kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

August 2011

Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS

Introduction

Nearly nine million people, including 5.5 million low-income seniors and 3.4 million people with disabilities under age 65, are dually eligible for and enrolled in both the Medicare and Medicaid programs.[1] They are among the sickest and poorest individuals covered by either program. Half of dual eligibles are in fair or poor health, more than twice the rate of other Medicare beneficiaries, often with multiple chronic conditions.[2] Dual eligibles are more likely than others on Medicare to have mental health needs, live in nursing homes, be hospitalized, use emergency rooms, and require long-term care.[3] They have disproportionately lower incomes compared to other Medicare and Medicaid beneficiaries, with 55% of dual eligibles having annual incomes below $10,000.[4]

Dual eligibles qualify separately for Medicare and Medicaid. Eligibility for Medicare is based on age (usually those aged 65 and over), disability, or a diagnosis of End-Stage Renal Disease or Amyotrophic Lateral Sclerosis (ALS). Medicaid eligibility generally is based on low income status, disability status along with somewhat higher income limits, or high medical or long-term care expenses relative to income. Most dual eligibles also qualify for Supplemental Security Income (SSI) benefits, which require them to have low incomes, limited assets and a significant disability that impairs their ability to work at a substantial gainful level. States also have the option to provide Medicaid coverage to other groups, including individuals whose incomes exceed the SSI limits but are still below the federal poverty level, people with disabilities who receive care in institutions, people with disabilities who qualify for home and community-based services, and people whose out-of-pocket unreimbursed monthly medical expenses are high enough to "spend down" to the Medicaid income limit.

Dual eligibles receive benefits under the Medicare and Medicaid programs. Medicare is the primary payer, covering medical care such as hospital, physician, diagnostic tests, post-acute and other services and prescription drugs, as it does for the other 39 million Medicare beneficiaries. For the majority of dual eligibles, known as "full duals" (6.9 million), Medicaid provides assistance with Medicare premiums and cost-sharing and pays for services that are not covered by Medicare, such as

[1] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," May 2011.
[2] Id.; Kaiser Commission on Medicaid and the Uninsured, "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending," July 2010.
[3] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," May 2011.
[4] Id.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/kcmu

dental, vision and other services provided at state option, and most notably, long-term care.[5] Medicare does not cover long-term care services and supports with the exception of post-acute home health services and limited skilled nursing facilities. For the remaining dual eligibles, known as "partial duals" (2.0 million), Medicaid provides assistance in paying for Medicare premiums and cost-sharing.[6]

Dual eligibles are attracting attention in part due to medical needs and associated health care costs that typically exceed those of other Medicare and Medicaid beneficiaries. For example, dual eligibles comprise 15% of Medicaid enrollees but 39% of total Medicaid spending.[7] Similarly, they represent 21% of Medicare enrollees but 36% of total Medicare expenditures.[8] The higher level of spending reflects dual eligibles' greater health needs and utilization of services compared to other Medicare and Medicaid beneficiaries. Motivated by these phenomena, the U.S. House of Representatives Energy and Commerce Committee held a hearing on June 21, 2011, focused on "Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Medicare and Medicaid were established as two distinct programs, by two different pieces of legislation. Consequently, the programs do not always work well together because they have different benefits, billing systems, enrollment, eligibility, and appeals procedures, and often different provider networks.[9] Further, states maintain that they have lacked the financial incentives to improve coordination between the two programs or to develop models that integrate Medicare and Medicaid benefits because any savings generated (for example, by reducing unnecessary hospitalizations) would be realized primarily by the federally funded Medicare program, while the program development and implementation costs would be borne by the states.

The integration of Medicare and Medicaid benefits for dual eligibles can present opportunities for innovation, as part of a broader strategy to improve care for high cost, high need populations. Such opportunities were recognized in the 2010 health reform law by the creation of the Federal Coordinated Health Care Office, now known as the Medicare-Medicaid Coordination Office, which is charged with improving the integration of Medicare and Medicaid benefits for dual eligibles.[10] The Office's Alignment Initiative seeks to "identify and address conflicting requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless, and cost-effective care for dual eligible

---

[5] Kaiser Family Foundation, "Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries," May 2011.

[6] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," May 2011; see also Kaiser Family Foundation, "Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries," Dec. 1999 (finding that only 16 states paid co-insurance at the full Medicare rate in 1999, down from 31 who did so in 1997).

[7] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," May 2011.

[8] Kaiser Family Foundation Program on Medicare Policy, "The Role of Medicare for the People Dually Eligible for Medicare and Medicaid," January 2011.

[9] Id.; see also Janet Adamy, "Overlapping Health Plans are Double Trouble for Taxpayers," The Wall Street Journal, June 27, 2011.

[10] Patient Protection and Affordable Care Act, § 2602 (2010).

beneficiaries."[11] To this end, the Office issued a Notice for Public Comment, seeking input on "opportunities to align potentially conflicting Medicaid and Medicare requirements."[12] Additionally, the Office is making available Medicare parts A, B and D data for dual eligibles to support States' care coordination efforts.[13]

The Medicare-Medicaid Coordination Office also is working with the Center for Medicare and Medicaid Innovation (CMMI), which awarded design contracts in April 2011, of up to $1 million each to 15 states to develop service delivery and payment models that integrate care for dual eligibles.[14] The states include California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.[15] The initial proposals submitted by states, on which the analysis in this brief is based, were limited to ten pages and were intended to succinctly present the states' initial concepts, in advance of meaningful stakeholder dialogue. States' initial proposal submissions were not intended to reflect their final designs and are expected to evolve based on stakeholder input and further design work. Over a period of 12 months, participating states will further develop their proposed designs, resulting in proposals that describe how they would "structure, implement and evaluate an intervention aimed at improving the quality, coordination and cost-effectiveness of care" for dual eligibles.[16] At the conclusion of the design phase, CMS will determine which of these states' proposals will move into the implementation phase, pending approval of the design and availability of funds.[17] Implementation of selected proposals is targeted for 2012.[18]

In July 2011, CMS released a "State Medicaid Director" letter containing preliminary guidance on opportunities to align Medicare and Medicaid financing, which outlines a capitated integration model and a fee-for-service integration model that CMS would like to test for full duals in the 15 states participating in the design contracts as well as in other interested states.[19] At least some of 15 states' initial design proposals may be modified in response to this guidance. The capitated model involves a three-way contract between CMS, the state and participating health plans, in which plans would receive a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports.[20] The Medicare and Medicaid payment rates under the capitated model are intended to allow

---

[11] Dep't of Health & Human Servs., Centers for Medicare and Medicaid Servs., "Medicare and Medicaid Programs: Opportunities for Alignment Under Medicaid and Medicare," 76 Fed. Reg. 28196-28207 (May 16, 2011).
[12] Id.
[13] CMS Medicare-Medicaid Coordination Office-Center for Medicaid, CHIP and Survey & Certification Informational Bulletin, Access to Medicare Data to Coordinate Care for Dual Eligible Beneficiaries, May 11, 2011.
[14] CMS Office of Public Affairs, "15 States Win Contracts to Develop New Ways to Coordinate Care for People with Medicare and Medicaid," April 14, 2011.
[15] Id.
[16] CMS Request for Proposals, State Demonstrations to Integrate Care for Dual Eligibles.
[17] Id.
[18] Id.
[19] Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011.
[20] Id.

both CMS and the state to share savings, as compared to the lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area.[21] CMS and the state would jointly select and monitor participating plans.[22] The capitated model permits passive enrollment of duals with opt-out available on a month-to-month basis and allows states to utilize "simplified and unified" rules in areas such as supplemental benefits, enrollment, appeals, auditing, and marketing.[23]

The managed fee-for-service model to be tested involves an agreement between CMS and the state in which the state would be responsible for duals' care coordination and the delivery of fully integrated Medicare and Medicaid benefits.[24] In return, the state would be eligible for a retrospective performance payment if a target level of Medicare savings, net of increased federal Medicaid costs, and specified quality thresholds are met, with final savings determinations made by CMS.[25] Providers would continue to be reimbursed on a fee-for-service basis by CMS for Medicare services and the state for Medicaid services, and states may be permitted flexibility to better align Medicare and Medicaid benefits and to target duals in a specific geographic area.[26] States that are interested in testing either or both of the models must submit letters of intent by October 1, 2011, and will then work with CMS to meet the established terms and conditions and enter into a Memorandum of Understanding.[27] Selected demonstrations will last no more than three years.[28]

This policy brief summarizes significant characteristics of the preliminary proposals submitted by selected states for integrated care demonstrations, including the type of entity to deliver benefits, target population and enrollment, benefits package, financing, beneficiary protections, stakeholder involvement, and proposed timeframe. States submitted these initial ideas when they applied for CMS design contracts to develop comprehensive demonstration proposals. The information in this brief is based on the states' initial proposals, which were due to CMS on February 1, 2011. The concepts contained in these initial proposals are subject to and expected to change and further develop as states progress through the design process, and CMS determines which proposals will be implemented.

Characteristics of the State Integrated Care Design Contract Proposals

Existing Service Delivery Models: Existing service delivery models for Medicare and Medicaid benefits for dual eligibles typically involve little to no integration or coordination among physical, behavioral health, pharmacy, and long-term care services. The majority of dual eligibles currently

[21] Draft Template Memorandum of Understanding for Capitated Model.
[22] Id.
[23] Id.
[24] Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011.
[25] Draft Memorandum of Understanding Template for Managed FFS Model.
[26] Id.
[27] Letter to State Medicaid Directors from CMS Medicare-Medicaid Coordination Office Regarding Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011.
[28] Id.

receive their Medicare benefits through the traditional fee-for-service Medicare program, while some receive these benefits through private Medicare Advantage plans, including Special Needs Plans. All Medicare beneficiaries have the option to enroll in Medicare Advantage plans but are not required to do so. Medicare part D benefits are offered through private health plans, either as part of a Medicare Advantage plan or as a stand-alone prescription drug plan.

