AHIP Proposal:
Achieving Medicare/Medicaid Integration for Dually Eligible Beneficiaries

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Introduction: The Challenge

Improving Medicare/Medicaid integration for beneficiaries eligible under both programs has become an increasing focus of attention as the Centers for Medicare & Medicaid Services (CMS) is implementing new initiatives and States that are facing serious fiscal challenges work to identify more efficient and effective strategies for health care delivery and address growing Medicaid program costs and promote innovation in care coordination.

Although they comprise only 15 percent of all Medicaid beneficiaries, dual eligibles account for nearly 40 percent of all Medicaid expenditures. Addressing the challenges of bringing together two distinct programs to produce a comprehensive approach to care can have substantial rewards for beneficiaries, offer efficiencies that produce savings for States and the Medicare program, and advance the goal of improving health care delivery.

Dual eligibles are among the nation's most vulnerable populations. They have a higher prevalence of multiple chronic conditions and correspondingly complex health care needs. The current lack of coordination between Medicare and Medicaid creates barriers for this population in accessing care. Moreover, at present they are less likely to have the opportunity to enroll in health plans that have pioneered programs to coordinate services across the continuum of sites of care and programs linking members to crucial services that facilitate access to care.

The Opportunity

Medicare/Medicaid integration is critical to providing access to comprehensive, coordinated care and support services for dually eligible beneficiaries. The strategy we are proposing is a road map to care improvement for this population and cost savings for States and the Medicare program.

Health plans have a pivotal role to play in this process. Through existing opportunities under both programs, including demonstrations that have been implemented in several States, health plans have demonstrated that their organized systems of care provide the means of achieving seamless coverage of Medicare and Medicaid benefits for their members, with accountability for both quality and cost effectiveness. Studies have shown how Medicaid health plans are delivering results for their enrollees and reducing costs for States, including dual eligibles who are frail and elderly[1] or who have

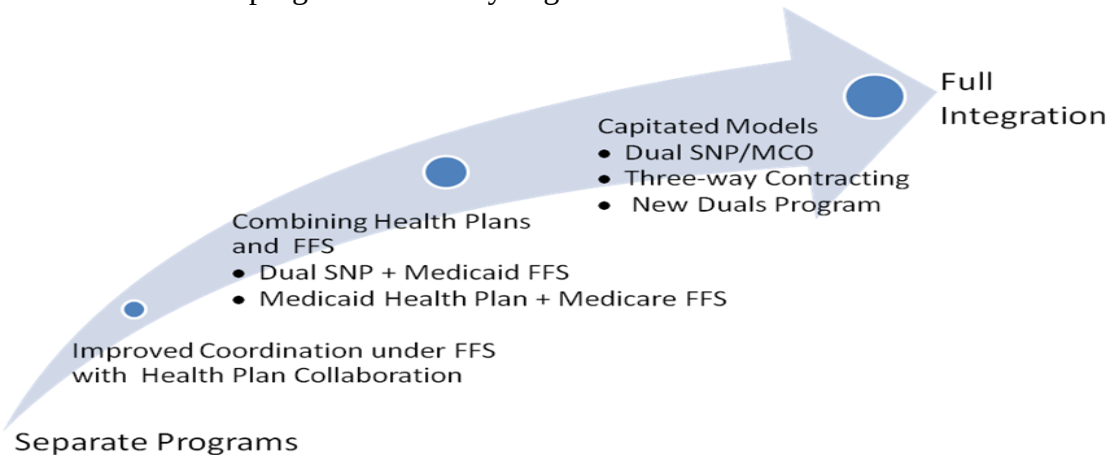
[1] JEN Associates, Incorporated, "MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons." (June 2008)

disabilities and reside in the community.[2] Moreover, a new study from Ken Thorpe demonstrates that the tools and techniques used by health plans, including initiatives to reduce hospital readmissions and improve medication adherence, have the potential to improve care for dual eligibles and achieve significant savings for the federal government and States.[3] AHIP urges Federal and State policymakers to support the launch of a broad effort that empowers States to work with the Federal government in ways that are responsive to the infrastructure in each State and take advantage of the tools health plans have available to organize the components of coordinated care models into a comprehensive approach to health care delivery for dually eligible beneficiaries under the Medicare and Medicaid programs.

