Integrated Care for Dually Eligible Individuals

NATIONAL CENTER ON LAW & ELDER RIGHTS

CHAPTER SUMMARY • November 2022

Tiffany Huyenh-Cho, Justice in Aging

Hannah Diamond, Justice in Aging

Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on populations traditionally lacking legal protection, such as women, people of color, LGBT individuals, and people with limited English proficiency. Justice in Aging authored this issue brief under a contract with the National Center on Law and Elder Rights.

Introduction

Approximately 12.2 million individuals were eligible for both Medicare and Medicaid in 2019.[1] Individuals dually eligible for Medicare and Medicaid navigate two separate systems of care, have higher rates of chronic illness, and are more likely to be persons of color compared to Medicare-only counterparts. Insufficient coordination between Medicare and Medicaid programs contributes to poor quality of care for this group and increased overall program spending. At both state and federal levels, efforts aim to better integrate Medicare and Medicaid services in order to improve consumer outcomes, advance health equity, and reduce overall spending.

This Chapter Summary:

1. Describes the basics of Medicare and Medicaid and the dually eligible population;
2. Examines different integration models for dually eligible individuals;
3. Highlights relevant regulatory updates; and
4. Showcases opportunities to improve the recipient experience based on evaluations of existing integration models.

Characteristics of Individuals Dually Enrolled in Medicare and Medicaid

Dually eligible individuals are all older adults or people with disabilities with limited income and assets. Compared to Medicare-only recipients, dually eligible individuals are more likely to be female, Black or Latino, experience higher rates of chronic disease, utilize high-cost emergency services, and be limited in English proficiency.[2] Due to higher medical and social needs, dually eligible individuals account for disproportionate percentages of Medicare and Medicaid spending compared to their percentage of enrollment.[3]

1 MedPAC, MACPAC, Beneficiaries Dually Eligible for Medicare and Medicaid, February 2022.

2 ATI Advisory, A Profile of Medicare Medicaid Dual Beneficiaries, June 2022.

3 Dually eligible individuals account for 34% percent of Medicare spending while only making up 19% of Medicare enrollees. Similarly, this group accounts for 30% of Medicaid spending while only comprising 14% of the total Medicaid population. Dually Eligible Beneficiaries: MACPAC.

Medicare and Medicaid

Medicare is the federal health insurance program for older adults who are age 65 and over and for younger people with disabilities. Medicare eligibility is not based on income or resources. Medicare has four parts: Part: A (hospital), Part B (primarily outpatient services), Part C (managed care), and Part D (prescription drugs). Medicare provides limited coverage for long-term services and supports, vision, dental, and hearing.

Medicaid is state administered and provides health care coverage and long-term services and supports for individuals who are low-income. Unlike Medicare, Medicaid is means-tested; recipients must have limited resources to qualify. Medicaid is the primary payer of long-term services and supports nationally.

For dually eligible individuals, Medicare is the primary payer of health services. Medicaid pays for Medicare cost sharing and provides wrap-around services not covered by Medicare, such as long-term services and supports in the community and institutional settings. Because Medicare and Medicaid can provide overlapping services, dually eligible beneficiaries may face challenges in care coordination between providers, which affects the quality of care and costs, and creates confusion for the beneficiary navigating these two systems.

Medicaid Eligibility for Individuals with Medicare

Dually eligible individuals can be fully or partially eligible for Medicaid benefits. A full benefit dually eligible individual receives both Medicare and Medicaid-covered services. Partially eligible individuals have full Medicare benefits but, based on income and assets, qualify only for Medicare Savings Programs (MSPs), with coverage limited to Medicare premiums and, in some cases, Medicare cost-sharing.[4] MSPs are administered by Medicaid agencies but do not provide access to Medicaid health benefits. This Chapter Summary focuses on programs available primarily to full benefit dually eligible individuals.