Similarly, the majority of dual eligibles presently receive their Medicaid-covered benefits through fee-for-service arrangements, in which providers are paid for each service supplied. However, states are increasingly transitioning to Medicaid managed care models, in efforts to improve care quality and decrease costs. Managed care arrangements include risk-based models, in which health plans (administered by state or local governmental entities or private companies) receive a fixed monthly capitated payment to provide all covered services to enrollees, and primary care case management (PCCM), in which primary care providers receive a fee to coordinate patients' specialty care, in addition to fee-for-service reimbursement. Some states exclude certain Medicaid benefits from their managed care plans. For example, behavioral health and long-term care services, including institutional care, frequently are provided outside of Medicaid managed care plans on a fee-for-service basis. Medicaid provides home and community-based long-term care services to dual eligibles primarily through waivers, most of which are financed on a fee-for-service basis, with some states moving toward managed care provision of long-term care services. Waivers allow states, with CMS approval, to deviate from federal Medicaid rules and provide services targeted to specific groups of beneficiaries (e.g., based on age or disability) and/or limited geographic regions. Consequently, Medicaid service delivery models vary significantly both across states and within states across populations and geographic areas.

Efforts to integrate the financing and delivery of care for dual eligibles thus far have been quite limited, with some notable exceptions. The Program of All-Inclusive Care for the Elderly (PACE), which is available on a limited basis and now includes approximately 20,000 enrollees, offers fully integrated Medicare and Medicaid benefits to dual eligibles over age 65 who qualify for a nursing home level of care, with capitated funding provided by both Medicare and Medicaid.

The following table details the total number of dual eligibles, as well as the number of dual eligibles enrolled in various forms of Medicaid managed care, Medicare special needs plans, and PACE, nationally and in each of the 15 states selected for integrated care design contracts.

State	Number of Dual Eligibles, 2009	Total Dual Eligible Enrollment in Medicaid Managed Care, 2009					Special Needs Plans (SNP), 2011		Number of Dual Eligibles in PACE, 2009
		Health Insuring Organizations	Managed Care Organizations	Primary Care Management Providers	Prepaid Inpatient Health Plans	Prepaid Ambulatory Health Plans	Number of Dual SNPs	Dual SNP Enrollees	
Total, United States	8,606,148	113,960	893,649	83,073	610,552	879,402	256	1,045,072	15,429
California	1,117,922	113,960	82,215	-	-	14,886	33	146,324	2,068
Colorado	70,693	-	2,788	4,786	53,278	-	5	7,870	1,356
Connecticut	88,313	-	-	-	-	-	2	4,109	-
Massachusetts	233,061	-	153	-	-	-	4	14,850	2,047
Michigan	233,942	-	-	-	-	-	2	8,487	370
Minnesota	117,797	-	49,553	-	-	-	12	38,816	-
New York	657,101	-	5,291	1,019	20,917	-	30	94,056	2,626
North Carolina	283,804	-	-	46,957	13,241	-	2	7,776	28
Oklahoma	100,340	-	-	-	-	98,219	2	752	46
Oregon	84,742	-	30,569	905	52,344	48,956	7	17,858	555
South Carolina	130,186	-	-	8,337	-	128,711	2	2,136	395
Tennessee	228,060	-	187,246	-	11,056	-	6	38,248	309
Vermont	31,593	-	14,832	-	-	-	No SNPs	-	72
Washington	141,877	-	519	-	97,637	-	3	6,103	304
Wisconsin	164,250	-	9,958	-	36,316	-	12	10,759	499

NOTE: Medicaid Managed Care Organizations include Commerical Managed Care Organizations and Medicaid-only Managed Care Organizations. In Tennessee, 192,774 dual eligibles are enrolled in the pharmacy benefit manager program and 347 dual eligibles are enrolled in the dental benefit manager program.

SOURCE: Number of dual eligibles, including dual eligibles receiving full or partial Medicaid benefits, as of December 31, 2009, available from CMS at http://www.cms.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp

Dual eligible enrollment in Medicaid managed care and number of dual eligibles in PACE from Medicaid managed care penetration rates by State as of June 30, 2009, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Number of dual SNPs from CMS SNP Landscape Source file, released October 2010. For more information, see Kaiser Family Foundation, Medicare Health Plan Tracker, available at http://healthplantracker.kff.org/topicresults.jsp?i=66&rt=2.

The Appendix to this policy brief summarizes each of the 15 states' proposals, based on the initial information submitted to CMS, which is subject to change as states proceed through the design process.

Proposed Service Delivery Models: Under the initial proposals submitted to CMS, states proposed changing their service delivery systems for dual eligibles to various forms of managed care models, including risk-based and non-risk-based. States indicated that they would explore offering different service delivery models in different geographic regions or for different subpopulations of dual eligibles. They also would retain existing PACE programs.

Two states (TN, WI) proposed to contract with risk-based private managed care organizations, which would provide services in exchange for capitated payments.

One state proposed to utilize county managed care plans (CA, also open to other models such as ACOs or PCCM enhanced FFS), and 1 state (VT) proposed having the state Medicaid agency become the managed care organization for dual eligibles.

Five states proposed using other models of care delivery, including several options that are newly available under the 2010 health care reform law. State proposals in this area included accountable care organizations, integrated care networks, and/or primary care case management (CO (hybrid ACO/PCCM involving risk capitation), CT (ICO, possible ACO), NC (PCCM), OK (ACO, PACE), OR (health homes, ACOs). ACOs are groups of medical providers that, pursuant to the health care reform law, will work together to coordinate care for Medicare beneficiaries and receive fee-for-service reimbursements. ACOs may share in cost savings resulting from care coordination if quality standards are met and also may be liable for some amount of losses.[29] Health homes are a Medicaid state plan option available under the health care reform law that allow beneficiaries with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider to coordinate the full range of primary and acute physical, behavioral health and long-term care services. [30] PCCM is a non-risk based managed care model in which primary care providers are paid a fee to manage beneficiaries' care, and reimbursements are made on a fee-for-service basis.

Five states proposed using a variety of entities (MA (managed care, direct provider networks, community health centers, medical homes, acute hospital networks, ACOs), MI (MCOs, ACOs, SNPs, other capitated entities), MN (health homes, ACO/TCC, FFS), SC (health homes, MCOs or other risk-based entities), WA (managed care, FFS)). One state would use the planning contract to determine the type of entity to be used to integrate care (NY).

Many states, including Colorado, Massachusetts, Oregon, North Carolina, Vermont, Washington, and Wisconsin, use or would plan to use their proposed integrated service delivery systems for other Medicaid beneficiaries, not just dual eligibles.

---

[29] Patient Protection and Affordable Care Act, § 3022.
[30] Id., § 2703.

Target Population: CMS's request for proposals directed states to describe plans to expand their integrated care models to include other populations and/or service areas if the models initially would be piloted on a less than statewide basis for all dual eligibles. A majority of states' initial proposals did plan to target all duals (CT, MI, NC, VT) or all full benefit duals (CA, CO, MN, OR, TN) in their demonstration models, either initially or upon full program implementation. Connecticut proposed to focus first on duals ages 65 and over receiving care in nursing facilities or the community, and expand to reach other duals in subsequent years. North Carolina's demonstration proposed to include different permutations for duals living at home, duals living in nursing homes, and duals living in adult care and assisted living homes.

State models that planned to target sub-populations of duals included Massachusetts, which proposed to focus on duals with disabilities ages 21-64 (with the new model to be used to inform an existing integrated service delivery program for elderly duals); Washington, which planned to limits its demonstration to full benefit duals who are categorically needy aged, blind or disabled; Wisconsin, which proposed to focus on duals who are elders and duals who are over 18 with physical and developmental disabilities who require a nursing home level of care; and South Carolina, which planned to limit its demonstration to duals with behavioral health diagnoses resulting in specified limitations and of a certain duration (30% of SC's duals have a serious mental illness). Four other states planned to include a special emphasis on duals with mental health needs (CO, MA, OK, OR). Massachusetts and Oregon also planned to devote particular attention to duals who use long-term care services and supports.

Part of Oklahoma's proposal focused on the subset of high risk/high cost duals. Washington planned to focus first on high risk/high cost duals and then on lower risk/lower cost duals, among the aged, blind and disabled population.

The July 2011 CMS Letter to State Medicaid Directors allows states to target duals in a specific geographic area as long as the number of duals served generates sufficient volume to evaluate the demonstration.[31]

Proposed Enrollment: Under current law, Medicare beneficiaries are not required to enroll in managed care plans for their Medicare-covered benefits. Requiring dual eligibles to enroll in the demonstration models would be a significant change, as most dual eligibles currently receive benefits on a fee-for-service basis with the option to participate in managed care. In the design contracts, five states proposed using passive enrollment, affording beneficiaries the ability to opt out (CT (both opt in and opt out would be part of design discussion), MI, SC, VT, WI (proposed opt-out after 6 months)). The capitated model described in CMS's July 2011 Letter to State Medicaid Directors permits passive enrollment of duals with an opt-out available on a month-to-month basis, contingent upon the state and CMS establishing appropriate beneficiary protections and mechanisms for sharing information with

[31] Draft Memorandum of Understanding Template for Managed FFS Model.

beneficiaries regarding their enrollment options.[32] Enrollment was proposed to be on a voluntary opt-in basis in California, Colorado, and Massachusetts's proposals, but appeared to be proposed as mandatory in Tennessee's plan.

In Minnesota, Medicaid managed care enrollment would remain mandatory for dual seniors under the integrated care proposal, but voluntary for duals ages 18 to 64 with disabilities and long-term care services, with fee-for-service options remaining. New York would consider several proposals, which might include mandatory enrollment or passive enrollment with an opt out for various groups of duals. North Carolina, Oklahoma, Oregon, and Washington's plans at this point did not specify whether enrollment would be mandatory or voluntary. Washington's proposal sought to maximize managed care enrollment, while recognizing that at least some high risk/high cost duals will likely always be served outside managed care.

Proposed Benefits Package: In their initial submissions to CMS, each of the 15 states selected for design contracts proposed to integrate Medicare and Medicaid benefits, although their initial proposals varied somewhat in terms of which specific benefits would be included. At least 8 states planned to offer duals benefits packages that fully integrated all existing Medicare (including parts A, B and D) and all current Medicaid services (MA, MI, MN (with some fee-for-service options proposed to remain for non-seniors), OR, SC, VT, WA, WI). The remaining states proposed to exclude one or more categories of Medicare and/or Medicaid services from their otherwise integrated proposed duals benefits packages.

All Medicare benefits, including those currently provided under parts A, B and D, were proposed to be integrated in the planned benefits packages for duals in California, Massachusetts, Michigan, Oregon, Vermont, and Wisconsin. Whether Medicare parts A, B and D benefits would be integrated in North Carolina and Oklahoma, and part D benefits in Minnesota, South Carolina, and Washington was unclear from the states' initial submissions. New York would use its planning contract to determine the extent of its proposed integrated benefits package.

