

BRIEF #2

Medicare-Medicaid Integration: Reflecting on Progress to Date and Charting the Path to Making Integrated Programs Available to all Dually Eligible Individuals

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*This issue brief is the second in a series of papers to examine the current status of Medicare-Medicaid integrated programs and approaches needed to increase program effectiveness and expand program access for all individuals dually eligible for full Medicare and Medicaid benefits. Based on review of the literature and available public information, this brief summarizes the elements identified for success and the barriers encountered by integrated programs. **Based on our review of the literature, the brief concludes with essential questions and next steps for moving forward with federal and state public policies and care delivery options centered around, informed by, and available to more dually eligible individuals.**¹*

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Summary

The 7.7 million people in the country eligible for full benefits under Medicare and individual state Medicaid programs are diverse in characteristics including age, disability status, medical status- often having multiple chronic conditions, behavioral health needs, culture and ethnicity, and geographies in which they live.² They must navigate a fragmented system of care across the two programs which is often not integrated or coordinated. Inadequate coordination across medical, behavior health and long-term services and support providers, as well as social support providers, can lead to poor health outcomes and quality of life. The federal government, states, and other stakeholders have undertaken important efforts to establish integrated financial and delivery programs to improve integration and coordination of covered services for dually eligible individuals across the two programs. Yet, today, only 10 percent of dually eligible individuals are enrolled in an integrated program.³

To identify barriers, challenges and success elements of integrated programs, Health Management Associates (HMA) conducted an extensive literature review of publications and other publicly available information on current Medicare-Medicaid integrated programs across models and states (See Appendix A for Bibliography). Our review identified challenges and elements of success for integrating care. The review also highlighted gaps in information and key questions that need to be answered by stakeholders, most importantly dually eligible individuals and their families and caregivers, to inform future policy and program design for integrated programs. Going forward, answers to these questions and others will assist policy makers at the state and federal levels to determine whether current models in place need to be modified or different models or new programs must be created to provide integrated, cost-efficient care that improves quality of life and is accessible to all dually eligible individuals moving forward.

Introduction

Medicare-Medicaid Dual Eligible Population

In 2019, 7.7 million people in the country were eligible for full benefits under Medicare and individual state Medicaid programs.⁴ They are a diverse population in characteristics and needs, including:

- 39 percent are under the age of 65, compared to 9 percent of Medicare-only beneficiaries⁵

- 61 percent are female, compared to Medicare-only enrollees, of whom 52 percent are female⁶
- Dually eligible individuals have an average of six chronic health conditions, compared to an average of four among Medicare-only enrollees⁷
- 28 percent report three or more limitations in activities of daily living (ADLs)⁸, compared to 9 percent of Medicare-only enrollees⁹
- Dually eligible individuals have greater social determinants of health (SDOH) risk factors that include low health literacy, poverty, lack of transportation, and food and housing insecurity often in communities that do not have adequate services to meet these needs¹⁰
- Individuals who reside in rural areas are more likely to be dually eligible than urban Medicare enrollees¹¹

Dually eligible individuals rely on a range of services provided by the two programs that historically have not been coordinated and operate in silos. They are more likely to experience gaps in care and experience poorer health outcomes. They account for high proportions of spending for both programs. Dually eligible individuals represent 20 percent of all Medicare enrollees and 34 percent of program costs; they represent 15 percent of all Medicaid enrollees and 33 percent of program costs.¹²

The federal government, states, and other stakeholders have undertaken important efforts to establish integrated financial and delivery programs to improve integration and coordination of covered services for eligible individuals and to reduce costs for both Medicare and Medicaid. Today, only one in 10 full benefit dual eligible individuals are enrolled in an integrated program.¹³ The low enrollment number is due to the lack of availability of integrated programs in many parts of the country, high rates of disenrollment from some programs and low rates of enrollment in opt-in models. The lack of availability and low enrollment in these programs is of particular concern during the Coronavirus (COVID-19) pandemic. The higher rates of morbidity and mortality from COVID-19 among people who are older and have multiple chronic conditions, many of whom are dually eligible individuals, highlights the need for greater coordination of care and access to integrated systems.¹⁴

Current Medicare-Medicaid Integrated Programs and Demonstrations

The Centers for Medicare and Medicaid Services (CMS) defines an integrated program as one that provides the full array of Medicaid and Medicare benefits *through a single delivery and financing system* in order to provide quality care for dually eligible people, improve care coordination, and reduce administrative burdens.¹⁵ Some of the current integrated program models are closer to meeting the CMS definition of an integrated program than others. Of note, some of these models do not cover Medicaid behavioral health services and many do not include Medicaid intellectual and developmental disability waiver services. Four integrated program models have emerged as predominant, with new integrated Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) options that will become available for calendar year (CY) 2021.