Our Proposal – Providing a Menu of Models for Medicare/Medicaid Integration

The current strong focus at the Federal and State levels on developing solutions to address the many longstanding differences between the Medicare and Medicaid programs holds for beneficiaries the promise of streamlined access to the combined benefits under both programs. As this work continues, it will be important to tailor integration strategies to each State's current health care infrastructure, from those relying wholly or principally on Medicaid fee-for-service programs to those that already have experience with efforts to integrate coverage offered through Medicaid managed care programs and Medicare health plans.

The comprehensive proposal outlined below, which groups six models into three alternative approaches suited to States with varying readiness for integration, would achieve this goal and promote widespread progress toward integrating the Medicare/Medicaid programs for dually eligible beneficiaries.[4]



[2] For example, see Texas Health and Human Services Commission, "Financial Impact of Proposed Managed Care Expansion in Texas" (February 2005)
[3] Kenneth E. Thorpe, "Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles" (September 2011)
[4] The term "dually eligible beneficiaries" refers to beneficiaries eligible for full Medicaid benefits and eligible for benefits under the Medicare program.

Accelerating Implementation of Medicare/Medicaid Integration through the Menu of Models:

State and federal interest in making progress toward Medicare/Medicaid integration for dually eligible beneficiaries has never been higher, and CMS has taken steps to create opportunities to move towards this important goal. To streamline opportunities for States and accelerate integration efforts, we recommend that CMS create templates for each of the models described above, with the exception of the final model which would require legislation. The templates would serve as a road map for States to move along the continuum of approaches toward seamless integration for beneficiaries. To that end, they should provide flexibility for States to design building blocks that respond to their unique circumstances within a specified framework. The agency should establish an expedited process for States to implement the options reflected in the templates. To provide the opportunity for the highest degree of integration, we recommend that legislation be enacted to create a new program for dually eligible beneficiaries that would include a single benefit package and other program rules. Through these strategies, beneficiaries and Federal and State governments can take advantage of the full potential for improved quality and cost effectiveness offered by health plans and their comprehensive programs for care and service coordination across acute, chronic, and long term care.

Menu of Models for Medicare/Medicaid Integration:

Alternative A: Health Plan Participation in Fee-for-Service Models to Move Toward Medicare/Medicaid Integration

- *States relying on fee-for-service Medicare and Medicaid programs* – Strategies designed to promote care coordination, quality measurement, and the most appropriate use of services for beneficiaries under the Medicare and Medicaid fee-for-service programs are underway, including formation of accountable care organizations; use of bundled payments; and medical home initiatives. Health plan collaborations with States and providers can facilitate these efforts by bringing to bear their experience with quality improvement, care coordination, and delivery system development. While these programs do not offer the opportunity to integrate benefits or payment streams for the Medicare and Medicaid programs, they provide a foundation for the more integrated models described below.

Alternative B: Models that Combine Health Plans with Fee-for-Service Programs to Advance Medicare/Medicaid Integration

- ***Model #1:*** *States with Medicare dual eligible SNPs and Medicaid fee-for-service* – For the same reason, State contracting with MA dual eligible SNPs (special needs plans) whose members will receive coverage through Medicaid fee-for-service programs represents an important incremental step forward. In some cases, States may not include dually eligible beneficiaries in their Medicaid

managed care programs, may not have established Medicaid managed care programs, or may limit opportunities for dual eligible SNPs to contract as Medicaid health plans, although they may have sizeable SNP enrollments. The requirement for contracts to be in place between States and dual eligible SNPs by January 1, 2013 has the potential to promote closer State/dual eligible SNP relationships that facilitate care coordination through data exchanges, increased cooperation to coordinate access to Medicare and Medicaid benefits, and the potential for States to seek Medicaid contracts with the same organizations.

