

# State Pathways to Integrated Care

**More than 12 million Americans are dually eligible for Medicaid and Medicare.** These individuals often receive fragmented and uncoordinated care from these two programs. Integrating financing and service delivery for this population has the potential to improve the care experience for enrollees, increase care quality, and reduce costs.

This tool shares steps that states can take to advance integration, beginning with simple actions to better understand dually eligible populations and improve their access to care. It also describes integration options based on state policy goals and delivery system structures, and avenues for charting a path toward integration.

One-on-one technical assistance is available to states looking to explore these options. To learn more, contact ICRC at: [ICRC@chcs.org](mailto:ICRC@chcs.org)

*Last updated: April 3, 2019*

## Capitated Managed Care

Contracting with managed care plans to deliver and coordinate both Medicare and Medicaid services.

## Managed Fee-for-Service

Contracting with entities that coordinate service delivery beyond standard fee-for-service arrangements.

## Integrated Care Paths

Choosing the best model to advance your policy goals.

## Initial Considerations

Understanding your population and environmental factors.

## State-Specific Models

Developing and testing innovative state-specific models.

## Addressing Foundational Issues

Making administrative changes to improve access to care and reduce burden.

**START HERE**





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- [Overview](#)
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As a group, dually eligible beneficiaries are the highest-need and highest-cost population in both Medicare and Medicaid because they often have:<sup>1</sup>

- Multiple chronic physical health conditions
- Co-occurring behavioral health conditions
- A need for long-term services and supports (LTSS)

Although dually eligible beneficiaries are likely to benefit from coordinated care, less than 10% nationally are receiving integrated care.<sup>2</sup>

The first steps toward integrating Medicare and Medicaid services are:

- [Understanding Your Dually Eligible Beneficiaries](#)
- [Assessing Environmental Factors and Opportunities to Integrate Care](#)





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# Understanding Your Dually Eligible Beneficiaries

Reports available [through CMS](#) and other sources provide detailed information on dually eligible beneficiaries. States can use these reports to design more integrated programs for this population. For example:

## [How States Can Better Understand Their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources](#)

describes resources with state/county-level demographic data.

- To find the number and types (QMB, QMB+, SLMB, SLMB+, FBDE) of dually eligible beneficiaries, go to page 3: “Dually Eligible Beneficiary State and County Monthly Enrollment Snapshots.”
- To find data on beneficiaries’ chronic conditions and their use of Medicare and Medicaid services, go to page 7: “Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS).”
- To find data on Medicare and Medicaid spending and payments, go to page 23.

[Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#) presents national-level data that can be used as a point of comparison for state/county-level data.

- To find data on dually eligible beneficiaries’ share of Medicare and Medicaid enrollment and spending, go to Exhibit 5.
- To find data on physical and behavioral health conditions, go to Exhibit 8.
- To find data on service utilization and spending on Medicare and Medicaid services, go to Exhibits 14 and 15.

For more detailed information about these reports and how states can use them, review the resources in the right sidebar.



## RELATED RESOURCES

[How States Can Better Understand Their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources](#)  
(ICRC, 2018)

[Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#)  
(MedPAC and MACPAC, 2018)

[Working with Medicare Webinars](#)  
(ICRC)

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# Assessing Environmental Factors and Opportunities to Integrate Care

Successful integrated care needs a strong foundation of:

- **Infrastructure** (e.g., staff, information technology resources, management systems), either within the state Medicaid agency or in outside entities, such as managed care organizations
- **Support from stakeholders** (e.g., from the governor, legislators, other state agencies, beneficiary advocates, and providers) for integration
- **Medicare knowledge** on the part of state staff and state-contracted entities
- **Managed care plans** or other entities that the state can contract with to integrate Medicare and Medicaid services for dually eligible enrollees

To learn more about understanding your current Medicare and Medicaid landscape and the characteristics of dually eligible beneficiaries in your state, review the resources in the sidebar.