Predominant Medicare-Medicaid Integrated Programs

Medicare-Medicaid Financial Alignment Initiative (FAI) Demonstrations - Nine states¹⁶ currently partner with CMS in administering a capitated model whereby a managed-care entity receives funding from both Medicare and Medicaid, and coordinates services covered under both programs. One state (Washington) participates in a Managed Fee-for-Service model, whereby the state is eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid.

Program of All-Inclusive Care for the Elderly (PACE) – With programs in 31 states,¹⁷ PACE uses capitated payments to provide all Medicare and Medicaid services primarily in an adult day health center (supplemented by in-home and referral services in accordance with individual needs) to certain frail, elderly people age 55 and older living in the community.

Medicare Advantage Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)* – In 11 states,¹⁸ a single health plan entity that is a Dual Eligible Special Needs Plan (D-SNP) with FIDE SNP designation provides Medicare benefits and Medicaid benefits, consistent with state policy (Medicaid state policy may include a carve out of Medicaid behavioral health services).

Medicaid Managed Long-Term Service and Supports Program (MLTSS) managed care organizations (MCOs) and aligned D-SNPs* (MLTSS+D-SNP) – Nine states¹⁹ currently require MLTSS managed care organizations (MCOs) to operate “aligned” or “companion” D-SNP in order to participate in Medicaid managed care.

For CY 2021 Medicare Advantage Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP)* – A D-SNP with HIDE SNP designation has, or its parent organization or another entity owned and controlled by the parent organization has, a capitated contract with the state Medicaid agency in the state it operates that includes Medicaid long-term services and supports (LTSS), behavioral health, or both, consistent with state policy.²⁰

*D-SNPs have dual integration requirements outlined in state Medicaid agency contracts (SMACs) in order to operate in a state.

Literature Review

HMA conducted an extensive review of more than 140 publications and other publicly available information on current Medicare-Medicaid integrated programs across models and states (See Appendix A for Bibliography) to identify challenges and elements of success for integrating care for dually eligible individuals. There is a large body of literature and publicly available information describing the FAI demonstrations and their successes and challenges. Researchers have also covered the PACE program extensively. However, information about the successes and challenges of effectively integrating care through FIDE SNPs and MLTSS+D-SNP programs, with exceptions of efforts in Minnesota,²¹ Massachusetts²² and Arizona,²³ have not been covered as widely but are an increasing focus of states and the federal government.

Our comprehensive review included formal CMS evaluations, peer-reviewed literature, advocacy organization position statements, and state stakeholder engagement materials to identify and synthesize the research evaluating the impact that integrated programs for dually eligible individuals have had on quality of care, beneficiary satisfaction, healthcare service utilization, and spending. In addition, the literature review sought to identify gaps in the literature as a means to guide future research and evaluations.

HMA's methodology used a robust list of search terms (See Appendix B) to search Google Scholar for literature published between 2012 and 2019, supplemented with a targeted review of the websites of advocacy organizations and states known to have examined or provided technical assistance to the programs of interest. Advocacy organizations included beneficiary advocates, provider associations, and health plan associations that represent or serve dually eligible individuals. Targeted states included those known to have integrated programs in the following categories: FAI, PACE, FIDE SNP, MLTSS+D-SNP, as well as select states that have indicated some interest in integration. We also conducted a subsequent search of literature published through May 31, 2020 to incorporate any significant new or updated information. Findings were compiled in a bibliography (See Appendix B) organized by topic and integrated model (i.e., general dual eligible people; general dual eligible integration programs; FAI (capitated, managed fee-for-service); PACE; and D-SNP (FIDE SNP, MLTSS+D-SNP non-FIDE)).²⁴

