models of care should include a diverse range of person-centered options. Dual eligibles are not a homogeneous population, and a one-size-fits-all (or even one-size-fits-most) approach could harm beneficiaries by limiting access to care or inadvertently imposing cost-sharing.
- The process of developing the proposal should be transparent, with multiple ongoing avenues for public review of and input on the development and implementation of models.
- Beneficiaries' participation in the demonstrations should not be mandatory.
- Robust consumer protections must be paramount to ensure that beneficiaries have access to the full range of services and protections afforded by Medicare and Medicaid.
- All initiatives must be subject to rigorous oversight by both states and CMS to ensure that beneficiary protections are fully honored.

Improving coordination between and integration of Medicare and Medicaid must be done in a way that improves the experience for beneficiaries. The focus must be on simplification and improved health outcomes. Savings should be the result of improved quality. In order to achieve this outcome, states will need to carefully think through a number of issues, not the least of which is resolving conflicts between the two programs. It will be the role of advocates to understand these issues, ask these important questions, and help the state work toward a solution that is best for beneficiaries. Some of these questions include the following:

1. What integration options is the state considering?
2. What state and federal laws, regulations, and rules apply? What, if any, conflicts in the state and federal laws exist? How will these conflicts be resolved?
3. Will the state need a waiver of federal Medicare or Medicaid requirements? If so, is such a waiver available? What are the implications of the waiver for beneficiaries?
4. What is the scope of the integration proposal? Will all health care services be included? Will it be statewide or regional? Will all populations be included or only sub-populations?
5. If the proposal is initially limited in scope, what is the state's timeline for scaling up? How will the state scale up? What are the implications of a proposal that is initially limited in scope?
6. How will the state enroll beneficiaries? Will enrollment be voluntary or mandatory? Will it be an opt-in or an opt-out model? Will the state use an attribution process? If so, will it be prospective or retrospective?
7. What are the patient's rights and responsibilities? How will the state ensure the protection of these rights? Will there be an ombudsman? What will the appeals process look like?
8. What role will care coordination play in the proposal? Will all beneficiaries be eligible for care coordination, or only certain sub-populations? How will beneficiaries obtain care coordination?
9. How will the state ensure that beneficiaries have adequate access to the full range of health care providers and support services that they may need?

These questions represent only a sample of the many issues that advocates will need to address with their state Medicaid agency as the state pursues integration. A more detailed list of questions and issues to consider, as developed by Alissa Halperin for the Health Action 2011 Conference, is in *Key Questions and Issues in State Medicare-Medicaid Integration Efforts*, available online at <http://www.healthaction2011.org/?db85f8f8>.

Conclusion

The health care law presents states with many opportunities to improve the health care system in a way that leads to better health and lower costs. States will have the flexibility to experiment with different approaches to improve the care and experiences of dual eligible beneficiaries. Advocates have an important role to play in ensuring that, whatever approach a state pursues, it does so in a thoughtful, careful way with the goal of not just lowering costs, but also improving quality and health outcomes.

Helpful Resources

Federal Coordinated Health Care Office: <http://www.cms.gov/dualeligible/>.

Center for Medicare and Medicaid Innovation: <http://innovations.cms.gov/>.

Medicare Payment Advisory Commission Report to Congress, *Aligning Incentives in Medicare*, Chapter 5: “Coordinating Care for Dual-Eligible Beneficiaries,” available online at http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

Center for American Progress, *The Dual Eligible Opportunity: Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid*, available online at http://www.americanprogress.org/issues/2010/12/pdf/dual_eligibles.pdf.

Center for Health Care Strategies, *Options for Integrating Care for Dual Eligible Beneficiaries*, available online at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1186550.

Endnotes

¹ Kaiser Family Foundation Program on Medicare Policy, *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid* (Menlo Park, CA: Kaiser Family Foundation, January 2011), available online at <http://www.kff.org/medicare/upload/8138.pdf>.

² Medicare Payment Advisory Committee Report to the Congress, *Aligning Incentives in Medicare*, Chapter 5: "Coordinating the Care of Dual-Eligible Beneficiaries" (Washington: MedPAC: June 2010), available online at http://www.medpac.gov/documents/jun10_EntireReport.pdf.

³ Department of Health and Human Services, *Letter to Congress: Federal Coordinated Health Care Office*, March 1, 2011, available online at <http://www.cms.gov/dualeligible/downloads/HHSDualsOfficeLettertoCongress.pdf>.

⁴ Centers for Medicare and Medicaid Services, *Request for Proposals: State Demonstrations to Integrate Care for Dual Eligible Individuals*, posted on November 16, 2010, available online at https://www.fbo.gov/index?s=opportunity&mode=form&id=cf51922c5bafa8eb44e360806df49a36&tab=core&_cview=0.

⁵ Department of Health and Human Services, *Press Release: New Flexibility for States to Improve Medicaid and Implement Innovative Practices*, April 14, 2011, available online at <http://www.hhs.gov/news/press/2011pres/04/20110414a.html>.

⁶ Medicare Payment Advisory Committee, *Care Coordination for Dual-Eligible Beneficiaries: Evaluating Special Needs Plans' Models of Care*, presented at the February 2011 Public Meeting, available online at http://www.medpac.gov/transcripts/Duals%20presenation_public_final.pdf.



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