## RELATED RESOURCES

[Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees](#)  
(ICRC, 2017)

[How States Can Better Understand Their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources](#)  
(ICRC, 2018)

[SNP Comprehensive Reports](#)  
(CMS)

[Medicare Advantage 2019 Spotlight: First Look](#)  
(Kaiser Family Foundation, 2018)

[Medicaid Managed Care Enrollment Report and Program Characteristics, 2016](#)  
(CMS, 2018)



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# Addressing Foundational Issues in Integrating Care

States can build a stronger base for integration by addressing some foundational issues. Making these administrative changes may improve dually eligible beneficiaries' access to care while reducing burden on state staff and providers. Administrative changes to consider include:

- [Executing Part A Buy-In Agreements](#)
- [Exchanging Files with CMS More Frequently](#)
- [Using Medicare Data to Improve Integration](#)
- [Using DME Policies to Improve Integration](#)
- [Improving Care for Nursing Facility Residents](#)

More details on ways that states can address foundational issues in integration can be found in the December 2018 State Medicaid Director Letter [Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare](#)

- [Overview](#)
- [Executing Part A Buy-In Agreements](#)
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# Executing Part A Buy-In Agreements

Most Medicare beneficiaries do not have to pay a monthly premium for Medicare Part A coverage, but some do. Low-income people may decline Part A enrollment because of this financial burden. The Qualified Medicare Beneficiary (QMB) program covers this premium for eligible beneficiaries, but beneficiaries must enroll in Part A to access that program, and Part A enrollment is generally restricted to an annual open-enrollment period.

To remedy this, 36 states and the District of Columbia have Part A buy-in agreements with CMS to facilitate Part A enrollment for QMB-eligible beneficiaries.<sup>3</sup>

The benefits of Part A buy-in agreements include:

- Allowing enrollment in Medicare Part A at any time of year
- Eliminating penalties for late enrollment in Part A
- Enabling beneficiaries to receive integrated care through Medicare Advantage plans or Medicare-Medicaid Plans (without Part A, beneficiaries who would otherwise be dually eligible cannot enroll in these managed care plans)
- Potentially reducing Medicaid costs because Medicare becomes the primary payer for inpatient and acute care services that would otherwise be covered by Medicaid

For more information about executing Part A buy-in agreements, review the resources in the right sidebar.



## RELATED RESOURCES

[Part A Buy-in Agreements for States - Q&A](#)  
(CMS, 2019)

[Building a Stronger Foundation for Medicare-Medicaid Integration: Opportunities in Modifying State Administrative Processes](#)  
(ICRC, 2018)

[Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare](#)  
(CMS, 2018)

[Program Operations Manual System \(POMS\): State Buy-In and Group Payer Provisions for QMBs](#)  
(Social Security Administration)

State Medicaid agencies can get more information about entering into Part A buy-in agreements by emailing [statebuy-in@cms.hhs.gov](mailto:statebuy-in@cms.hhs.gov) with “Part A Payer Conversation” in the subject line.

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# Exchanging Files with CMS More Frequently

States exchange “MMA” files<sup>4</sup> with CMS to identify dually eligible beneficiaries and to generate Part A and B premium notices (“buy-in” files). States must submit these files at least monthly, but more frequent file submission offers several benefits:

- Beneficiaries can access Medicare subsidies faster, enabling quicker access to Medicare Part A and B services without out-of-pocket costs
- States, health plans, and providers can more clearly communicate with beneficiaries about cost-sharing liability
- Medicaid administrative processes can be streamlined
- Provider burden can be reduced

Many states already exchange files with CMS daily. Before deciding to submit files more frequently, states will need to determine whether their administrative and data systems will support this change.

For more information about state/CMS file exchange, review the resources in the right sidebar.



## RELATED RESOURCES

[Building a Stronger Foundation for Medicare-Medicaid Integration: Opportunities in Modifying State Administrative Processes](#)  
*(ICRC, 2018)*

[Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare](#)  
*(CMS, 2018)*

[State Medicare Modernization Act \(MMA\) File of Dual Eligible Beneficiaries Q&A](#)  
*(CMS, 2017)*

[Medicare Advantage Prescription Drug State User Guide](#)  
*(CMS, 2017)*

[Effects of Medicaid Coverage of Medicare Cost-Sharing on Access to Care](#)  
*(Medicaid and CHIP Payment and Access Commission, 2015)*



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# Using Medicare Data to Improve Integration

As states design and implement integrated care programs, the ability to access Medicare data can help with care coordination and program oversight. States that obtain Medicare data and link these data to their own Medicaid data can create a more complete view of dually eligible beneficiaries' service use and spending.