Our literature review highlighted that research is promising that integrated models can produce superior cost and quality outcomes for enrolled individuals,²⁵²⁶²⁷ but there are some significant factors that limit the ability of these programs to effectively implement an integrated program approach. Success factors cited for some integrated programs include appropriate service utilization and improved consumer satisfaction and quality of life.²⁸²⁹ Of particular note, individuals enrolled in integrated programs are pleased with reduction in cost-sharing, improved access to medical (including durable medical equipment), behavioral, and the availability of enhanced services such as community behavioral health or additional dental services, and more reliable medical transportation services.³⁰³¹ For example, participants in the South Carolina capitated financial alignment initiative stated they used income not spent on copays for food and other essential items and were no longer turned away at providers' offices for not having sufficient funds to receive care.³²

However, the literature highlighted that gaps in data, lack of standardized metrics, and other evaluation challenges make it difficult to draw conclusions on the full impact of programs or to identify one optimal model among existing programs. Specifically, the lack of available Medicaid data precluded measurement of the impact on total costs.³³ Additional research is needed to: 1) evaluate outcomes for particular populations; 2) assess health care outcomes other than hospitalizations and nursing facility use; and 3) the effects of integrated models on Medicaid spending.³⁴

The literature highlighted some of the challenges encountered across programs. Table 1 below provides a high-level summary of challenges described in the literature faced by each of these models. **We next focus the main section of the paper on key elements for success in integrated programs followed by questions that need to be addressed in order to move forward in a meaningful way to extend the availability of current or new fully integrated program options to all dually eligible individuals.**

Table 1. Predominant Medicare-Medicaid Integration Program Model Challenges and Barriers

PROGRAM FINDINGS	
FAI	<ul style="list-style-type: none"> ✓ Insufficient state capacity and resources ✓ Low enrollment and high opt-out rates³⁵³⁶ ✓ Commission structures for agents/brokers, who report making greater commissions selling Medicare Advantage products as alternatives to MMP³⁷ ✓ Populations carved out³⁸ ✓ Geographic limitations³⁹ ✓ Consumer confusion about programs and benefits ✓ Consumer organization ongoing concerns about passive enrollment⁴⁰ ✓ Identification and engagement of individuals for care coordination⁴¹ ✓ Provider disengagement and pushback⁴² ✓ Timely payment and capitation rate issues ✓ Payment inadequacy and program complexity⁴³ ✓ Inadequacy of payment rates for care coordination⁴⁴ ✓ Financial sustainability of health homes at program outset⁴⁵ ✓ LTSS providers and clinical providers have different views of the program – one more medically focused and the other more socially focused⁴⁶ ✓ Data interoperability issues ✓ Lack of Medicare-Medicaid alignment⁴⁷ ✓ Lack of Medicaid data for program evaluation and to assess Medicaid savings as well as savings to Medicare⁴⁸ ✓ Lack of population specific, quality of life and outcome measures⁴⁹
PACE	<ul style="list-style-type: none"> ✓ Limitations on scalability due to site-based nature of program⁵⁰ ✓ Mixed findings on increase or decrease in nursing facility use across studies⁵¹ ✓ Most enrollees must change their primary care provider (PCP) to the PACE PCP ✓ Transportation costs and logistics and available membership associated with rural communities ✓ Perceived as more expensive/Mixed results on Medicaid spending

	<ul style="list-style-type: none"> ✓ Administrative burdens⁵²
MLTSS+D-SNP	<ul style="list-style-type: none"> ✓ Lack of data on achieving aligned enrollment in highly integrated plans⁵³ ✓ Both types of plans (MLTSS and D-SNP) may not be offered in all areas of a state limiting enrollment⁵⁴ ✓ Consumer organization ongoing concerns about default enrollment⁵⁵ ✓ Lack of integrated consumer materials ✓ Variation in D-SNP implementation makes evaluation challenging⁵⁶ ✓ Data interoperability issues ✓ Lack of Medicare-Medicaid administrative and financial alignment ✓ MLTSS and D-SNP contracts may be held by different parts of the same corporate parent company which can lead to different plan structures and platforms including provider networks, claims platforms, care management structures and information technology platforms⁵⁷
FIDE SNP	<ul style="list-style-type: none"> ✓ Variation in program implementation and structure across states⁵⁸ ✓ Limited evaluation of programs beyond a few states⁵⁹ ✓ To date, limited take-up rate by health plans and states

Elements for Success

Our review highlighted several elements for successful program planning, implementation, oversight and evaluation that can inform future program model evolution and federal and state policy frameworks. These elements may contribute to increased integrated program success and expand the availability to all dually eligible individuals.