- ***Model #2:*** *States with Medicaid health plans and Medicare fee-for-service* – Dually eligible beneficiaries have frequently not been included in State Medicaid managed care programs that have focused heavily on the TANF (Temporary Assistance for Needy Families) population, but program expansions to include these beneficiaries are now under consideration. Establishing at the planning stage a forum for key stakeholders to forge working relationships can ensure that their issues and insights are properly considered. Medicaid health plans can provide added value to beneficiaries with high health care needs through their systematic approach to care delivery and provide new opportunities for States to evaluate the quality and increase the efficiency of the services provided. Although Medicare coverage continues on a fee-for-service basis in this scenario, making Medicaid health plans available to dually eligible beneficiaries can provide an important element of the foundation for States to move along the path towards Medicare/Medicaid integration.

Alternative C: Capitated Health Plan Models for Medicare/Medicaid Integration

- ***Model #1:*** *States with Medicare dual eligible SNPs and Medicaid health plans* – States that are prepared to contract under Medicaid managed care programs with organizations that offer dual eligible SNPs are well-positioned to work with CMS, health plans, and stakeholders to promote Medicare and Medicaid integration. Those that have already taken this step have experience with addressing the operational challenges resulting from the contrasting features of the Medicare and Medicaid programs discussed above that is producing meaningful progress toward integration for beneficiaries. In addition, their practical experience can contribute to designing program changes in the areas discussed above to address existing barriers to integration and seamless coverage for beneficiaries.

- ***Model #2:*** *States prepared for capitated Medicaid and Medicare contracting* – Another avenue for addressing the issues arising from separate health plan contracting under the Medicaid and Medicare programs is an option for health plans, States, and CMS to enter into a single contract that can coordinate requirements under both programs as well as Federal and State oversight roles. This approach is designed to permit use of contract terms that build upon existing requirements for Medicaid and Medicare health plans but allow modifications to produce closer alignment, for example, by coordinating benefits, providing for a single enrollment process, coordinating quality oversight, establishing a combined

beneficiary appeals process, and establishing a single payment stream. CMS has recently issued parameters providing an option for such "three-way contracting" that could be in place for a three year period. This or another similar approach could serve as an important step toward program integration for dually eligible beneficiaries.

- ***Model #3:*** *Seamless Medicare/Medicaid integration for beneficiaries through health plans* – A unified approach to providing Medicare and Medicaid benefits to dually eligible beneficiaries would feature such elements as a combined benefit package, a payment mechanism that provides funding appropriate to the health status of members and Federal/State sharing of savings, a single appeals process that could be more easily navigated by beneficiaries and a streamlined approach to oversight with clearly defined and coordinated roles for Federal and State governments. Health plans are uniquely prepared to offer to beneficiaries the seamless integration of the Medicare and Medicaid programs for beneficiaries that can best be achieved through a unified set of benefits and program rules.

Building Blocks Necessary to Implement the Menu of Models

The models described above offer opportunities to meld key elements of the Medicare and Medicaid programs to differing degrees along a continuum leading to full integration. A number of these crucial building blocks are highlighted below and the opportunities for integration across the strategies discussed above are depicted in Chart 1.

Developing and Implementing Integration Strategies

- **Stakeholder engagement:** Establishing effective lines of communication and meaningful opportunities for engagement for stakeholders at the State level, including beneficiaries, health plans, providers, and others during the development process of initiatives to bring dually eligible beneficiaries into more organized care models is a critical step in crafting programs that are sensitive to the variety of needs and priorities of dually eligible beneficiaries, including low-income aged beneficiaries, individuals with disabilities residing in the community, and individuals who are aged and/or disabled residing in institutions. AHIP recommends that CMS continue to promote early stakeholder involvement in State planning processes and an ongoing process for obtaining and responding to stakeholder input that continues into implementation.