Several states proposed to leave Medicare part D services outside their otherwise integrated benefits packages. For example, Colorado proposed to integrate Medicare parts A and B services, but not pharmacy services, although capitated behavioral health providers would be financially and contractually accountable for the quality and total cost of pharmacy benefits in some fashion. Connecticut proposed integrating Medicare parts A and B benefits, but not part D at least initially, although a pharmacist would provide medication management as part of the integrated plan's medical home team. In Tennessee's proposed model, Medicare parts A and B would be included, but part D would remain outside the integrated benefits package, although managed care coordinators would assist duals with accessing separate part D plans.

[32] Draft Template Memorandum of Understanding for Capitated Model.

Two-thirds of the participating states did not propose carving out any Medicaid services from their proposed integrated benefits packages for duals. All services currently covered under existing Medicaid state plans, including primary, acute, specialty, behavioral health, institutional, and home and community-based services, would be offered in the proposed duals integrated benefits packages in Connecticut, Massachusetts, Michigan, Minnesota, Oregon, South Carolina, Vermont, Washington, and Wisconsin.

In addition to the states named above, California also proposed blending home and community-based services funding with its funding for Medicaid acute and institutional long-term care services. The inclusion of home and community-based services in the integrated plans is potentially significant, as these services typically are provided through Medicaid waivers with capped enrollment, resulting in often lengthy waiting lists. For example, Michigan's proposal notes that more people are currently on its home and community-based services waiver waiting list than are currently receiving waiver services. Providing home and community-based waiver services through integrated benefit plans could have a positive impact on beneficiary access to these services and thereby further community integration efforts.

California has not yet determined whether to integrate behavioral health services, or alternatively, whether those services would remain separate from, although coordinated with, its planned duals integrated benefits package. The remaining states proposed continuing to exclude one or more categories of Medicaid services from their integrated benefits packages. For example, Colorado proposed to maintain its Medicaid capitated behavioral health program carve-out separately from its duals integrated benefits package, with mental health services becoming the contractual responsibility of the managed care behavioral health system, paid under risk capitation. Tennessee proposed to maintain its existing carve-outs for dental and pharmacy benefits. The extent of integration of Medicaid services was not specified in North Carolina's initial proposal.

Some states were considering using the design contracts as opportunities to identify service needs particular to and among duals. For example, based upon the limited available data, Washington has identified distinctions in Medicaid service utilization patterns among elderly duals and non-elderly duals.

One-third of the states selected for design contracts proposed to expand services for duals in their integrated benefits packages. Massachusetts was planning to offer an expanded continuum of community-based diversionary behavioral health services and community long-term care support services, with the particular services to be determined in the planning process. Michigan might offer additional social supports. Connecticut, Vermont, and Washington also were considering offering limited additional services to duals that are not currently available through Medicare or Medicaid, depending upon the amount of savings realized from their proposed integrated care delivery models.

It is not clear whether states would have the authority to alter cost-sharing requirements for dual eligibles in an integrated care model. However, Tennessee's initial proposal indicated that it is considering removing or adjusting Medicare cost-sharing requirements (payment of parts A and B

premiums, co-insurance, deductibles) and was planning to examine how to address these payments going forward. The initial proposal stated that such costs would possibly be paid, depending upon budget availability, although it was unclear whether payment would be contingent upon savings being generated from the proposed integrated care model.

The July 2011 CMS Letter to State Medicaid Directors allows states to better align Medicare and Medicaid benefits.[33]

Proposed Financing Arrangements: Under current law, Medicare pays for services provided to Medicare beneficiaries through the traditional fee-for-service program or by making capitated payments to Medicare Advantage plans. Separately, Medicaid pays for Medicaid-covered services for dual eligibles either on a fee-for-service or capitated basis. In general, several of the 15 selected states proposed to receive payments from Medicare for dual eligibles residing in their state and to integrate those payments with Medicaid dollars to coordinate the financing and delivery of care for their dually eligible population. States' initial proposals varied in the extent to which they specified how Medicare payments to the state would be determined and whether they intended to share savings attributable to the reduction of Medicare-covered services with Medicare. None of the 15 states' initial proposals were explicit in defining the level of Medicaid payments per enrollee. CMS's July 2011 Letter to State Medicaid Directors, discussed above, outlines a capitated model and a managed fee-for-service model for integrated Medicare and Medicaid financing.

Medicare Payments to States. Most states' initial proposals did not directly address how Medicare payments would be determined in their proposed integrated care models. Five states (CA, NC, OR, SC, and WA) did not mention Medicare payments. Other states (MI and WI) proposed receiving Medicare risk-adjusted, capitated payments from CMS, with the formula to be further specified in the future. Similarly, Massachusetts proposed that CMS would provide an amount equal to what Medicare would have spent on the dual eligibles absent any savings created by the new model. Likewise, Tennessee proposed using Medicare's current spending for duals to determine the amount of Medicare funding to the state.

Colorado proposed a more significant role for CMS: the State would have CMS bear the administrative costs of modifying for duals the ACC program that is being used for Colorado's other Medicaid beneficiaries and take primary responsibility for making capitated payments to Colorado's proposed integrated care management organizations and providers, with the State assuming primary responsibility for financing the data analytics, and further details to be determined in the design process.

Other states proposed receiving Medicare payments in an amount that would be more consistent with Medicare spending for dual eligibles in the Medicare Advantage or PACE programs, which could result in higher Medicare payments and higher Medicare spending. For example,

[33] Draft Memorandum of Understanding Template for Managed FFS Model.

Minnesota proposed to have Medicare payments based on PACE county payment rates. Three states (OK, OR, and NY) proposed expanding their existing PACE or Medicare Advantage Special Needs Plans (SNPs) and did not mention changes in Medicare payments for those programs. Similarly, Washington proposed exploring opportunities for the State to become the SNP operator. In these latter states, payments to Medicare Advantage plans for enrollees are generally higher than the costs of care under the traditional fee-for-service Medicare program. Lastly, Vermont proposed becoming a Medicare managed care entity, with capitated payments from Medicare to be negotiated. Becoming a Medicare managed care entity or Medicare Advantage plan would not require that Vermont receive Medicare payments equivalent to a Medicare Advantage plan, and the state has not suggested this in its preliminary proposal. However, it would seem to be in the State's financial interest to be paid as a Medicare Advantage plan since benchmarks for Medicare Advantage plans in the state are higher than the costs of Medicare fee-for-service in all counties.

Shared Savings with Medicare. Several of the states' initial proposals acknowledged the potential to achieve savings from reductions in Medicare-covered services for dual eligibles, such as emergency room visits and unnecessary hospitalizations. However, most of the 15 states' initial proposals did not address the extent to which any savings would be shared with the Medicare program. Some states indicated that they would be open to sharing some of the savings with Medicare (CT, CO, WA, WI, CA, MN, and NY); however, only Connecticut proposed a specific share: Connecticut proposed retaining 70% of program savings and sharing 30% with CMS, after the State recouped the money it would spend on care management fees paid to its ICO, with savings to be calculated based on comparisons to the projected per member per month budget target used for Medicare Advantage programs for dual SNPs. Michigan proposed to assume full financial risk for providing Medicare services to duals but was open to "moderate gain sharing" with Medicare. By contrast, Tennessee's proposal did not plan to share savings with Medicare; rather it proposed to use savings to pay for care coordination for duals and to expand home and community-based service options.

The July 2011 CMS State Medicaid Director Letter envisions both CMS and the state sharing in savings, as compared to the lower of expected fee-for-service or managed care spending for Medicare and Medicaid, respectively, for each service area under the capitated model.[34] The fee-for-service model outlined in the July 2011 Letter makes states eligible for a retrospective performance payment if a target level of Medicare savings, net of increased federal Medicaid costs, and specified quality thresholds are met, with final savings determinations to be made by CMS.[35]

State Payments to Plans and Providers. Most states' preliminary proposals planned to use capitated methods to pay their integrated care entities, either initially or eventually. For example, Connecticut initially would reimburse providers at Medicaid fee-for-service rates, with risk-based payments to be phased in during the program demonstration. Michigan proposed initially sharing risk with its managed care entities, with full risk eventually transferring to the entities. Massachusetts

[34] Draft Template Memorandum of Understanding for Capitated Model.
[35] Draft Memorandum of Understanding Template for Managed FFS Model.

proposed making one global risk-adjusted payment for all covered Medicare and Medicaid services and administrative and care management costs to its contracted entities, with details to be determined in the design process. Oregon proposed paying its regional plans primarily through capitation, Washington proposed reimbursing providers through bundled and capitation payment methods, and Wisconsin proposed paying its entities a single fully integrated risk-based capitation payment.

Some of the states' initial proposals also indicated an intention to share savings with managed care entities and/or providers. A minority of states have committed to make gain sharing payments to plans and/or providers at this stage of the design. For example, Colorado's plan would put health homes at risk for care outcomes by offering incentive payments contingent upon actual improvement in health outcomes. Connecticut also proposed sharing with its ICOs program savings, using a combined Medicare/Medicaid budget target, that exceed the cost of care management fees. In turn, Connecticut would expect its ICOs to share part of the savings with providers through performance incentives. Oregon proposed using payment incentives for its integrated plans, with little additional detail provided in its initial proposal. Oklahoma proposed dedicating one of its pilot programs' savings to the public good by expanding medical education programs.

Several other states proposed to use the design stage to determine whether or how to share savings with plans and providers. For example, Massachusetts' demonstration proposed modeling strategies for designing incentive payments to integrated care entities, including shared savings arrangements, during the design phase. Minnesota proposed to use its demonstration to develop risk-adjusted performance measures and provider gain and loss sharing payment models specific to duals and duals subgroups. Wisconsin might share savings with managed care entities, and NY proposed to explore gain sharing with providers during the program design.

The capitated model described in the July 2011 CMS State Medicaid Director Letter envisions plans receiving a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports.[36]

Integration of Medicare/Medicaid Funds. Some but not all state proposals indicated at this point how they would integrate funds from Medicare and Medicaid. At least 6 states proposed to combine funds at the state level (MA, MI, part of OK's program, TN, WI, VT). California proposed to determine whether to combine funding at the state or plan level during planning for its demonstration. The remaining eight states did not address this issue explicitly in their initial proposals.

Beneficiary Protections: Nearly all of the states' initial proposals did not provide detail on how beneficiaries' rights would be protected.[37] CMS did not require states to provide great detail on this or other aspects of state plans in their initial proposals, which are only the starting points for beginning the

[36] Draft Template Memorandum of Understanding for Capitated Model.