Our review identified six critical success elements to improve dually eligible individuals' support of and connection to the programs and to improve the programs' ability to serve them.

1. Individual Consumer Engagement in Program Design, Communications, Implementation and Ongoing Program Oversight
2. Provider Engagement and Robust Networks
3. Care Coordination and Risk Stratification
4. Strong State and Federal Government Collaboration
5. Adequate State Capacity
6. Performance and Outcome Measures Tailored to the Population

Individual Consumer Engagement in Program Design, Communications, Implementation and Ongoing Program Oversight

Our review of the literature found that successful programs involve dually eligible individuals, their families, caregivers, and providers involvement with the design before, during, and after program implementation. This involvement ensures that programs meet consumers’ needs and preferences, and achieve sufficient enrollment, engagement, and positive outcomes. Key areas of program design where this feedback is particularly useful include: (1) marketing materials (pre-enrollment); (2) educational and communication materials (post-enrollment); and (3) certain operational processes (e.g. engagement of consumer advisory councils to inform program policies and procedures).

To support enrollment and continued enrollment in integrated programs, individuals and their caregivers require tailored, linguistically and culturally appropriate information about how the program differs from existing service delivery, program benefits including enhanced benefits, participating providers, maintaining provider relationships (to the extent applicable), and how to contact a care coordinator.

Lack of targeted outreach and appropriate information can produce consumer confusion and fear of change leading to high opt-out including disenrollment rates for program participation. The capitated FAI programs use passive enrollment⁶⁰ to bolster enrollment. D-SNPs, with the support of states in which they operate, are seeking default enrollment of their members enrolled in their comprehensive Medicaid managed care plans into their D-SNP when the member becomes newly eligible for Medicare in addition to Medicaid.⁶¹ Consumer groups are concerned these approaches can disrupt dually eligible individuals’ care and supports and state that the best practice is to share program successes and benefits to drive consumer enrollment.⁶²

Both consumer groups and health plans view consumer advisory councils as successful mechanisms to ensure voices of older adults, persons with disabilities and their caregivers provide input into the design, implementation and oversight of the capitated FAI demonstrations. The federal government and participating states require capitated FAI Medicare-Medicaid Plans (MMPs) to have a consumer advisory council.⁶³ Information in the literature was limited as to the extent input from these councils informed ongoing integrated program policies and operations. Table 2 provides critical elements of success for consumer engagement.

Table 2. Consumer and Family/Caregiver Engagement Recommendations from the Literature

FINDINGS	
✓	Use integrated consumer materials covering Medicare and Medicaid program benefits, beneficiary protections and enrollment and other administrative processes such as individual grievances and appeals ^{64,65}
✓	Target materials and program approaches to the distinct needs of dual eligible subpopulations and work with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, to inform a strong

and coordinated communication process.⁶⁶ Dual eligible subpopulations have distinct needs and preferences which contribute to enrollment and satisfaction with programs.

For example:

- **Immigrant populations** engage CBOs to supplement information received about integrated care programs. Despite accessing CBOs in California, immigrant populations experienced greater challenges accessing health care and information compared to US-born citizens. In California the experience of disempowerment was significant for Latino immigrants.⁶⁷
- **Limited English Proficient (LEP) populations** need culturally and linguistically appropriate services from their providers.⁶⁸ Certain individuals with LEP had higher opt-out rates in California’s capitated FAI.⁶⁹ Use the translation standards that promote the greatest access.⁷⁰ In 2014, there were approximately 8.7 million LEP persons enrolled in Medicare, Medicaid, or both programs.⁷¹
- **Individuals with cognitive impairments and/or multiple health care issues** require an understandable “what matters most to you” discussion to link individuals with high-needs and their caregivers to appropriate services⁷²
- ✓ **Consumer test all materials**⁷³
- ✓ **Use plain language** and a reading level no higher than sixth grade⁷⁴
- ✓ **Tailor consumer notices and communications to the individual’s circumstances** and include only information directly relevant to the purpose of the communication⁷⁵
- ✓ **Require Ombudsman programs and Consumer Advisory Councils**⁷⁶