Program Administration – Benefits, Enrollment, and Access

- **Benefits:** The focus of Medicare on coverage of acute care services in contrast to the Medicaid focus on optimizing the health of a high proportion of dually eligible individuals with chronic health care conditions of varying degrees of severity, including those with physical disabilities and behavioral health needs, is reflected in the differing nature and scope of services covered under each

program. A beneficiary may find that services for a single condition and related co-morbidities or medical and supporting services for individuals with disabilities are partially covered under different rules and by different providers under each program in order to stitch together the necessary treatment plan. Further under State Medicaid programs, in some cases, important benefits such as prescription drug coverage are carved out of Medicaid managed care programs. AHIP recommends that interim steps be implemented to encourage data sharing and collaborations between health plans, States, and providers and that a combined benefit package that provides the full continuum of coverage of acute, chronic, and long-term care and supporting services be developed for dually eligible beneficiaries to simplify access to and coverage of a comprehensive, core set of benefits. Opportunities may be available to offer a combined benefit package under three-way contracting arrangements, as well as through enactment of permanent program changes. Flexibility should be provided for States and health plans to offer incentives for beneficiaries to seek care in ways that promote better health and access to the most appropriate services, such as taking advantage of disease management programs, reducing emergency room use, and remaining enrolled in coordinated care models.

- **Eligibility and enrollment rules:** In some cases, dually eligible beneficiaries may be able to enroll in a dual eligible SNP and a Medicaid health plan offered by the same organization. However, seamless enrollment into both plans is frequently not available to beneficiaries. For example, beneficiaries are required to complete separate enrollment applications and health plans may face challenges in meeting CMS requirements for confirming Medicaid eligibility. AHIP recommends that in these circumstances and under three-way contracting arrangements a one-stop enrollment process be developed to streamline the enrollment process for beneficiaries.

  Further, dually eligible beneficiaries enrolled in Medicaid health plans typically have the opportunity to select a plan once each year or immediately following a determination or redetermination of eligibility with a specified period for switching plans. In contrast, dually eligible beneficiaries may change Medicare health plans on a monthly basis. Aligning Medicare and Medicaid enrollment rules to provide for stable beneficiary enrollment can provide greater opportunities for plan members to benefit from care coordination, disease management and other plan programs and avoid interruptions in continuity of care. AHIP recommends that dually eligible beneficiaries be passively enrolled into Medicare and Medicaid plan options offered by the same organization, where available, with a specified period to switch plans. In other circumstances, States should be permitted to establish incentives for dually eligible beneficiaries to choose health plans and other care coordination programs and models.

- **Health plan provider networks and access requirements:** The Medicare program and State Medicaid programs have established criteria for contracting health plans to demonstrate network access for beneficiaries, which include

differing time and distance criteria, as well as differing provider qualifications for delivering services of similar types. As dually eligible beneficiaries enroll increasingly in health plans, it will be important for these requirements to be sensitive to their unique health care needs, for example the differing needs of those who are over age 65 and those under age 65 with disabilities who may be living in the community or in institutions, including those with physical disabilities and those with behavioral health needs. AHIP recommends that CMS work with States and health plans to develop a template for review of network access so that a consistent approach can be applied under the Medicare and Medicaid programs, including elements to address the full range of health care needs of dually eligible beneficiaries.

Care Coordination and Quality Improvement

- **Care coordination/management:** Programs such as care coordination, disease management, health coaching, nurse help lines, linkages to social services, supporting services for individuals with disabilities residing in the community, and other non-health care programs that complement medical services are widely available through health plans serving dually eligible beneficiaries under the Medicare and/or Medicaid programs. The benefit distinctions between the Medicare and Medicaid programs impact the ability of health plans and providers to obtain and share clinical information among the providers caring for dually eligible beneficiaries across the entire range of health care services they receive. Each dual eligible SNP is required to establish a Model of Care (MOC) and report on Structure & Process measures to demonstrate the special steps they are taking to focus on the needs of their members. Medicaid health plans have similar accountability. When health plans are able to obtain contracts under both programs, either as SNPs and Medicaid health plans or under three-way contracting arrangements, they are able to give their members the greatest value from the care coordination that they make available. However, these contracting opportunities are not always available and Medicare and Medicaid program rules continue to create a variety of significant challenges. AHIP recommends that steps should be taken to make opportunities for collaborations between States, health plans, and providers broadly available through coordinated or combined Medicare and Medicaid program administration.