Efforts that can be improved by linked data include those designed to:

- Reduce overutilization of emergency departments
- Create predictive modeling tools
- Inform care planning and care coordination
- Support beneficiary outreach and engagement
- Support auditing

For more information on using Medicare data to improve integration, review the resources in the right sidebar.



## RELATED RESOURCES

[State Data Resource Center](#)  
(SDRC)

[Medicare-Medicaid Data Integration: What Can the Master Beneficiary Summary File Do for You?](#)  
(SDRC, 2018)

[Public Data Files and the Dual Eligible Population](#)  
(SDRC, 2018)

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# Using DME Policies to Improve Integration

Because Medicare coverage and Medicaid coverage for durable medical equipment (DME) differ in complex ways, dually eligible beneficiaries may face obstacles and delays when trying to access these services. Most states require DME suppliers to submit claims to Medicare first and to obtain a final payment denial. Due to this payment uncertainty, providers may be reluctant to supply DME items to dually eligible beneficiaries.

To improve beneficiaries' experience and reduce administrative burden, states can:

- Develop provisional prior authorization procedures for certain DME items
- Publish lists of DME items not covered by Medicare and allow DME suppliers to bill Medicaid directly for these items

These changes can help clarify who to bill when, while reducing administrative burden and improving beneficiary access. States can design tools and documents to reflect state-specific billing processes and statutory requirements.

For more information on DME policies, review the resources in the right sidebar.



## RELATED RESOURCES

[Strategies to Support Dual Eligible Beneficiaries' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies](#)  
*(CMS, 2017)*

[Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches](#)  
*(ICRC, 2018)*

[Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative](#)  
*(ICRC, 2014)*

[Medicare National Coverage Determinations Manual, Chapter 1, Part 4](#)  
*(2017)*

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# Improving Care for Nursing Facility Residents

In both fee-for-service and capitated managed care systems, states can take steps to improve care for dually eligible residents of nursing facilities. One area of focus is [reducing avoidable hospitalizations](#), which are common among dually eligible beneficiaries and have been shown to lead to poor health outcomes and higher costs.<sup>5</sup>

States using fee-for-service payment systems can make changes in those systems to encourage nursing facilities to reduce resident hospitalizations. States with managed care systems can promote efforts to reduce hospitalizations through contract requirements, performance incentives, and performance improvement projects.

For more information about reducing avoidable hospitalizations among dually eligible beneficiaries, review the resources in the right sidebar.



## RELATED RESOURCES

[Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options for States](#)

*(ICRC, 2015)*

[CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents \(NFI\)](#)

*(ICRC, 2017)*

[Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed care Plans](#)

*(ICRC, 2017)*

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## Managed Fee-for-Service

Contracted entities coordinate service delivery beyond what is typically done in fee-for-service.

### Questions to consider:

- Does your state want to improve care for dually eligible beneficiaries who are often not well served in fee-for-service systems?
- Are capitated MCOs not available, not mandatory for all populations, or not otherwise capable of meeting your state's needs?
- Does opposition to capitated managed care make MFFS options more feasible?
- Has your state established or is it considering a health home program or PCCM program that can be tailored to advance integration?

## Capitated Managed Care

Integrated care is provided through contracts with managed care plans responsible for delivering both Medicare and Medicaid services.

### Questions to consider:

- Does your state have an MLTSS program or experience contracting with Medicaid MCOs?
- Do Medicaid MCO benefit packages include behavioral health services?
- Does your state have options to enhance Medicaid MLTSS and D-SNP contracting to further integration?
- Can your state align enrollment between Medicare D-SNPs and Medicaid MLTSS plans?

## State-Specific Models

Innovative models may include elements of demonstrations under the Financial Alignment Initiative or other types of delivery system reforms.

### Questions to consider:

- Has your state had experience with either capitated or MFFS models? What elements did or did not work?
- Are payers or providers champions of a particular approach (e.g., value-based payments, episode-based payments)?
- Do stakeholders have ideas for how to address social determinants of health or promote consumer empowerment and independence?