Provider Engagement and Robust Network

The literature finds that provider engagement and buy-in are critical to ensure individuals have access to a sufficient provider network and providers they know and prefer. A large portion of dually eligible individuals and their caregivers express strongly the need to retain their providers, which may include primary care, long term services and supports (LTSS), and other specialty providers. Integrated programs need to offer a wide choice of providers and protect continuity of care to reduce disenrollment. Some capitated FAI programs experienced very high opt-out rates and disenrollment due to inability to retain existing provider relationships.^{77,78} Many providers will not join networks even when offered Medicare-comparable rates due to concerns about stricter health plan utilization management and authorizations practices than the traditional Medicare fee-for-service program. Provider continuity can alleviate individuals’ concerns about enrollment in integrated programs and promote consumer satisfaction and quality outcomes. Table 3 provides critical elements of success for provider engagement.

Table 3. Provider Engagement and Network Recommendations from the Literature

FINDINGS	
✓	Invest in provider relationships to promote program success ⁷⁹ and support enrollment of the individuals they serve
✓	Educate providers lacking experience with managed care delivery systems or serving patients with complex conditions common among dually eligible individuals. Particularly focus on pre-authorization processes and claims submission ⁸⁰

- ✓ **Clearly inform providers about the integrated model’s goals and benefits** for individuals served, as well as supports for providers to avoid administrative challenges⁸¹
- ✓ **Streamline and train providers on navigating program** participant data and reporting and referral/authorization processes⁸²
- ✓ **Ensure adequate provider and MCO rates**
- ✓ **Encourage adoption of value-based payment arrangements that reward better outcomes**
- ✓ **Pay sufficient provider rates** and make payment in a timely matter⁸³
- ✓ **Solicit ongoing provider engagement** ⁸⁴

Care Coordination and Risk Stratification

A primary motivation for creation of integrated programs for dually eligible individuals is to be able to offer sophisticated systems of care coordination for members.⁸⁵ Care coordination is defined as the development of personalized needs assessments and person-centered care plans and interdisciplinary care teams who ensure that patients receive care consistent with their needs and defined care plans. The literature also defines person-centered care coordination to include a distinct focus on caregiver participation, transitions of care, and individuals’ social determinants of health (SDOH). Risk stratification is defined as the assessment tools and analytics to identify levels and intensity of care coordination that should be provided. Such assessment tools and analytics target interventions toward individuals at high-risk for hospitalization, readmission and nursing home admission.⁸⁶

The literature finds that consumer dissatisfaction in some capitated FAI programs resulted from lack of knowledge of who is their assigned care coordinator and confusion between roles of care coordinators and care managers.⁸⁷ An identified critical element of success is to ensure that individual consumers and their caregivers understand the specific functions of the care coordinator, who that person is and, if there are multiple care managers and coordinators, what their respective roles are and how well they coordinate with each other. Table 4 provides critical elements of success for care coordination and risk stratification.

Table 4. Care Coordination and Risk Stratification Recommendations from the Literature

FINDINGS	
✓	Increase consumer awareness about the availability of care coordinators , as well as the specific roles and supports they provide through outreach and education . ⁸⁸
✓	Establish positive relationships through early welcome calls and face-to-face visits as appropriate and possible ⁸⁹
✓	Use community-based partners such as providers of independent living and home health, area agencies on aging or LTSS coordinators, to facilitate access to and coordination of medical, behavioral health, and LTSS systems ⁹⁰
✓	Assess and address individual SDOH risk factors for dually eligible individuals through care coordination ⁹¹

- ✓ **Focus on “patient activation” and engagement** to empower them to set goals, engage with physicians, and make health decisions that will improve their health and quality of life⁹²
- ✓ **Co-locate health plan care coordination staff in county agencies and the community**, and target dementia training⁹³
- ✓ **Standardize risk assessment tools and stratify individuals into risk groups** help to better target care coordination and interventions⁹⁴
- ✓ **Use interdisciplinary care teams** facilitate care transitions and reduce re-hospitalizations (such as PACE)⁹⁵

Strong State and Federal Government Collaboration

Regardless of what specific type of model that is adopted long-term, the literature cites increased collaboration between federal and state government partners as a key success factor. For example, in the capitated FAI demonstrations, joint state and CMS contract management teams convene on a weekly and ad-hoc basis to oversee and resolve administrative and operational issues in addition to care delivery and enrollee-specific concerns.⁹⁶ The Minnesota FIDE SNP program which operates an administrative FAI demonstration with program administrative flexibilities also has a joint state and CMS contract management team (renamed the Demonstration Management Team). State officials note that the team has had a significant effect on the state’s ability to align Medicare and Medicaid policies to improve consumers’ experience in the program and achieve program objectives.⁹⁷ Table 5 provides critical elements of success for federal and state coordination.