- **Quality improvement:** Measures are currently in use to evaluate the quality of care and service for health plan members under both the Medicare and Medicaid programs and quality improvement programs have been fundamental to health plans since their inception. These initiatives have provided precedents for development of similar reporting requirements and quality measurement for providers under the Medicare and Medicaid fee-for-service programs, although use of quality measures for oversight is at an earlier stage of development. As with other aspects of Medicare and Medicaid program implementation, data reporting elements, requirements for health plan quality improvement programs and projects, and selection of measures are not coordinated for plans and

providers serving dually eligible beneficiaries and States may apply unique quality metrics or measures. AHIP recommends development of a comprehensive quality strategy that includes a core set of measures applicable not only to Medicaid health plans and dual eligible SNPs but across the range of providers that serve dually eligible beneficiaries under the variety of approaches States may pursue to move forward with Medicare/Medicaid integration. It is also essential that measures address dimensions of quality important to dually eligible beneficiaries with differing needs for medical care and supporting services.

Beneficiary Information and Appeals

- **Beneficiary information:** MA plans, including dual eligible SNPs, are required to provide a number of pre-enrollment and post-enrollment materials to beneficiaries. The content of required materials is evolving to include versions that are tailored to dually eligible beneficiaries and the process of adjusting required materials is ongoing. These materials are often subject to review by both Federal and State governments raising concerns about the potential for conflicting requirements and delays in disseminating materials to beneficiaries. State requirements for Medicaid health plans also include mandated materials and State review and approval processes. The Medicare and Medicaid fee-for-service programs also disseminate information to beneficiaries. AHIP recommends that CMS develop model materials for dually eligible beneficiaries with special attention to health literacy and cultural considerations in close consultation with States, health plans, and beneficiary representatives and that State and Federal roles in reviewing materials be clearly defined to avoid duplication and promote consistency in reviews.

- **Appeals:** Medicare and Medicaid appeals processes to ensure that beneficiaries have effective means to seek resolution of complaints that may arise about coverage and service include distinctive elements that have been in place for many years. For example, the Medicare hearing process has no step that is comparable to the State Fair Hearing available to Medicaid beneficiaries. Currently, where efforts at integration have been implemented, for example to ensure that a beneficiary enrolled in a dual eligible SNP and in a Medicaid health plan offered by the same organization receives the full appeal rights available under both programs, both processes are available in parallel raising the potential for beneficiaries to receive conflicting determinations. AHIP recommends establishment of a single, integrated appeals process for dually eligible beneficiaries that incorporates time frames and elements of existing Medicare and Medicaid appeals processes that are most favorable to beneficiaries.

Payment and Financing

- **Medicare/Medicaid payment rates and financing:** Capitated payment methodologies are used for health plan contracting under both the Medicare and Medicaid programs, although the basis for calculating these payments differ

significantly, including differing risk adjustment mechanisms, trend factors and other bid components, and bidding processes and timelines. Concerns have arisen in some cases about the adequacy of MA risk adjustment for dual eligible SNPs and compliance of State Medicaid managed care rates with actuarial soundness requirements. AHIP recommends that the Medicare and Medicaid rate setting processes be closely coordinated or combined along with the payment streams for both programs and that the Medicare risk adjustment mechanism be evaluated and modified as needed to better align it with the health status of dually eligible beneficiaries.

Although Federal and State governments both have a strong interest in improving integration between Medicare and Medicaid, it is often not apparent to the States that savings to Medicare will be shared with them. Thus it may be difficult for States to justify State investment in efforts to generate such savings, for example through programs intended to decrease acute hospitalizations or increase reliance on Medicaid-covered services. AHIP recommends that States be given opportunities to share with the Federal government and with health plans, as appropriate, in savings generated through increased integration.