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# Managed Fee-for-Service Options



Managed fee-for-service (MFFS) approaches offer states an opportunity to improve service delivery and care quality for dually eligible beneficiaries. Well-designed MFFS programs should have a clear vision of integration and involve an accountable entity capable of coordinating the fragmented pieces of the fee-for-service system. To be successful, major up-front investments in management, staff, and information systems may need to be made at the state and/or accountable entity level.

Options and resources for states implementing MFFS models include:

- [Medicaid Health Homes](#)
- [Managed Fee-for-Service Model Demonstrations under the Financial Alignment Initiative](#)
- [Primary Care Case Management](#)





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# Medicaid Health Homes

The goal of Medicaid health homes is to improve care coordination and management for beneficiaries with chronic physical or behavioral health conditions. Health home providers integrate and coordinate all primary, acute, behavioral health and LTSS. Health home services must include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Individual and family support
- Referral to community and social support services

States receive a 90% enhanced Federal Medical Assistance Percentage for health home services for the first eight quarters.

States may not exclude dually eligible individuals from health homes. However, because Medicare pays for most acute care services (primarily hospital and physician services and prescription drugs) for this population, states would not usually be able to share in savings from reduced service use. An important consideration for states is that the health home model may be difficult to implement without a state information system that can integrate Medicare and Medicaid data. In addition, states using this model would need to ensure that dually eligible individuals are meaningfully connected to LTSS when needed.

For more information on serving dually eligible beneficiaries through Medicaid health homes, review the resources in the right sidebar.

## RELATED RESOURCES

[Health Home Information Resource Center](#)  
*(CMS)*

[Developing Health Homes to Effectively Serve Medicare-Medicaid Enrollees](#)  
*(ICRC, 2013)*

[Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences](#)  
*(ICRC, 2019)*





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## Managed Fee-for-Service Model Demonstrations under the Financial Alignment Initiative

To help states access Medicare savings resulting from Medicaid FFS interventions, CMS has offered the opportunity to create managed fee-for-service (MFFS) demonstrations.

Washington State created such a demonstration using a health home platform, and CMS has made interim performance payments to the state.

CMS recommends that proposed new demonstrations use an approach similar to Washington's (i.e., providing a high-intensity interventions to high-risk beneficiaries). This MFFS model uses a retrospective shared-savings approach.

For more information on serving developing MFFS model demonstrations, review the resources in the right sidebar.

State staff interested in testing the MFFS model should contact Lindsay Barnette in MMCO at [Lindsay.Barnette@cms.hhs.gov](mailto:Lindsay.Barnette@cms.hhs.gov).



### RELATED RESOURCES

[Three New Opportunities to Test Innovative Models of Integrated Care](#)  
*(CMS, 2019)*

[Financial Alignment Initiative](#)  
*(CMS)*

[Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences](#)  
*(ICRC, 2019)*





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# Primary Care Case Management

Primary care case management (PCCM) is a Medicaid state plan option in which the Medicaid agency contracts with primary care providers and/or a care coordination entity to “provide, locate, coordinate, and monitor . . . services for Medicaid beneficiaries who select or are assigned into the program by the state.” <sup>6</sup>

The PCCM entity is responsible for care management, administrative oversight, performance measurement, and reporting, as well as bringing the pieces of the fee-for-service system together to meet the complex needs of dually eligible beneficiaries.

For more information on integrating care for dually eligible beneficiaries through PCCM, review the resources in the right sidebar.



## RELATED RESOURCES

[Integrating Care for Medicare-Medicaid Enrollees Using a Managed Fee-for-Service Model](#)

*(ICRC, 2012)*

[Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States](#)

*(CHCS, 2009)*





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# Capitated Managed Care Options



Many states recognize the potential to reduce costs and improve quality when dually eligible beneficiaries enroll in integrated health plans. Because nearly half of all dually eligible beneficiaries use long-term services and supports (LTSS), states developing capitated health plan arrangements are increasingly contracting with health plans to integrate LTSS and Medicare services.