[37] For specific recommendations for consumer protections in this area, see National Senior Citizens Law Center, "Ensuring Consumer Protection for Dual Eligibles in Integrated Models," July 2011.

design process. In their initial proposals, some states did acknowledge that different rules currently govern grievances, appeals, marketing, enrollment and member materials under Medicare and Medicaid, but only California explicitly stated that it planned to hold its pilots "the highest standard" where conflicts exist between Medicare and Medicaid rules for member rights and benefit determinations.

A few states mentioned preserving continuity of care with duals' current providers, but no further details were provided at this point about how safeguards to ensure adequate provider network capacity would be implemented and enforced. Connecticut proposed to permit individuals to seek care through their choice of provider whether or not a provider was affiliated with their ICO. Connecticut's proposed integrated care network design intentionally would include both large and small primary care providers, in an effort to continue duals' relationships with their existing providers and strengthen provider collaboration. Colorado proposed to recruit existing providers in an effort to preserve existing care relationships.

The July 2011 CMS State Medicaid Director Letter allows states electing the capitated model to utilize "simplified and unified" rules in areas such as supplemental benefits, enrollment, appeals, auditing, and marketing.[38]

Stakeholder Involvement: All the states' initial proposals included plans for a variety of stakeholder involvement initiatives, such as focus groups, interviews, existing or newly created advisory workgroups or legislative oversight bodies, public meetings, and web-based outreach to aid in program design. It is important that stakeholders, including dual eligibles themselves, have meaningful opportunities to provide input throughout the design process.

Key Issues to Consider Moving Forward

The initial proposals forming the basis for the design contracts enable states to receive funds to further develop their plans to integrate the financing and delivery of care for Medicare beneficiaries who are also covered by Medicaid. States' design plans will continue to evolve throughout this process, and they must submit final design proposals to CMS by April 2012.[39] Implementation of the proposals is not guaranteed and is contingent upon CMS approval of the final design and availability of funding.[40] The 2010 health reform law allows models tested through CMMI to be expanded if they either (1) reduce spending while improving or maintaining quality, or (2) improve patient care without increasing spending, giving CMS considerable flexibility in determining which state plans will go forward.

The design projects could present opportunities to improve the coordination of care, improve the quality of care, and potentially reduce costs, while widening access to home and community-based long-term care services. Data linkages and analysis emerging from these projects have the potential to

[38] Draft Template Memorandum of Understanding for Capitated Model.
[39] CMS Request for Proposals, State Demonstrations to Integrate Care for Dual Eligibles.
[40] Id.

identify service utilization patterns among subgroups of dual eligibles, which could further inform benefits package design and service delivery improvements and identify opportunities to reduce unnecessary and costly service use. Meaningful participation and involvement by stakeholders, including beneficiaries, is vitally important to successful project design and implementation as states move forward in this process. Given the vulnerability of the dual eligible population, and their rights as Medicare and Medicaid beneficiaries, careful design and oversight of integrated care models is required. While integrated care models may improve services and reduce costs over the long-term, current state budgetary pressures might affect states' administrative capacity to devote sufficient resources to effectively plan and execute these projects. At the same time, states also must work to implement the Medicaid expansion, health insurance exchanges, and other aspects of health care reform by January 2014.

As policymakers move beyond the planning phase, they may want to consider a number of issues related to integrated care for dually eligible beneficiaries.

Enrollment. Under current law, enrollment in a managed care plan as an alternative to the fee-for-service Medicare program is voluntary for all beneficiaries, and most dual eligibles currently are covered under the fee-for-service program. What are the implications of requiring low-income dually eligible beneficiaries to enroll in a managed care plan for their Medicare-covered benefits, as in some states' current proposals, thus treating low-income Medicare beneficiaries differently from all other Medicare beneficiaries? If enrollees were dissatisfied with the coverage and care, could they disenroll and retain their Medicare benefits? How would dual eligibles be informed about plan choices and enrollment and disenrollment procedures in states' integrated care design models?

Benefits, Cost-Sharing, Provider Access, and Appeals. What services would the integrated benefits package contain? Would states be permitted to modify or restrict benefits and cost-sharing arrangements currently available under Medicare and Medicaid? Given the current inadequate supply of home and community-based long-term care services, to what extent would the integrated care proposals expand access? What measures would be taken to minimize disruptions in care arrangements so that elderly and disabled dually eligible beneficiaries who have long-standing ties to their providers would not be required to switch doctors under the new state programs? Would dual eligibles be subject to Medicaid or Medicare rules pertaining to grievance and appeals procedures?

Financing. Several states proposed to combine Medicare and Medicaid funding in their demonstration projects. A potential change in the administration of Medicare funds raises some questions pertaining to Medicare spending and program integrity that are significant in light of the fiscal challenges facing the Medicare program. For example, how much would Medicare pay states to provide Medicare-covered services for the dual eligible population, and how would these payments be calculated? What are the cost implications for Medicare, if payments to states were based on Medicare Advantage benchmarks, as some states currently proposed? What share of the savings associated with reduced use of Medicare-covered services, such as emergency room visits and hospitalizations, would be retained by the states, and what portion would be shared with the Medicare program? How would

CMS track and audit Medicare spending and savings by the states to maintain the fiscal integrity of the Medicare program?

Program Evaluation. What role would CMS and the states play in monitoring quality and access to care under the new integrated programs, and will evaluations be timely? How would CMS and states assess the extent to which plans have the capacity and experience to serve a population with significant medical and long-term care needs and frailties?

While integrating the benefits and financing of Medicare and Medicaid has the potential to improve the efficiency and quality of care for dual eligibles, these questions and others warrant careful consideration as the integrated care designs are further developed.

This policy brief was prepared by MaryBeth Musumeci, John Connolly and Jhamirah Howard of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured and Gretchen Jacobson of the Kaiser Family Foundation Program on Medicare Policy.

Appendix:

Summaries of the 15 State Design Contracts Funded by CMS to Integrate Medicare and Medicaid Service Delivery and Payment for Dual Eligibles

The following charts summarize the major characteristics of the initial proposals for the 15 state design contracts funded by CMS to develop service delivery and payment models that integrate care for dual eligibles under the Medicare and Medicaid programs. This analysis is based upon the states' original ten-page submissions to CMS, which are expected to evolve during the design process. At this point, CMS has neither endorsed any of the proposals nor committed to moving any of them forward into the implementation process. Those decisions will be made after the states' final proposals are submitted.

The 15 states include:

-California

-Colorado

-Connecticut

-Massachusetts

-Michigan

-Minnesota

-New York

-North Carolina

-Oklahoma

-Oregon

-South Carolina

-Tennessee

-Vermont

-Washington

-Wisconsin

Copies of the states' initial proposals are available at the Families USA website, http://www.familiesusa.org/issues/medicare/state-demonstrations-to.html .

California:

Current Service Delivery Model for Dual Eligibles:*	
1.1 million dual eligibles in California (2009); about 13 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, 10 percent received Medicaid benefits through Medicaid Health Insuring Organizations, and 9 percent received Medicaid benefits through other Medicaid managed care plans in 2009, according to CMS. Most dual eligibles in CA received Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	State legislation directs Medi-Cal to implement integrated care pilots in 4 counties, including at least 1 managed by a County Organized Health System (strong interest expressed by San Mateo and Orange Counties) and at least 1 in the Two-Plan County Model. PACE would remain an option in counties where it is available. State is also open to other models, such as ACOs or PCCM enhanced FFS. Would also explore other integrated care options for duals in rural areas.
Target Population and Enrollment:	Initially would target all full benefit duals in 4 pilot counties (up to 150,000 duals). Planning to expand statewide by 2015, affording all dual eligibles the option to enroll in fully integrated system of care. Would have special focus on duals with mental health needs.
Proposed Integrated Benefits Package:	*Medicare*: Would include all medical services currently covered by Medicare parts A, B, and D.
	Medicaid: Would include all medical services covered by Medi-Cal, including services that Medicare does not cover, and coinsurance, copayments and deductibles for Medicare-covered services (Medicare part A and B premiums currently paid by State would continue to be paid outside of pilot programs). Would include coverage of LTCSS (might vary depending upon readiness of pilot areas and plans; services to be considered for integration include institutional LTC, HCBS waiver services, personal care, adult day health care, home modifications, meals, paramedical/nursing services, and physical, speech and occupational therapies). Would blend HCBS funding with acute and LTC institutional funding to align incentives to stay out of institutions. Would explore coordination with or coverage for behavioral health (including specialty MH and DD waiver services and community behavioral health services).
Proposed Financing:	*Medicare Payments to State:* Proposes that Medicare would make payments to state for services covered under Medicare parts A, B and D. Does not specify how Medicare payments to state would be calculated.
	Shared Savings with Medicare: State is open to developing shared-savings program across Medicare and Medi-Cal, but no specifics are proposed at this point.
	Plan to Combine Medicare and Medicaid Funds: Design process, including stakeholder involvement, would determine whether Medicare and Medicaid funding would be combined at state or plan level.

	Shared Savings with Integrated Entities and/or Providers: Not specified in initial proposal.
Beneficiary Protections:	Would use single set of rules for grievances, appeals, marketing, enrollment, and member materials. Would hold pilots to "the highest standard" where conflicts exist for member rights and benefit determinations. Expressed interest in preserving beneficiary choice of providers.
Stakeholder Involvement:	Stakeholder engagement process in 2010 identified core "achievable principles" for integrated care. Major stakeholder meetings in May 2011, October 2011 and March 2012. Targeted outreach to stakeholders July through September 2011. Local stakeholder meetings to commence after pilot announcement in March 2012.
Proposed Implementation Timeframe:	Demonstration plan to be submitted to CMS – Sept. 1, 2011 Request for Proposals to be issued – October 2011 Pilot sites and contractors to be announced – March 2012 Pilots to be launched– Last quarter 2012

***** Source: Data contained in Table 1, supra.

** Source: Calif. Dep't of Health Care Servs., Response to Request for Proposals, Jan. 28, 2011.

Colorado:

Current Service Delivery Model for Dual Eligibles:*	
Of the almost 71,000 duals in Colorado, 13 percent received Medicare covered benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, most (75%) received Medicaid inpatient benefits through Medicaid prepaid inpatient health plans and 11 percent received Medicaid benefits through managed care organizations or primary care management providers in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Would enroll duals in state's Accountable Care Collaborative (ACC) Program, a hybrid model with ACO and PCCM characteristics with emphasis on medical home model of care (ACC rolling out Spring 2011, without duals, and is to become primary delivery system for all Medicaid clients); 3 elements: Regional Care Collaborative Organizations (RCCOs – voluntary managed care/risk capitation program), Primary Care Medical Providers (PCMPs), and Statewide Data and Analytics Contractor (SDAC); health homes would be multidisciplinary teams including PCMP, behavioral health capitation provider, and LTC provider/case manager
Target Population and Enrollment:	Would expect participation of at least 30,000 full benefit duals statewide to start and would target all duals statewide; would have special focus on duals with mental health needs. Enrollment would be voluntary.
Proposed Integrated Benefits Package:	*Medicare:* Parts A and B would be included in integrated benefits package. Part D pharmacy would not move into risk contract.
	Medicaid: Would continue to offer existing services. State would evaluate options to redesign benefits packages after data analysis, including development of profile for subgroups of duals that share similar health status. Would link physical and behavioral health systems with LTC services and support systems. RCCOs would coordinate care with Medicaid capitated behavioral health carve-out, with mental health services to become the contractual responsibility of the managed care behavioral health system, to be paid under risk capitation.
Proposed Financing:	*Medicare Payments to State:* Medicare would take primary responsibility for payments to managed care/risk contract programs and primary care medical provider, with specific amounts to be determined. Medicare also would pay for administrative costs for the Accountable Care Collaborative program.
	Plan to Combine Medicare and Medicaid Funds: Precise nature of shared financial responsibility for duals would be determined by in-depth analysis after contract award. Not specified further in initial proposal. See above.
	Shared Savings with Medicare: State would be willing to share financial risk. No further details specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: RCCOs and PCMPs would receive PMPM payment and opportunity for incentive

	payments based on outcomes. Anticipate using gain-sharing payments similar to ACO shared savings model; would put health homes at risk for outcomes with incentive payments contingent upon actual improvements in health outcomes; would evaluate options for model provider payment reforms after data analysis. Capitated behavioral health providers would be financially and contractually accountable for quality and total cost of pharmacy benefit. No further details specified in initial proposal.
Beneficiary Protections:	Would recruit duals' existing providers to serve as PCMPs so as to not disrupt established care relationships.
Stakeholder Involvement:	Existing advisory committees' monthly meetings, 2 stakeholder public forums. Would establish workgroup with representatives from health plans, PACE, SNPs, case management agencies, mental health organizations, LTC service providers, primary care clinics and public health programs. Center on Improving Value in Health Care, which convenes stakeholders, would partner in finalizing payment reforms. Program design progress would be available on website.
Proposed Implementation Timeframe:	Plan to be submitted to CMS – January 1, 2012 Duals to be enrolled in ACC Program – October 1, 2012 Full implementation would be prior to end of 2012

***** Source: Data contained in Table 1, supra.

** Source: Colorado Dep't of Health Care Pol'y and Financing, Proposal for State Demonstrations to Integrate Care for Dual Eligible Individuals, updated March 17, 2011.

Connecticut:

Current Service Delivery Model for Dual Eligibles:*	
88,000 dual eligibles with the vast majority (96%) in the state receiving Medicare and Medicaid benefits on a fee-for-service basis; only 5 percent received Medicare covered benefits through Medicare Advantage SNPs for dual eligibles, and no dual eligibles were enrolled in PACE plans or received Medicaid benefits through Medicaid managed care plans in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	State would contract with local Integrated Care Organization (ICO) provider consortia. Might build ACO model as part of demonstration. ICOs would feature partnerships among multiple provider types and offer health home to access enhanced seamless services. Each ICO would have 1 or more primary care centers or hubs to make a broad array of healthcare professionals and services available, especially for individuals with multiple serious chronic or disability conditions, unstable conditions, or who need LTC. At least 1 center in each ICO would be Tier 1, likely to be FQHCs, large physician groups, hospitals, nursing facilities, adult day care centers, and local mental health or substance abuse treatment agencies. ICOs also would be encouraged to include Tier 2 centers, small primary group practices that provide less than full complement of Tier 1 services and receive Tier 1 support. Goal would be to continue successful relationships with duals' existing array of providers, while strengthening provider collaboration and aligning incentives.
Target Population and Enrollment:	Initial participation would be offered to all full and partial duals ages 65 and over receiving care in nursing facilities and community (not HCBS waiver participants initially, other than the Home Care Program for Elders waiver; Medicare Advantage Plan enrollees would remain there unless opt otherwise) – 13,000 to 20,000 estimated initial enrollment. Initially, estimated to have 3 to 6 ICOs statewide. In year 3, expand to duals under age 65 and younger duals with disabilities. Eventually, would be statewide. Goal would be for all duals to have at least one ICO available by end of year 3. Individuals under the care of a primary care provider associated with a participating ICO would be attributed to that ICO, with individual freedom of choice to switch to another available ICO or disenroll from the demonstration at any time. Opt in and opt out attribution methodologies would be part of the design discussion.
Proposed Integrated Benefits Package:	*Medicare:* Would include the full range of primary, acute, specialty, behavioral health, and institutional services currently provided by Medicare. Would consider creating customized benefits packages with services not currently available under Medicare or Medicaid, to be funded by State, if sufficient savings were generated. At least initially, prescriptions would continue to be provided through Medicare part D plans, but pharmacist would be member of medical home team to provide medication management. Tier 1 services would include PCPs, RNs, care coordinators, HCBS case managers, pharmacist, and behavioral health practitioners, and would provide

	comprehensive initial and annual assessments, home visits, preferred specialty care networks, assistance with linking to services such as transportation, person centered care plans, medication management, hospital rehabilitation and nursing facility transition coordination, dementia assessment, nutrition counseling, intensive case management, onsite level of care assessments, EMR, dedicated team to address questions, and State dual eligibles ombudsman.
	Medicaid: Would include full range of primary, acute, specialty, behavioral health, HCBS and institutional services currently provided by Medicaid. As demonstration expanded to all duals, would have access to services provided by HCBS waivers. Also would include state funded wrap-around HCBS for elders who do not meet waiver LOC requirements or for elders who meet LOC but do not meet Medicaid financial eligibility.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Proposal for Combining Medicare and Medicaid Funds: See above.
	Shared Savings with Medicare: CMS would retain 30% total savings realized in each year of demonstration, and 70% would flow to State. Savings would be measured against projected PMPM budget target, calculated based on the approach used by Medicare Advantage program for duals SNPs (to include risk adjusted payments and adjustments for Medicare program changes and fee schedules outside the State's control). Additional adjustments might be needed to reflect any risk characteristics not currently reflected in the Medicare Advantage program rate-setting methodology, such as differentiation by nursing home versus community. Any savings up to maximum of State's contribution of care management fee would accrue 100% to State before shared savings formula applied.
	Shared Savings with Integrated Entities and/or Providers: State would share any combined Medicare/Medicaid savings with ICOs using a combined Medicare and Medicaid budget target. Medicare target would be calculated as described above. Medicaid target would be risk adjusted. State would initially fund PMPM case management fee for duals attributed to an ICO to help fund infrastructure costs, retain additional staff, perform assessments, and support incentive payments to provider partners. Any shared savings between State and ICO would be reduced by PMPM fee, so that ICO would be expected to generate savings at least equal to case management fee paid by Medicaid before any additional savings would be paid to ICO by State. Amount of shared savings to ICO would depend on ICO's ability to meet quality and outcome targets. Part of savings disbursed to ICOs would be expected to be directed to ICO practices and network partners in the form of performance incentives. Initially, State would pay providers at prevailing Medicaid fee schedules (FFS

	reimbursement but would establish risk-adjusted global budgets to assess ICOs' effectiveness in managing overall cost). During planning, would examine alternative reimbursement models, such as global capitation, partial capitation, and episode-based bundled payments, to be phased-in during demonstration.
Beneficiary Protections:	Individuals would be permitted to seek care through their choice of provider whether or not provider is affiliated with their ICO. Quality and outcome targets for shared savings returnable to ICO would include measures of beneficiary satisfaction.
Stakeholder Involvement:	Would continue existing collaborations with stakeholders – support for this proposal was received from over 30 groups representing consumer advocates, providers and other state agencies. Legislative oversight body would provide input into demonstration design and implementation. ICOs would be required to have advisory board including duals, family caregivers and advocates.
Proposed Implementation Timeframe:	Target implementation October 1, 2012.

***** Source: Data contained in Table 1, supra.

** Source: State Demonstrations to Fully Integrate Care for Dual Eligible Individuals, State of Connecticut Response to CMS Solicitation.

Massachusetts:

Current Service Delivery Model for Dual Eligibles:*	
More than 233,000 dual eligibles in Massachusetts (2009); about 7 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, and less than 1 percent received Medicaid benefits through Medicaid managed care plans in 2009, according to CMS. Most dual eligibles in Massachusetts (93%) received Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	MassHealth would assume complete operational responsibility for care, including administration, management and oversight, of all Medicare and Medicaid funded services. MassHealth would use combined Medicare and Medicaid funding to contract with entities to integrate comprehensive care and provide both MassHealth and Medicare services. Potential bidders may include a variety of existing and emerging entities – managed care entities, direct care provider networks, community health centers, patient centered medical homes, acute hospital networks, ACOs.
Target Population and Enrollment:	Would target all full benefit duals ages 21 to 64 – 115,000 statewide. Subgroup of concern would be individuals with behavioral health needs. Would use strategies to encourage maximum participation/enrollment. Experience with this new model would inform potential improvements for existing service delivery to elderly duals and MassHealth only enrollees.
Proposed Integrated Benefits Package:	*Medicare:* Would include all Medicare parts A, B, and D services. Integrated entities would have a foundation of primary care practices that possess core competencies for patient centered medical homes, with highly developed acute, primary care, behavioral health, and LTSS networks.
	Medicaid: Would include all current Medicaid state plan services and an expanded continuum of community-based diversionary behavioral health services and community support services. Planning funds would be used to finalize service package and to determine which additional LTCSS would be most effective to include in benefits package.
Proposed Financing:	*Medicare Payments to State:* CMS would provide a negotiated Medicare payment per participant to State, with funding to be consistent with the amount Medicare would have spent absent any savings created by new model. In design phase, State would develop with CMS the methodology to determine the appropriate level of Medicare payment.
	Plan to Combine Medicare and Medicaid Funds: Would combine at State level.
	Shared Savings with Medicare: In design phase, State would assess risk adjustment approaches and mechanisms, such as shared savings and/or risk corridors, with CMS. No further detail provided in initial proposal. Initial savings estimates project 1.5% to 2.0% of savings

	(including a decrease of 5.5% on Medicare-covered services and an increase of 1.25% on Medicaid-covered services) in the first year, after accounting for additional administrative expenses and service package enhancements. Savings are projected to grow in subsequent years.
	Shared Savings with Integrated Entities and/or Providers: State would make one global payment for all covered Medicare and Medicaid services and administrative and care management costs, using risk adjustment, to contracted entities. Design phase would assess risk adjustment approaches and model shared savings arrangements with integrated entities.
Beneficiary Protections:	Would protect individual rights consistent with Medicare and Medicaid principles. Further details unspecified in initial proposal.
Stakeholder Involvement:	Convened consumer advocates group of over 30 organizations that serve duals ages 21-64. Engaged other state agencies in design. Focus groups with beneficiaries. Request for Information in Feb. 2011 sought input from providers and potential delivery system partners. Public meetings.
Proposed Implementation Timeframe:	Would award contracts to integrated care entities by Fall 2012.