Contracting and Oversight

- **Contract terms and timelines:** Medicare health plan contracts are renewed on a calendar year basis, but dual eligible SNPs must also enter into contracts with State Medicaid agencies starting with 2013. State contracting is typically on a State fiscal year basis, which may mean that new Medicaid managed care contract terms begin on either July 1 or October 1 of each year. In addition to navigating this issue, CMS requires that dual eligible SNP contracts reflect agreement between the SNP and the State about the Medicaid eligibility categories that will be the focus of the SNP. A number of other terms are also required, for example addressing data sharing and coordination with or coverage of Medicaid benefits depending upon whether the organization offering the dual eligible SNP also contracts as a Medicaid health plan. Further, in some cases, States seek to include provisions that appear in Medicaid managed care contracts that may overlap with terms in Medicare health plan contracts with CMS. The sunset of the SNP program at the end of 2013 raises additional challenges because the future of the program is not certain. AHIP encourages CMS to move forward with its initiative to develop operational policy that better interfaces with both State budgetary and contracting timelines.

  Beyond the opportunities represented by the SNP program, three-way contracting between States, the Federal government, and health plans through approaches, such as the one announced earlier this year by CMS, has the potential to unify program requirements by combining coverage of the full range of acute, chronic and long-term care services, defining the roles of State and Federal governments, and providing a single payment stream with the prospect of shared savings for the State, the Federal government, and potentially health plans. We believe that

implementation of such an approach can make a significant contribution to integration efforts. We also recommend that CMS engage in discussions with States and health plans to identify other steps, within existing options or through new initiatives, to improve coordination of the Medicare and Medicaid contracting processes and terms for plan accountability under both programs.

- **Federal and State oversight roles:** As illustrated in many of the specific areas highlighted above, Federal and State governments exercise overlapping oversight when health plans and providers participate in both programs that results in potentially conflicting requirements and increased administrative costs for governments and plans and an oversight structure that reinforces program differences rather than complementing integration efforts. AHIP recommends that the roles of the Federal and State governments be clearly defined to avoid duplication of oversight.

Chart 1
Medicare/Medicaid Integration Opportunities Across the Continuum of Integration Strategies

Note: None = –; Partial integration = Levels 1 – 2; Full integration = Level 3

Building Blocks	Alternative A: Health Plan Collaboration with FFS	Alternative B: Combining Health Plans and FFS		Alternative C: Capitated Models		
	FFS Medicare/ Medicaid w/ Health Plan Collaboration	Model #1: Medicaid FFS/ Medicare DE SNPs	Model #2: Medicaid health plans/ Medicare FFS	Model #1: Medicaid health plans/ Medicare DE SNPs	Model #2: Three-way Contracting among Health Plans, States, & Medicare	Model #3: New Dual Eligible Program
Stakeholder engagement	1	1	1	2	2	3
Benefits	–	1	1	1	1	3
Beneficiary information	–	1	1	2	2	3
Care coordination/ management	1	1	1	2	2	3
Quality improvement	1	1	1	2	2	3
Appeals	–	1	1	1	1	3
Access	–	1	1	2	2	3
Payment rates	–	1	1	1	2	3
Contracting	–	1	1	1	2	3
Federal and State roles	–	1	1	1	2	3

Conclusion

There is widespread support for achieving Medicare/Medicaid integration for dually eligible beneficiaries and recognition that reaching this goal is critically important to improve care and service delivery and quality as well as to achieve cost savings. Building on the infrastructure that currently exists across States by offering opportunities along a continuum of models that rely on the demonstrated success of health plan models and care coordination programs provides the greatest opportunity for accelerating program integration. As outlined in our proposal, the health plan community strongly supports the implementation of streamlined processes for States and the Federal government in collaboration with beneficiaries, health plans and other key stakeholders to accelerate availability of seamless coverage for all dually eligible beneficiaries.