Some states have achieved integration by conducting demonstrations under the [Financial Alignment Initiative](#), in partnership with CMS. In these demonstrations, which are now open to additional states, Medicare and Medicaid benefits are coordinated through a single health plan.

Others are advancing integration by aligning Medicaid managed long-term services and supports (MLTSS) plans and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). States at varying stages of MLTSS and/or D-SNP program design or contract development may wish to explore the following options:

- [Capitated Model Demonstrations under the Financial Alignment Initiative](#)
- [Managed Long-Term Services and Supports \(MLTSS\)](#)
- [D-SNP Contracting](#)
- [Advanced D-SNP Contracting](#)
- [Programs of All-Inclusive Care for the Elderly \(PACE\)](#)





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# Capitated Model Demonstrations under the Financial Alignment Initiative

In these demonstrations, the state, CMS, and health plans enter into a three-way contract. Plans receive a prospective, blended payment to provide comprehensive, coordinated Medicare and Medicaid services. This actuarially developed rate provides a shared savings opportunity for both states and the federal government. The joint rate setting process includes the opportunity for both states and the federal government to prospectively share in demonstration savings.

Ten states implemented capitated model demonstrations, and this opportunity is now open to additional states. Building on lessons learned to date, new demonstrations should include:

- Meaningful stakeholder engagement and collaboration;
- Robust beneficiary support mechanisms;
- Significant outreach and education for beneficiaries and providers;
- Careful preparation and system testing prior to implementation;
- Phased implementation and/or enrollment of beneficiaries;
- Minimization of administrative burden for providers;
- State-specific savings factors that reflect local market dynamics and are designed to increase over time; and
- Quality withholds and risk arrangements for plans that allow CMS and the state to share in plan savings/losses.

State staff interested in testing the capitated model should contact Lindsay Barnette in MMCO at [Lindsay.Barnette@cms.hhs.gov](mailto:Lindsay.Barnette@cms.hhs.gov)



## RELATED RESOURCES

[Three New Opportunities to Test Innovative Models of Integrated Care](#)  
(CMS, 2019)

[Financial Alignment Initiative](#)  
(CMS)

[Joint Rate-Setting Process for the Capitated Financial Alignment Model](#)  
(ICRC, 2015)

[Engaging Providers in Integrated Care Programs for Medicare-Medicaid Enrollees: Tips for States](#)  
(ICRC, 2015)

[State Insights on Refining Integrated Care for Dually Eligible Beneficiaries](#)  
(CHCS, 2016)

[The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#)  
(Mathematica, 2019)



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# Managed Long-Term Services and Supports

Nearly half of the nation's Medicaid programs have shifted LTSS from fee-for-service to managed care via managed LTSS (MLTSS) programs.

The design of an MLTSS program can affect the level of clinical integration and administrative alignment that can be achieved through linkages with D-SNPs. In fully integrated models, Medicaid MLTSS and linked D-SNPs receive Medicaid and Medicare payments for LTSS, primary, acute, and behavioral health services, and Medicaid enrollment and contracting strategies promote alignment.

States should consider the degree to which they can support a fully aligned (MLTSS/D-SNP) enrollment model, in which beneficiaries are enrolled in aligned D-SNP and MLTSS plans through the same parent company.

States exploring aligned enrollment options may wish to review these [key considerations for D-SNP contracting](#).

For more information on developing MLTSS programs and aligning D-SNP and MLTSS enrollment, review the resources in the right sidebar.



## RELATED RESOURCES

[Summary of Essential Elements of Managed Long-Term Services and Supports Programs](#)  
(CMS)

[Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment](#)  
(ICRC, 2018)





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## D-SNP Contracting

Dual Eligible Special Needs Plans (D-SNPs) offer a higher level of integration than regular Medicare Advantage plans or traditional Medicare fee-for-service. Some key requirements and considerations for using this option include the following:

- D-SNPs must have a contract with the state to facilitate coordination of Medicare and Medicaid services for enrollees.
- The requirements established between state Medicaid agencies and D-SNPs determine the level of administrative, clinical, and financial integration that can be achieved.
- States with the most detailed and extensive contracts with D-SNPs have (1) Medicaid MLTSS programs, (2) experienced D-SNPs that contract with the state, and (3) Medicaid agency leaders and staff who are knowledgeable about both Medicaid and Medicare managed care.