***** Source: Data contained in Table 1, supra.

** Source: Commonwealth of Massachusetts, Executive Office of Health and Human Servs., Office of Medicaid, Proposal in Response to the Center for Medicare and Medicaid Innovation: State Demonstrations to Integrate Care for Dual Eligible Individuals , Jan. 28, 2011.

Michigan:

Current Service Delivery Model for Dual Eligibles:*	
Of the nearly 234,000 duals in Michigan, less than 4 percent received Medicare covered benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, and no dual eligibles received Medicaid benefits through Medicaid managed care plans in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	State Medicaid program would serve as designated entity assuming complete financial and administrative oversight for Medicare and Medicaid funds and services for duals. State would contract with entities to manage and coordinate care on local level – traditional MCOs, ACOs, SNPs, other capitated entities. Delivery model would include robust care coordination program with health homes with a single care coordinator and comprehensive provider network. Would assess practicality of more than one model in dissimilar areas of state (ACO, MCO).
Target Population and Enrollment:	Would target all dual eligibles – estimated 220,050 by April 2012. Statewide basis as soon as feasible based on provider readiness in various regions, with phased-in implementation. Enrollment would be mandatory to achieve economies of scale but would offer choice to opt out of plan.
Proposed Integrated Benefits Package:	*Medicare:* Would include acute, pharmacy, long term and behavioral health. Would include all core Medicare services with potential for additional social supports. Would use single standardized assessment tool to determine beneficiary needs.
	Medicaid: Would include acute, pharmacy, long term and behavioral health. Would include all core Medicaid services with potential for additional social supports. Design phase would include planning to integrate behavioral health and LTC waiver services.
Proposed Financing:	*Medicare Payments to State:* Medicare payments would be based on historical utilization and Medicare spending for dual eligibles in the state.
	Plan to Combine Medicare and Medicaid Funds: Would be combined at state level.
	Shared Savings with Medicare: State proposes assuming full financial risk for Medicare services for duals, but is open to moderate gain sharing.
	Shared Savings with Integrated Entities and/or Providers: Risk initially would be shared between State and managed care entities, with full risk for Medicare and Medicaid services eventually to be transferred to contractors. Rate setting structure and payment methodology would be determined during model development.
Beneficiary Protections:	Would use grievance and appeal procedures that meet standards required by both Medicare and Medicaid. Further details not specified in initial proposal.
Stakeholder Involvement:	Statewide process for input during Summer 2011 – regional stakeholder meetings of consumers, providers and advocacy groups.

	Website to be developed to distribute information and respond to questions.
Proposed Implementation Timeframe:	Implement proposal – April 2012.

***** Source: Data contained in Table 1, supra.

** Source: Michigan's Response to CMS Solicitation State Demonstrations to Integrate Care for Dual Eligible Individuals.

Minnesota:

Current Service Delivery Model for Dual Eligibles:*	
Nearly 118,000 dual eligibles in Minnesota (2009); about 33 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles, with no dual eligibles enrolled in PACE plans, and 42 percent received Medicaid benefits through Medicaid managed care organizations in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Proposal would further integrate SNBC physical and behavioral health coverage with FFS LTCS through HCH relationships, perhaps including financial incentives or risk sharing. Proposal would (1) fill in gaps in implementation of statewide Medicare and Medicaid HCH program for duals; (2) advance provider level payment reforms, including integrated Medicare and Medicaid ACO/TCC models to improve coordination for duals enrolled in both FFS and managed care; and (3) stabilize payments for current integrated programs.
Target Population and Enrollment:	Would target all 106,629 (monthly average) full benefit duals statewide. All dual seniors already are required to enroll in Medicaid managed care and choose between MSHO and MN Senior Care Plus – includes 37,000 duals in 8 nonprofit SNPs. People with disabilities ages 18-64 are not required to enroll in managed care but currently may enroll voluntarily in SNBC for integrated primary, acute and behavioral health services with HCH, through 6 MCOs, 5 of which are also integrated Medicare/Medicaid SNPs. Proposal would expand SNBC statewide (currently in all but 9 counties). Current state policy is to preserve choice between managed care and FFS for duals with disabilities and for LTC to remain FFS.
Proposed Integrated Benefits Package:	*Medicare:* Proposal would include comprehensive coverage for Medicare and Medicaid primary, acute, behavioral, and long-term care services for seniors under MSHO. People with disabilities could end up with separate care plans for county SNP, LTC, behavioral health, and HCH, but would expect one caregiver to have oversight of all care coordination efforts and clear identification of party with primary responsibility for each component of care plan. Integration of part D benefits not specified in initial proposal.
	Medicaid: Both MSHO and MSC+ include Medicaid coverage for primary, acute, mental health, and LTC and all elderly waiver services for dual seniors. MSC+ is not integrated with Medicare. SNBC is designed especially for people with disabilities and includes most state plan services and all Medicaid mental health services.
Proposed Financing:	*Medicare Payments to State:* Medicare payments would be calculated using the PACE county rate book.
	Plan to Combine Medicare and Medicaid Funds: State proposes to build new HCH/ACO/TCC provider payment models with aligned incentives between Medicare and Medicaid in both FFS and managed care. MCOs, including DE-SNPs, would have to provide payments to

	certified HCHs.
	Shared Savings with Medicare: Would explore shared savings models with CMS for the State's dual eligible SNPs in place of the current bid process. Additional detail not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: SNPs have already adopted payment models that align incentives through risk or gain sharing with providers, but State lacks consistent measures to evaluate effectiveness of care of duals across SNP-based TCC models. The state would develop risk adjusted performance measures and provider gain and loss sharing payment models specific to duals and dual subgroups in FFS and managed care.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Would consult existing stakeholder groups and establish Dual Demo Stakeholder group.
Proposed Implementation Timeframe:	Final report to CMS, February 2012. Implementation, May 2012.

***** Source: Data contained in Table 1, supra.

** Source: Minnesota Dep't of Human Servs., Design Proposal State Demonstrations to Integrate Care for Dually Eligible Individuals, Feb. 1, 2011.

New York:

Current Service Delivery Model for Dual Eligibles:*	
More than 657,000 dual eligibles in New York (2009); almost 15 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, and 3 percent received Medicaid inpatient benefits through Medicaid prepaid inpatient health plans, while less than 1 percent received Medicaid benefits through managed care organizations or primary care management providers in 2009, according to CMS. Most dual eligibles in New York received Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Propose developing options to more fully integrate Medicare and Medicaid services for duals, including primary, acute and LTCS. Proposal options: (1) NY would assume full risk – state would integrate delivery, management, and administration of all Medicare benefits with Medicaid; (2) Would promote existing managed LTC initiatives – (a) would increase enrollment by mandating enrollment in Medicaid Advantage and Medicaid Advantage Plus for duals already enrolled in Medicare managed care plan, (b) would allow Medicaid managed care plans to passively enroll members who become Medicare eligible into their Medicare managed care product with ability to opt out, (c) would require duals age 21+ in need of community based LTC to enroll in comprehensive coordinated model of care, (d) would require all dual SNPs to develop and market products integrating Medicare and Medicaid; (3) Would provide care coordination for nursing home residents by enrolling in Medicare SNPs; (4) PACE without walls, which would allow for duals to maintain existing provider relationships in community, and/or would allow duals under 55 to participate in PACE model designed for their needs; (5) Gain sharing demonstration – would provide care management function through Medicaid for duals without taking on full risk for Medicare benefit package; (6) Managed care for people with DD – would develop and pilot specialized care coordination or managed care models to provide medical and LTC for duals with DD, with emphasis on primary and preventative care. With availability of Medicare data, State would be better able to craft demonstration responsive to duals' needs.
Target Population and Enrollment:	Target population TBD based on data analysis and stakeholder input. Enrollment in managed care currently voluntary. Changes if any TBD. Passive enrollment options with opt out at any time should be considered.
Proposed Integrated Benefits Package:	*Medicare:* TBD. Plan to more fully integrate primary, acute and LTC services. Further details not specified in initial proposal.
	Medicaid: TBD. See above.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: For managed care for persons with DD, care manager would receive capitated payments from both the Medicare and Medicaid programs and be at risk for the

	cost of all services for the enrolled population. Additional detail was not provided with respect to combining financing for other elements of the proposal in the initial submission to CMS.
	Shared Savings with Medicare: TBD. Gain sharing demonstration savings would be shared between state, providers and Medicare. No further details provided in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: TBD. See above.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	To hold series of stakeholder meetings and interviews.
Proposed Implementation Timeframe:	Implementation – October 2012.

***** Source: Data contained in Table 1, supra.

** Source: State Demonstrations to Integrate Care for Dual Eligibles: The New York State Dep't of Health Proposal, Jan. 28, 2011.