Medicare and Medicaid Delivery Systems

All Medicare enrollees have freedom of choice in how they receive their Medicare-covered services: they can choose to access Medicare Part A and Part B services through Original Medicare, also known as fee-for-service (FFS), or decide to enroll in Part C Medicare Advantage managed care plans. Although there are mechanisms where, in certain scenarios, dually eligible individuals can be passively enrolled or "crosswalked" into Medicare Advantage plans, they have the right in all cases to opt-out of enrollment in a Medicare plan. In contrast, with Centers for Medicare & Medicaid Services (CMS) approval, state Medicaid agencies can mandate managed care enrollment for their Medicaid delivery systems. States are increasingly moving to managed care for Medicaid services for some or all of their dually eligible populations.[5]

Integration Models for Individuals Dually Eligible for Medicare & Medicaid

Currently, three capitated models are available to integrate the delivery of Medicare and Medicaid services. These integration models aim to align the delivery, financing, and administration of Medicare and Medicaid services to improve the quality of services and health outcomes, reduce consumer confusion, and decrease healthcare expenditures. Models offer varying levels of integration, ranging from coordination-only plans to care provided by a single entity.[6]

This paper provides an overview of current models: the Financial Alignment Initiative (FAI), a demonstration program that will end in 2025, Dual Eligible Special Needs Plans (D-SNPs), and the Program of All-Inclusive Care for the Elderly (PACE).

4 National Council On Aging, What Are Medicare Savings Programs?, February 2022.
5 MACPAC, Managed Long-Term Services and Supports, June 2022.
6 MACPAC, Chapter 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context, June 2020; Integrated Care Resource Center, Working with Medicare: Medicare 201, March 2021.

Financial Alignment Initiative (FAI)

The Financial Alignment Initiative (FAI) is a demonstration pilot program that began in 2011 to test strategies to integrate Medicare and Medicaid benefits, improve the quality of care and consumer experience, and reduce spending.[7] Also known as the dual eligible demonstration, the Capitated FAI models are currently active in 10 states: California, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, Rhode Island, South Carolina, and Texas.[8] As of January 2022, approximately 478,000 beneficiaries were enrolled in FAI demonstrations nationwide.[9] The FAI is currently winding down with states planning to transition members in FAI demonstration plans into D-SNPs. California will complete its transition by December 31, 2022; other states have different timelines, but CMS has imposed a deadline of no later than December 2025.[10]

Within the FAI model, a single health plan entity provides Medicare and Medicaid benefits for enrollees and coordinates care across the two programs. Innovations introduced in the FAI capitated model include unified appeals and grievances at the internal plan level, the establishment of a neutral Ombudsman program to assist enrollees, and a blended capitated payment of Medicare and Medicaid monies that serve to incentivize health plans to improve health outcomes.

FAI Evaluation Results

Evaluative findings of the FAI demonstrations are mixed.[11] For example, while analyses demonstrate that the FAI was generally associated with decreased hospitalizations and emergency department use, models did not significantly reduce nursing facility admissions.[12] Models also produced mixed findings regarding Medicare savings, with outcomes varying by year and state.[13] Learnings from the FAI, including care coordination and health assessments, unified appeals processes, and facilitated beneficiary feedback, are now being incorporated into other integration models.

Advocate Opportunity

Advocates in FAI states should work with their state Medicaid agencies to minimize disruption during the unwinding of the FAI and to ensure lessons learned from the FAI are incorporated into new delivery models.

Dual Eligible Special Needs Plans (D-SNPs)

Dual Eligible Special Needs Plans (D-SNPs) are the largest and fastest-growing integrated model. D-SNPs are a subset of Medicare Advantage plans specifically designed for, and exclusively available to, dually eligible individuals. D-SNP enrollment has grown significantly in recent years, with one in three dually eligible individuals, approximately 4.12 million enrollees, enrolled in 700 plans as of November 2021.[14]

7 Financial Alignment Initiative (FAI) | CMS
8 Washington State is piloting a fee-for-service model. Colorado and Virginia ended their FAI demonstrations in December 2017, New York ended one of its models in 2019.
9 MACPAC, Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare, May 2022.
10 87 Fed. Reg. 27704 (May 9, 2022), available at govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf.
11 CMS, Evaluations.
12 MACPAC, Evaluations of Integrated Care Models for Dually Eligible Beneficiaries Key Findings and Research Gaps, August 2020.
13 Id.
14 Kaiser Family Foundation, Medicare Advantage 2022 Spotlight: First Look, November 2021.