Table 5. State and Federal Government Collaboration from the Literature

FINDINGS
<ul style="list-style-type: none"> ✓ Implement federal and state contract management teams as CMS has done with states participating in the capitated FAI to help monitor alignment issues in other Medicare-Medicaid integration models⁹⁸ ✓ Use contract management teams as a vehicle for addressing program misalignment issues such as beneficiary materials development and network adequacy⁹⁹

Adequate State Capacity

The literature describes the extent of state resources that integrated programs require to establish, implement and oversee integrated programs. States need dedicated resources to not only design program goals but to actively oversee them and monitor consumer experiences. One paper noted that state commitment to secure resources in order to effectively contract with D-SNPs is essential to ensure that integration goals are achieved.¹⁰⁰ States additionally need staff with Medicare expertise to effectively work with health plans and the federal government.

The literature finds that more fully integrated programs require substantial upfront and sustained investment in state resources. For example, Virginia did not have the resources needed to design its

capitated FAI prior to implementation of its program as it did not get an earlier design contract from CMS providing start-up grant funding. This caused program design planning to occur as it began enrollment into the program.¹⁰¹ Other states faced challenges due to changes in state leadership commitment that caused delays and pauses in their program implementation. They also experienced instability in implementation and oversight due to state agency reorganization that reassigned needed staff that impacted program monitoring.^{102,103} Table 6 provides critical elements of success for federal and state coordination.

Table 6. Adequate State Capacity from the Literature

FINDINGS	
✓	Ensure adequate state supports and resources to reduce barriers in state capacity to support implementation of integrated programs ¹⁰⁴
✓	Seek additional resources and technical assistance from the federal government ¹⁰⁵
✓	Develop strong Medicare expertise within state agencies ¹⁰⁶

Performance and Outcome Measures Tailored to the Population

Standardized performance measures that are reflective of the population(s) served are critical to promote accountability and assess program success.¹⁰⁷ The literature cites a clear need for standardized measures of LTSS, and quality of life and outcome measures.¹⁰⁸ National and state disability stakeholders provided input early on during the implementation of capitated FAI programs that not enough attention was focused on the development of appropriate metrics and that further work was needed to determine success of the demonstrations.¹⁰⁹ Of note, Ohio's capitated FAI included quality measures related to home and community-based services and LTSS rebalancing among the criteria that health plans must meet to earn the quality withhold portion of the capitated rates in the financial alignment demonstration.¹¹⁰ Table 7 provides critical elements of success for performance and outcomes measures

Table 7. Performance and Outcome Measures Tailored to the Population from the Literature

FINDINGS	
✓	Develop measures to evaluate outcomes for particular populations ¹¹¹
✓	Expand measures beyond hospitalizations, visits, and nursing facility use ¹¹²
✓	Ensure quality of life measures reflect the needs and preferences of dual eligible individuals and of specific subpopulations of dual eligible individuals ¹¹³
✓	Establish clear goals for program success and measures developed to measure success

Looking Forward: Essential Questions and Gaps to Address to Make Integrated Programs Available to and Accessible for All Dual Eligible Individuals

Our review of publications and other publicly available information identified both barriers and successful features of integrated programs to date. It also highlighted gaps in data, limited engagement of diverse consumer stakeholders, lack of standardized metrics, and evaluation challenges that make it difficult to draw conclusive evidence on the full impact of programs or to identify one optimal model among existing programs. The gaps in the literature, along with mixed evidence on successful outcomes to date raise numerous questions that need to be addressed in order to move forward to extend availability of fully integrated program options. Future program design must be informed by engaging stakeholders, particularly dually eligible individuals and their caregivers, to address these pressing issues. Key questions in the future design, implementation and oversight of these programs include:

Primacy of Consumer Role

- How can integrated programs assure consumer priorities are central in the design, implementation, and ongoing monitoring and improvement of an enhanced integrated care model?
- How can high satisfaction levels among some participants be employed to increase overall enrollment?