North Carolina:

Current Service Delivery Model for Dual Eligibles:*	
Nearly 284,000 dual eligibles in North Carolina (2009); almost 3 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans. Nearly 17 percent received Medicaid primary care benefits through primary care management providers and 5 percent received Medicaid inpatient benefits through prepaid inpatient health plans in 2009, according to CMS. Most dual eligibles in North Carolina receive Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Propose new statewide delivery system that would build on Community Care of North Carolina (CCNC), the existing statewide population management system, which includes access to primary care medical homes, care management and provider collaboration. Integration strategy would be built around duals' living arrangements: (1) Duals living at home – CCNC's Chronic Care Program for aged, blind, and disabled emphasizes enhanced case management with strong ties to medical homes and connections with community based LTC providers and hospitals – patient- centric to address physical, social, and behavioral health needs – would use best practices from this program for integrated duals system (see below under Benefits Package); (2) Duals living in nursing homes – would integrate Chronic Care Program services into nursing home setting and would develop targeted nursing home integration plan to improve transitions in care and manage prescription drugs; would also work to reduce need for hospitalizations through nurse practitioners tied to CCNC networks and medical homes to supplement nursing home staff in providing early identification and preventable care; (3) Duals living in adult care and assisted living homes – no clinical staff on site, would develop integrated care program to improve management of patient care through better assessment, communication, and outreach – current pilot in 27 homes.
Target Population and Enrollment:	Would target all duals statewide – 284,160. Initial proposal does not specify whether enrollment would be mandatory or voluntary.
Proposed Integrated Benefits Package:	*Medicare:* Inclusion of parts A, B, and D not specified in initial proposal. Would provide services from Community Care networks 646 demonstration best practices, including: -Home visits to patients by case managers after discharge. -Medication reconciliation through network pharmacists. -Embedding nurse practitioner in primary care practice to perform home visits to all patients discharged from hospital in 3-5 days. -Care management in adult care homes – RN care managers would develop relationships with home staff, assess patients and identify gaps in care; multidisciplinary teams of RN care manager, doctor and pharmacist would go to 2 homes per week for acute and follow-up visits. -Group medical visits for select chronic care patients.

	-Nursing home initiative – would embed care managers in nursing homes and embed care managers and pharmacists in hospitals to review admissions data and target nursing home education for preventable readmits. -Palliative Liaison Advance Care Team – evidence based approach to identify residents at high risk of death – experts would work with nursing home staff, residents, families and providers to put into practice specific end of life care.
	Medicaid: See above for practices relevant to LTCSS. No further detail specified in initial proposal.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: Not specified in initial proposal.
	Shared Savings with Medicare: Not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: Not specified in initial proposal. Would explore incentive payment to nursing homes for reducing avoidable hospitalizations and ED admissions.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Would hold regular state and local stakeholder meetings, focus groups.
Proposed Timeframe for Implementation:	Implementation late April 2012.

***** Source: Data contained in Table 1, supra.

** Source: North Carolina's Proposal to the Centers for Medicare and Medicaid Services for the State Demonstration to Integrate Care for Dual Eligible Individuals.

Oklahoma:

Current Service Delivery Model for Dual Eligibles:*	
Of the more than 100,000 duals in Oklahoma, less than 1 percent received Medicare covered benefits through Medicare Advantage SNPs for dual eligibles or PACE plans, but the vast majority (98%) received Medicaid ambulatory benefits through prepaid ambulatory health plans in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Proposal includes (1) Tulsa Health Innovation Zone's (THIZ) Pilot for Duals – would create an ACO with embedded medical education programs to specifically serve high-cost duals. Three features currently exist: patient centered medical home teams, health access network care coordination initiative, and health information exchange. Propose a 4th program – a set of teams focused on high-risk high-cost duals. The 4 components would be organized into an ACO; (2) New Benefit Plan for Duals, Patterned After Shared Savings Model – would be administered and operated by state, similar to ACO model; (3) OK PACE Program Statewide Expansion.
Target Population and Enrollment:	(1) About 2200 duals (among others) in THIZ Pilot. (2) All duals with emphasis on those with behavioral health needs in new state plan. (3) Duals in need of nursing home level of care would be targeted in PACE expansion. Initial proposal does not specify whether enrollment would be mandatory or voluntary.
Proposed Integrated Benefits Package:	*Medicare:* Under New Benefit Plan for Duals, would include behavioral health services—additional detail not specified in initial proposal. PACE program would include primary care and other acute Medicare-covered services.
	Medicaid: Under New Benefit Plan for Duals, would include behavioral health services—additional detail not specified in initial proposal. PACE program would include LTSS, HCBS, and other Medicaid-covered services.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: (1) Payment model for THIZ ACO integrating Medicare and Medicaid payment would be developed in planning and design process. (2) New Benefit Plan for Duals administered by State would combine Medicare & Medicaid funding streams to purchase coverage through a plan and network developed and administered by State. (3) The existing PACE program, Cherokee Elder Care, currently uses capitated payments paid through Medicare, Medicaid and private pay.
	Shared Savings with Medicare: Not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: THIZ Pilot proposes to use gain sharing savings for public good to expand medical education programs and new outreach specialty services. No further detail specified in initial proposal.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder	Would convene large working group, smaller subgroups, focus groups

Involvement:	and ad hoc discussions. All groups would meet at least monthly. Website would be used to distribute meeting information.
Proposed Timeframe for Implementation:	To be determined.

***** Source: Data contained in Table 1, supra.

** Source: State Demonstration to Integrate Care for Dual Eligible Individuals, Oklahoma Proposal, Feb. 1, 2011.

Oregon:

Current Service Delivery Model for Dual Eligibles:*	
Nearly 85,000 dual eligibles in Oregon (2009); almost 22 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans. More than 36 percent of dual eligibles received Medicaid benefits through managed care organizations, almost 11 percent received Medicaid primary care through primary care management providers, 62 percent received Medicaid inpatient benefits through prepaid inpatient health plans, and almost 58 percent received Medicaid ambulatory benefits through prepaid ambulatory health plans in 2009, according to CMS. Most dual eligibles in Oregon received Medicare or Medicaid benefits through some type of managed care plan.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Would develop person-centered health homes and regional ACOs to deliver benefits to duals, with responsibility for integrated care assigned to a single entity, at total cost consistent with risk adjusted global payment or capitation rates. Would be part of broader effort to provide integrated care for all Medicaid and CHIP enrollees. Would contract with more than one plan in each region where feasible.
Target Population and Enrollment:	Would target full benefit duals statewide. Key subpopulations would be those with persistent mental illness/severe emotional disorders and those who receive LTCS. Initial proposal does not specify whether enrollment would be mandatory or voluntary.
Proposed Integrated Benefits Package:	*Medicare:* Would include full range of Medicare parts A, B, and D.
	Medicaid: Would include full range of Medicaid benefits covered under state plan based on beneficiaries' eligibility category. Would integrate preventative and chronic care, behavioral health, and LTCSS. Would eliminate Medicaid carve-outs. Would pay particular attention to benefits that are not strictly medical but designed to assure good outcomes, including preventative services, behavioral health, and services supporting independence and continued residence at home. Would have access to case management.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: State would contract with regional plans, with payments primarily through capitation. Further detail not specified in initial proposal.
	Shared Savings with Medicare: Not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: Not specified in initial proposal. Payment incentives to plans would be aligned to maximize efficient care choices, eliminate cost sharing and develop intensive care management that would address social supports as well as health care.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Health System Transformation Team appointed by Governor discussed the demonstration contract proposal. Would do broader stakeholder outreach, develop specialized groups, and conduct town hall style meetings.
Proposed	Demonstration proposal to CMS no later than September 1, 2011.

Implementation Timeframe:	Beneficiary enrollment in new entities no later than July 2012.

***** Source: Data contained in Table 1, supra.

** Source: State Demonstrations to Integrate Care for Dual Eligible Individuals, Oregon Proposal for Design Contract.

South Carolina:

Current Service Delivery Model for Dual Eligibles:*	
Nearly 130,000 dual eligibles in South Carolina (2009); almost 2 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans. The vast majority (99%) received Medicaid ambulatory benefits through prepaid ambulatory health plans, and 6 percent received Medicaid primary care benefits through primary care management providers in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Project SC DuE would complete a continuum of integrated primary and behavioral health demonstrations for children, adults and duals with mental health needs in SC. Proposed integrated care model would use new Health Home option in ACA. Specific type of entity would be determined in planning and design process (MCO or another risk-based entity).
Target Population and Enrollment:	Would target duals with behavioral health diagnosis (major diagnostic mental disorder or Alzheimer's) that impairs ADLs resulting in limited caregiver support, self directed care or choice of living arrangements, lasting 2 or more years and requiring ongoing supervision and prescription drugs to address behavioral health diagnoses. Proposed passive enrollment with opt out to HCBS waiver or FFS (or PACE if available); HCBS waiver participants could enroll in demonstration. Would pilot/phase in implementation.
Proposed Integrated Benefits Package:	*Medicare:* Would include Medicare parts A and B. Initial proposal does not specified whether part D also would be included.
	Medicaid: Would include all primary and behavioral health services and provide linkages to community LTSS and social and family supports. Would provide enhanced primary care, multidisciplinary team, medical management (disease management, medication management and education), LTC services and supports and family and social services (respite). Would include all Health Home services: comprehensive case management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings including appropriate follow up, and individual and family support.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: TBD in planning and design.
	Shared Savings with Medicare: TBD in planning and design.
	Shared Savings with Integrated Entities and/or Providers: TBD in planning and design.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Would establish Integrated Care Workgroup of consumers/advocacy organizations, Stage agencies/executive level policymakers, and providers to design model and develop implementation plan. Workgroup would act as independent body of expert consultants.

Proposed Implementation Timeframe:	Model design and implementation plan submitted to CMS – Jan. to March 2012. Phase 1 implementation (establish evaluation indicators and contracting requirements) – April 1, 2012-March 30, 2013. Phase 2 implementation (initiate pilot) – April 1, 2013-March 30, 2014. Phase 3 implementation (expand contracting requirements for statewide implementation) – April 1, 2014-March 30, 2015. Phase 4 implementation (full implementation) – April 1, 2015-March 30, 2017.

***** Source: Data contained in Table 1, supra.

** Source: South Carolina Dual Eligible Demonstration Project (SC DuE), Jan. 31, 2011.

Tennessee:

Current Service Delivery Model for Dual Eligibles:*	
More than 228,000 dual eligibles in Tennessee (2009); almost 17 percent received Medicare benefits through Medicare Advantage SNPs for dual eligibles or PACE plans. Most (82%) received Medicaid benefits through managed care organizations, and 5 percent received Medicaid inpatient benefits through prepaid inpatient health plans in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Would create TennCare PLUS, in which state would contract with private MCOs to integrate Medicare and Medicaid benefits and coordinate care for duals.
Target Population and Enrollment:	Would target all full benefit duals statewide (~137,000).
Proposed Integrated Benefits Package:	*Medicare:* Would include Medicare parts A and B services. Medicare part D would remain outside TennCare PLUS, but TennCare care coordinators would assist duals with accessing part D plans.
	Medicaid: Would include all existing TennCare covered physical and behavioral health services. Would add care coordination component for duals who do not participate in CHOICES (Medicaid managed LTC program for NF LOC). Duals with certain conditions also would be eligible to participate in TennCare disease management programs. Duals who meet a NF LOC could access NF services and HCBS, including some HCBS not currently furnished by CHOICES, subject to HCBS enrollment cap. Dental and pharmacy benefits would remain carved out of TennCare MCOs. Would consider removal or adjustment of requirements for Medicare cost-sharing (parts A & B premiums, co-insurance, deductibles) – would examine how to address these payments going forward depending upon budget availability – would possibly be paid depending on funding availability.
Proposed Financing:	*Medicare Payments to State:* Medicare funding would be calculated based on what Medicare spends on full benefit duals services in TN today.
	Plan to Combine Medicare and Medicaid Funds: Medicare funds would go to Bureau of TennCare which would contract with its MCOs. MCOs would negotiate with Medicare providers to establish payment rates and conduct prior approval. Up to half planning contract would be used to develop model for new rate setting process.
	Shared Savings with Medicare: Not specified in initial proposal. Program savings would be reinvested in TennCare PLUS to add care coordination component for duals and support continued efforts to expand HCBS access and rebalance LTC system.
	Shared Savings with Integrated Entities and/or Providers: Not specified in initial proposal.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Would build on stakeholder work in planning and development of TennCare CHOICES. Would focus on stakeholder groups with particular expertise and interest in Medicare, including beneficiaries.