In addition to complying with Medicare Advantage regulations and guidance, all D-SNPs must provide some level of coordination with Medicaid benefits. Each plan must also enter into a state contract, known as a State Medicaid Agency Contract (SMAC).[15] Via this contract, states can impose additional requirements on plans to meet specific objectives.[16] A state can, for example, choose to only enter into contracts with D-SNPs operated by plan sponsors that also are contracted with the state's Medicaid program to provide Medicaid services. States can also influence service offerings by specifying the supplemental benefits and coordination requirements that plans must provide.[17]

Advocate Opportunity

Advocates can work with their states to develop SMAC contract provisions with strong beneficiary protections.

D-SNPs Vary Greatly in Level of Integration

Some "aligned" D-SNPs offer matching Medicaid Managed Care plans (MCOs), while some "coordination-only" D-SNPs do not. "Exclusively aligned" D-SNPs limit their enrollment to dually eligible individuals who are also enrolled in their MCO plan, but other aligned D-SNPs do not. The extent to which D-SNPs and their aligned MCO plans offer full Medicaid services also varies and depends primarily on state policy on Medicaid carve-outs.

Fully Integrated Special Needs Plans (FIDE-SNPs) are the most comprehensive D-SNPs. FIDE-SNPs contract with states to provide virtually all Medicaid-covered services through the D-SNPs. From the point of view of the dually eligible individual, a FIDE-SNP looks very similar to the capitated model within the FAI, although the financing mechanisms and the governing regulations are different. Highly Integrated Special Needs Plans (HIDE-SNPs) also are contracted with the state for most Medicaid services but are permitted to have a carve-out of either behavioral health services or long-term services and supports, but not both. HIDE and FIDE-SNPs currently represent a small proportion of D-SNPs, but several states, including some that participated in the FAI, are moving toward implementing these more integrated models. [18]

Default Enrollment Is Allowed in Some Circumstances.

CMS permits state Medicaid agencies to opt for default enrollment into D-SNPs of Medicaid individuals who are newly eligible for Medicare.[19] Newly Medicare-eligible Medicaid managed care plan enrollees can be auto-enrolled into the D-SNP operated by the same parent company as their Medicaid plan and must affirmatively opt-out to avoid default enrollment. Default enrollment is only permitted in plans that have approval from CMS, meet specific requirements, and adequately notify enrollees in advance.[20] While default enrollment in D-SNPs is permitted, as noted above, individuals always have the right to receive their Medicare through Original Medicare. However, enrollment in a health plan for Medicaid may be mandatory.

15 See, e.g., 42 C.F.R. § 422.107 and Medicare Managed Care Manual, Ch. 16(b); 42 U.S.C. § 1395w-28(f)(3) (Section 1859(f)(3) of the Social Security Act).

16 42 U.S.C. § 1395w-28(f)(3)(D) (Section 1859(f)(3)(D) of the Social Security Act); 42 C.F.R. § 422.107.

17 See, e.g., 42 C.F.R. § 422.107 and Medicare Managed Care Manual, Ch. 16(b); 42 U.S.C. § 1395w-28(f)(3) (Section 1859(f)(3) of the Social Security Act).

18 Georgia Burke, Dual Eligible Special Needs Plans (D-SNPs): What Advocates Need to Know, Justice in Aging, January 2022.

19 See 42 C.F.R. §.422.66(c)(2).

20 Integrated Care Resource Center, Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries, July 2019.

D-SNP Evaluations Have Been Limited

Evaluations of D-SNPs have been limited in scope, and looked at performance in a narrow range of states.[21] With D-SNP enrollment growing rapidly and states increasingly looking to D-SNPs as a primary vehicle for serving their dual eligible populations, there is a need for significantly more data collection and evaluation of beneficiary experience, outcomes and costs. D-SNP evaluations demonstrate reduced beneficiary hospitalizations, readmissions, and nursing facility admissions.[22] However, data limitations hinder conclusive findings regarding whether D-SNPs achieve overall savings.[23] Health equity has not been emphasized in evaluations, but CMS recently invited public comments on approaches to address health equity in the Medicare Advantage Program.[24]

Regulatory Update for D-SNPS

Recent regulations contained many technical provisions tightening definitions of D-SNP types and providing clearer directions to states. Of particular interest to advocates, the regulations incorporate some successful aspects of the FAI demonstration into D-SNPs, effective January 2023, which include:[25]

- Unified Appeals and Grievance Process:
  - » Drawing on successful pilot testing during the FAI initiative, exclusively aligned D-SNPs must now have a unified appeal and grievance process at the plan level that incorporates Medicare and Medicaid.[26] For overlapping services covered by both Medicare and Medicaid, the plan must review the request under both Medicare and Medicaid criteria at the initial review and the first internal appeal level. The plan must then issue a single decision outlining the reasons for approval or denial under Medicare and Medicaid coverage rules.
- Consumer Advisory Committee
  - » CMS now requires all D-SNPs to create advisory committees, a successful element of the FAI, comprised of plan members.[27] Under the new rule, plan sponsors with more than one D-SNP in the state can consolidate advisory committees.