States exploring D-SNP contracting options may wish to review these [key considerations for D-SNP contracting](#).

For more information on D-SNP contracting, review the resources in the right sidebar.

### RELATED RESOURCES

[State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options](#)

*(ICRC, 2016)*

[Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans](#)

*(ICRC, 2017)*

[Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment](#)

*(ICRC, 2018)*

[CMS Releases Final Rule on D-SNP Integration and Integrated Appeals](#)

*(ICRC, 2019)*



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# Key Considerations: D-SNP Contracting

States may wish to consider the following as they seek to integrate care for dually eligible beneficiaries, particularly when designing MLTSS programs and related policies:

- **Assessing state and D-SNP capacity:** States considering D-SNP contracting should assess which D-SNPs already operate in the state (or are interested in doing so) and whether the state can design and implement meaningful integration requirements.
- **Understanding and aligning with Medicare contracting dates and processes:** States should be aware of CMS Medicare Advantage enrollment and contracting processes, which require submission of plan bids and other critical documents within certain time frames. States can choose to align Medicaid managed care contracting and enrollment processes with Medicare to promote coordination.
- **Leveraging opportunities to fully integrate care:** States developing or expanding MLTSS programs can achieve a significant degree of alignment by contracting with Fully Integrated Dual Eligible Special Needs Plans to cover Medicaid benefits, including LTSS.

[Review Additional D-SNP Contracting Considerations](#)



## RELATED RESOURCES

[State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options](#)  
*(ICRC, 2016)*

[Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans](#)  
*(ICRC, 2017)*

[Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment](#)  
*(ICRC, 2018)*

[CMS Releases Final Rule on D-SNP Integration and Integrated Appeals](#)  
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# Additional Considerations: D-SNP Contracting

(continued from [Key Considerations: D-SNP Contracting](#))

- **Promoting aligned enrollment between MLTSS and D-SNP health plans for dually eligible beneficiaries:** States can require MLTSS plans to operate D-SNPs, limit D-SNP contracts to MLTSS contractors, and/or develop mechanisms that encourage enrollment in the most integrated options available. Limiting enrollment in D-SNPs to beneficiaries who enroll in a Medicaid plan through the same parent company is an effective way to achieve alignment.
- **Promoting integrated options:** States invested in linking Medicaid enrollment and service delivery with Medicare options can develop targeted outreach approaches to encourage enrollment in integrated options. This outreach can be conducted by state agencies, health plans, or other partners.

For more information on developing MLTSS programs and aligning D-SNP and MLTSS enrollment, review the resources in the right sidebar.



## RELATED RESOURCES

[State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options](#)  
(ICRC, 2016)

[Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans](#)  
(ICRC, 2017)

[Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment](#)  
(ICRC, 2018)

[CMS Releases Final Rule on D-SNP Integration and Integrated Appeals](#)  
(ICRC, 2019)



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- [State-Specific Models](#)

# Advanced D-SNP Contracting Options

State investment in D-SNP contracting and MLTSS program development can advance alignment over time through strategies that encourage aligned enrollment, coordinated benefits, and improved beneficiary access to care.

The resources in this section highlight lessons and strategies in key areas:

- Increasing enrollment in integrated health plans
- Providing value-added services for enrollees
- Preventing improper billing of enrollees
- Integrating behavioral and physical health care
- Improving coordination of home health and DME benefits

For more information on advanced D-SNP contracting, review the resources in the right sidebar.



## RELATED RESOURCES

[State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries](#)  
*(ICRC, 2017)*

[Providing Value-Added Services for Medicare-Medicaid Enrollees: Considerations for Integrated Health Plans](#)  
*(CHCS, 2017)*

[Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual Eligible Special Needs Plans](#)  
*(ICRC, 2018)*

[Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working with Managed Care Delivery System](#)  
*(ICRC, 2017)*



# State Pathways to Integrate Care

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## Integrated Care Paths

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# Programs of All-Inclusive Care for the Elderly (PACE)

PACE organizations deliver fully integrated Medicare- and Medicaid-covered services, including primary, acute, specialty, and long-term services and supports. Enrollment is voluntary. About 90% of PACE participants are dually eligible beneficiaries. To be eligible, participants must be age 55 or older, live in a PACE service area, be certified nursing-home eligible in their state, and be able to live safely in the community at the time of enrollment. If participants need nursing facility care after joining a PACE program, the PACE organization must cover the cost.