Proposed Implementation Timeframe:	Month 12 of contract – would finalize plan for care integration and consult with CMS and stakeholders about feasibility of developing plan into proposed amendment to TennCare demonstration.

***** Source: Data contained in Table 1, supra.

** Source: Innovations Proposal: TennCare PLUS, Jan. 31, 2011.

Vermont:

Current Service Delivery Model for Duals:*	
Of the more than 31,000 dual eligibles in Vermont, no dual eligibles received Medicare benefits through Medicare Advantage SNPs for dual eligibles and less than 1 percent received Medicare benefits through PACE plans. Almost 47 percent received Medicaid benefits through managed care organizations in 2009, according to CMS. Most dual eligibles in Vermont received Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	The State Medicaid agency would be a managed care entity to manage Medicare and Medicaid for all duals. State also would further expand its Advanced Primary Care Practices (APCP) – could more comprehensively link case management services for duals whose primary waiver services are LTC, developmental services or mental health services by adding these existing case managers to APCP teams. APCP insurers (Medicaid, Medicare, and 3 largest commercial insurers) participate in aligned payment reforms (enhanced payments to APCPs based on quality of care delivered, and shared costs for core Community Health Teams that provide community-based multi-disciplinary supports), which are designed to assure that APCP practices provide timely access to consistent, thorough, well-coordinated and cost effective health services with systematic data-guided processes to support practice transformation, qualification as an APCP, ongoing quality improvement and statewide expansion.
Target Population and Enrollment:	Would target all duals statewide – 21,379. Would use passive enrollment with opt out.
Proposed Integrated Benefits Package:	*Medicare:* Would include all benefits including parts A, B and D.
	Medicaid: Would include all existing benefits – proposal would not substantially change the current benefits package. State would seek more flexibility in how services are provided – could offer services not currently covered by Medicare, increase PCP access by making incentive payments for those difficult to serve, invest in health care coaches for outreach, invest in prevention efforts.
Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plans to Combine Medicare and Medicaid Funds: Medicare and Medicaid funds would be managed by State.
	Shared Savings with Medicare: Not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: Not specified in initial proposal.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Would establish statewide advisory group of consumers and providers to meet at least monthly. State would attend regular meetings of advocate groups, provider groups and other involved advisory groups. Would use web-based tool to gather input and share developments.
Proposed Implementation Timeframe:	Demonstration plan to be submitted to CMS – mid-April 2012. Implementation to be within 3 months of CMS approval.

***** Source: Data contained in Table 1, supra.

** Source: State Demonstrations to Integrate Care for Dual Eligible Individuals, Vermont, Jan. 31, 2011.

Washington:

Current Service Delivery Model for Dual Eligibles:*	
Of the nearly 142,000 dual eligibles in Washington, almost 5 percent received Medicare benefits via Medicare Advantage SNPs for dual eligibles or PACE plans. Less than 1 percent of dual eligibles in Washington received Medicaid benefits through managed care organizations, but most (69%) received Medicaid inpatient benefits through prepaid inpatient health plans in 2009, according to CMS.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	Phase One: For high risk/high cost duals (about 25% of total dual population), initially would focus on expanding existing Chronic Care Management (CCM) models (focused on long-term community-based services), with statewide implementation in 2012. Proposed goal would be to have 60-65% of high risk/high cost duals participate in CCM program. Model includes health home in which nurse care managers work with high risk-high cost duals to develop care plan, coordinate with PCP, facilitate behavioral health and other referrals, provide information to clinicians for more effective office visits (prescriptions across providers), coach providers on behavioral health resources and issues, and identify community social supports (transportation, housing). Phase Two: Would target lower risk/lower cost duals as part of planned transfer of categorically needy aged, blind, and disabled population into full managed care as part of 2012 joint procurement contract with plans. Phase Three: Would continue development of fully integrated delivery and financing systems of care for all duals with statewide implementation by 2017. Would need to determine how to best transition high cost/high risk duals into managed care, recognizing that some duals will likely always be served outside managed care. State would also consider application for Medicare SNP. Initial proposal does not specify whether enrollment would be mandatory or voluntary.
Target Population and Enrollment:	Would target full benefit duals who are categorically needy aged, blind and disabled. (52% are elders, 46% ages 18-64 with disabilities). 25,000 in 2012, full implementation of ~100,000 by 2017.
Proposed Integrated Benefits Package:	*Medicare:* Would include full range of Medicare acute, behavioral health, and LTCSS. Integration of part D benefits not specified in initial proposal.
	Medicaid: Would include full range of Medicaid medical, behavioral health, and LTCSS. Also would integrate services under HCBS waivers. Would include other supplemental benefits as feasible with program savings. Based on existing data, Medicaid service utilization patterns for elderly and non elderly duals are quite distinct.

Proposed Financing:	*Medicare Payments to State:* Not specified in initial proposal.
	Plan to Combine Medicare and Medicaid Funds: Would explore integration of Medicaid and Medicare including opportunities for state to be SNP operator and develop contract/payment models with existing insurers and providers. Pilot would model financing options for duals. Details not specified in initial proposal.
	Shared Savings with Medicare: Would develop payment methodology for CMS and State to share savings. Details not specified in initial proposal.
	Shared Savings with Integrated Entities or Providers: Would reimburse providers through bundled and capitation payment methods.
Beneficiary Protections:	Not specified in initial proposal.
Stakeholder Involvement:	Outreach to ongoing working groups and coalitions. Targeted focus groups/discussions with beneficiaries and their representatives, healthcare plans and community-based providers.
Proposed Implementation Timeframe:	Phase 1: Statewide CCM expansion for high cost/high risk duals – 2012. Phase 2: Increased enrollment in managed care for low cost/low risk duals – July 2012. Phase 3: Integrated financing pilots in 4 counties – late 2012; access to fully integrated delivery systems in additional counties - late 2013; access to fully integrated primary/LTSS systems for duals statewide – 2017.

***** Source: Data contained in Table 1, supra.

** Source: Washington State Proposal to Integrate Care for Dual Eligible Individuals, Jan. 28, 2011.

Wisconsin:

Current Service Delivery Model for Dual Eligibles:*	
Of the more than 164,000 dual eligibles in Wisconsin, almost 7 percent received Medicare benefits via Medicare Advantage SNPs for dual eligibles or PACE plans. More than 6 percent of dual eligibles in Washington received Medicaid benefits through managed care organizations, and 22 percent received Medicaid inpatient benefits through prepaid inpatient health plans in 2009, according to CMS. Most dual eligibles in Wisconsin received Medicare and Medicaid benefits on a fee-for-service basis.	
State Proposal for Integrated Care Design Model**	
Proposed Entity:	State would function as Medicare/Medicaid entity, similar to PACE authority, but not restricted to a specific physical site, and with broader authority than Medicare SNP. State would contract with entities such as existing PACE/Partnership organizations (relieved of administrative requirements of being Medicare SNP), new entities composed of an existing Family Care MCO (existing Medicaid managed LTC program including HCBS) in collaboration with an acute/primary HMO or clinic, or other types of entities. Goal would be for one entity to be responsible for all acute, primary and LTCS and provide care coordination. Aging and Disability Resource Centers would inform current and prospective LTC clients of the new program option(s). Would pilot in 3 to 4 sites in mid-2012 with different types of contracted entities.
Target Population and Enrollment:	Would target duals who are elders and adults ages 18 and older with physical and developmental disabilities who require nursing home level of care. Pilot would be with 20,000 duals in 2012. Full implementation would encompass 53,000 duals by 2015. Pilot sites would adopt "all-in" enrollment with opportunity to opt out after 6 months.
Proposed Integrated Benefits Package:	*Medicare:* Would include all Medicare services (parts A, B, and D).
	Medicaid: Would include all Medicaid services, including acute, primary and LTC.
Proposed Financing:	*Medicare Payments to State:* State would receive Medicare capitation payment for each enrollee, with details to be specified.
	Plans to Combine Medicare and Medicaid Funds: State would combine Medicare capitation payment with Medicaid capitation payment to generate single fully integrated risk-based capitation payment to the contracted entities.
	Shared Savings with Medicare: Would develop formula in which both state and feds share savings relative to baseline Medicare and Medicaid expenditures for demonstration population. Details not specified in initial proposal.
	Shared Savings with Integrated Entities and/or Providers: Contracted entities might benefit through the shared savings model to be developed. Details not specified in initial proposal.
Beneficiary Protections:	Medicare and Medicaid rules would be aligned at state and MCO levels for enrollment, eligibility, marketing, appeals, and performance

	to minimize unnecessary administrative burden while preserving beneficiary protections. Details not specified in initial proposal.
Stakeholder Involvement:	Existing Statewide Long Term Care Council (which includes consumers, advocates, Partnership and Family Care MCOs, ADRCs, and LTCS providers) would create subcommittee to advise on proposed demonstration with representatives from Council and additional representatives with relevant expertise, such as those from acute/primary care industry. Focus groups. Involvement of MCOs through monthly meetings with leadership and special topic workgroups.
Proposed Implementation Timeframe:	Planning through June 2012. Pilot implemented in 3 to 4 demonstration sites by July 2012. Establish additional demonstration sites – January to December 2013.

***** Source: Data contained in Table 1, supra.

** Source: Wisconsin Proposal for Innovative Demonstration Project for dual Medicaid/Medicare members.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

This publication (#8215) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.