Advocate Opportunity

Advocates can be particularly helpful in identifying consumer candidates for the advisory committees and ensuring that the committees represent the diversity of plan members. Advocates can also help identify accessibility needs for committee members with disabilities and those with limited English proficiency.

21 MACPAC, Evaluations of Integrated Care Models for Dually Eligible Beneficiaries Key Findings and Research Gaps, August 2020.

22 Id.

23 Id.

24 CMS, 87 FR 46918, available at https://www.federalregister.gov/documents/2022/08/01/2022-16463/medicare-program-request-for-information-on-medicare.

25 CMS, 87 FR 27704, available at https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

26 See 42 C.F.R. § 422.561(2)(ii).

27 See 42 C.F.R. § 422.107(f).

- No Ombudsman Program:
  - » In contrast to FAI demonstration programs, the current D-SNP program design does not include provisions for an ombudsman program and does not include ombudsman funding.

Advocate Opportunity

In the absence of a robust formal ombudsman program, advocates can work with states and plans to at least develop channels for identifying systemic problems and ensuring that they are addressed quickly.

D-SNP Look-Alikes

In recent years, some insurers began marketing non-D-SNP, regular Medicare Advantage plans almost exclusively to dually eligible individuals. These plans, which came to be called "D-SNP look-alikes," were not subject to the same level of state and federal oversight as D-SNPs, despite their high level of dual eligible enrollment.[28] To address concerns that these plans are inconsistent with policy objectives, CMS issued regulations phasing out non-D-SNP plans with 80% or more dually eligible enrollees by 2023.[29] In most cases, individuals in these plans are being cross-walked into D-SNPs operated by the same plan sponsor.

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

PACE is an integration option that provides services to individuals 55 and older who can live in the community but require a nursing home level of care. PACE provides all Medicare and Medicaid services, although the funding streams for the two programs remain distinct.[30] The PACE model primarily delivers services at health centers and utilizes a comprehensive care team to address dually eligible individuals' medical, social, and community needs. PACE primarily operates in a closed network, enrollees receive care at PACE facilities with PACE providers. PACE enrollment is relatively small, with approximately 50,000 enrollees nationwide.[31]

Conclusion

Dually eligible individuals can choose to receive health care from multiple delivery models. There is an ongoing need for evaluations to determine whether integrated models are improving the health outcomes of people dually eligible for Medicare and Medicaid. Advocacy opportunities exist for working with individual clients, as well as at the federal and state levels, to inform these integrated models, including ensuring a focus on health equity.

28 See CMS Final Rule CMS-4190-F1 p. 10, and Justice in Aging, Dual Eligible Special Needs Plans (D-SNPs) Look-Alikes: A Primer, July 2019.

29 CMS, Dual Eligible Special Needs Plans Look-Alike Transitions for Contract Year 2021 (hhs.gov), June 2020.

30 Individuals with Medicare enrollment who do not also have Medicaid coverage are permitted to join PACE and pay a monthly premium for services that Medicaid would cover. PACE | Medicare. However, PACE enrollment is overwhelmingly comprised of people who are dually eligible for both programs.

31 Integrated Care Resource Center, Program of All Inclusive Care for the Elderly (PACE) Total Enrollment by State and by Organization, October 2020.

Additional Resources

- CMS: Medicare-Medicaid Coordination Office
- NCLER: Legal Basics: Dual Eligibles
- NCLER: Legal Basics: Medicare Part C & Medicare Advantage
- NCLER: Updates on Managed Care for Dual Eligibles and Medicare Coordination Programs

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

This Chapter Summary was supported by contract with the National Center on Law and Elder Rights, contract number HHS75P00121C00033, from the U.S. Administration on Community Living, Department of Health and Human Services, Washington, D.C. 20201.