PACE organizations must qualify as Medicare providers. States can choose to provide PACE to Medicaid beneficiaries as a state plan option. As of 2019, there are 126 PACE programs in 31 states, serving about 45,000 dually eligible participants. Medicare and Medicaid pay capitated rates to PACE organizations, which assume full financial risk for the benefits covered under each program. Unlike insurer-based health plans offering MLTSS and D-SNP products, which rely mostly on contracted provider networks, PACE organizations are a provider-based model in which interdisciplinary teams of health professionals serve people in adult day centers and have direct-care relationships with enrollees.

For more information on PACE, review the resources in the right sidebar.



## RELATED RESOURCES

[CMS Pace webpage](#)  
(CMS, 2017)

[Strategies for Incorporating PACE into State Integrated Care Initiatives: A Toolkit for States](#)  
(National PACE Association, 2014)

[PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations](#)  
(National PACE Association, 2016)

[Serving Adults with Serious Mental Illness in the Program of All-Inclusive Care for the Elderly: Promising Practices](#)  
(CHCS, 2018)

[Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011](#)  
(Assistant Secretary for Planning and Evaluation, 2015)

[PACE for States](#)  
(CMS)





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## State-Specific Models

CMS is open to partnering with states to test new state-developed models for better serving dually eligible individuals. These models can be broadly applicable to all dually eligible individuals in the state or focus on certain segments of the population, such as people using LTSS, younger people with disabilities, and/or people living in rural areas.

State-specific models could include elements from the Financial Alignment Initiative demonstrations or other types of delivery system reforms (e.g., alternative payment methodologies, value-based payments, or episode-based bundled payments).

CMS is especially interested in models that:

- Address social determinants of health
- Promote empowerment and independence for dually eligible individuals
- Increase access to coordinated care, encompassing both Medicare and Medicaid services
- Enhance the quality of care furnished to individuals, with an emphasis on health outcomes
- Reduce expenditures for the Medicare and Medicaid programs
- Preserve: (1) access to all covered Medicare benefits; (2) cost-sharing protections for full-benefit dually eligible individuals; and (3) beneficiary choice of providers

Robust stakeholder engagement should be a focus in both model design and implementation.

### RELATED RESOURCES

[Three New Opportunities to Test Innovative Models of Integrated Care](#)  
(CMS, 2019)

State staff interested in partnering with CMS on developing and testing new innovations should contact Lindsay Barnette in MMCO at [Lindsay.Barnette@cms.hhs.gov](mailto:Lindsay.Barnette@cms.hhs.gov)



# State Pathways to Integrate Care



Initial Considerations



Addressing Foundational Issues



Integrated Care Paths

## References

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- <sup>2</sup> Medicare Payment Advisory Commission (MedPAC). “Report to the Congress: Medicare and the Health Care Delivery System, Chapter 9: Managed Care Plans for Dual Eligible Beneficiaries.” June 2018. Available at [http://medpac.gov/docs/default-source/reports/jun18\\_medpacreporttocongress\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0)
- <sup>3</sup> Social Security Administration. “State Buy-In and Group Payer Provisions for QMBs.” 2018. Available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140!opendocument>
- <sup>4</sup> MMA files are named after the Medicare Prescription Drug Improvement and Modernization Act of 2003. For details on these files, see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/StateMMAFile.html>
- <sup>5</sup> Segal, M., E. Rollins, K. Hodges, and M. Roozeboom. “Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations.” *Medicare & Medicaid Research Review*, vol. 4, no. 1, 2014. Available at [https://www.cms.gov/mmrr/Downloads/MMRR2014\\_004\\_01\\_b01.pdf](https://www.cms.gov/mmrr/Downloads/MMRR2014_004_01_b01.pdf)
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