Prioritization of Goals

- Given that evidence suggests one integration model will not likely improve all outcomes or meet the needs of all dually eligible subpopulations or stakeholders, how can policy makers, consumers and other stakeholders reach consensus on goals of integrated programs, and then focus program design accordingly? For example, what are the highest priorities among: reducing costs, program simplification (for consumers, providers, states) and reducing redundancies, lowering inappropriate service utilization, improving health outcomes, providing equal access for all dually eligible people regardless of where they live and their conditions, providing choice to consumers or to states, and improving quality of life? What metrics would best measure “success”?
- What are potential new designs that address current barriers, meet consumer needs, and promise to achieve high priority goals? For example, what changes are needed in payment, administration, or care delivery?
- Do goals vary across states? Is more than one integration framework needed?

Addressing State Diversity and Enhancing State Capacity

- How should integrated programs be tailored to the array of state characteristics including distinct delivery systems, populations, geography, availability of financing and resources, culture and other characteristics?
- How can state capacity be enhanced to make integrated programs sustainable and more widely available?

Federal and State Supports that Increase Participation

- What federal regulatory and policy changes are needed to attain an achievable and effective integrated program and delivery system?
- What federal supports - resources, incentives, guidance, regulations, metrics, oversight – would spark greater participation by states, providers, MCOs, and dually eligible people?
- How can CMS build on recent D-SNP requirements to strengthen and broaden approaches into a fully integrated model? Are D-SNPs an appropriate vehicle for integration or are there other models that CMS should pursue in addition to/in lieu of D-SNPs?
- How can CMS learn from capitated FAI program experience to create a fully integrated model, and are MMPs the appropriate vehicles?
- What is the optimal balance between prescriptive structuring/ensuring accountability and allowing/encouraging flexibility?
- If current integrated program options using health plans are kept, (i.e. enrollment in MMPs, MLTSS+D-SNP, FIDE SNPs) how can state and federal policy and actions support enrollment in them that helps dual eligible individuals enroll in the best option for them?

Upcoming meetings and interviews supported by Arnold Ventures will engage consumers and their caregivers or representatives, state and federal leaders, providers, and MCOs in grappling with these questions. They are intended to result in recommendations for designing effective integrated programs and ensuring that dually eligible individuals have access to programs appropriate to their needs.

Appendix A: Bibliography

HMA conducted an extensive review of more than 140 publications and other publicly available information on current Medicare-Medicaid integrated programs across models and states to identify challenges and elements of success for integrating care for dually eligible individuals. A comprehensive list of these sources is available [here](#).

Appendix B: Literature Review Search Terms

Search Terms	
Peer-reviewed Literature	D-SNP dual eligibility dual eligible dually eligible dual integrated care dual Medicaid Medicare dual special needs plan Financial Alignment Initiative managed long term services supports Medicare financial alignment Medicare financial integration Medicare Medicaid coordination Medicare Medicaid eligible Medicare Medicaid integrated demonstration Medicare Medicaid integration Medicare Medicaid plan MLTSS Program All Inclusive Care Elderly social determinants of health Medicaid social determinants of health Medicare
State and Advocacy Organization Website	Dual CMMI Dual eligible stakeholder Dual eligible state legislative Dual eligible state legislature full benefit dual eligible Medicare Medicaid integration Medicare Medicaid integrated plan social determinants of health Medicaid Medicare

¹ In this brief, when referencing the dually eligible population, we are referencing Medicare-Medicaid full benefit dual eligibles (FBDEs), those who qualify for full Medicaid benefits. Others who solely qualify for assistance with payment of Medicare premiums, and in some cases, Medicare cost sharing, are referred to as partial benefit dually eligible individuals and not the subject of this brief.

² “People Dually Eligible for Medicare and Medicaid,” The Centers for Medicare and Medicaid (CMS) Medicare and Medicaid Coordination Office (MMCO), March 2020, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

³ Sarah Barth, et al., “Medicare-Medicaid Integration: Integrated Model Enrollment Rates Show Majority of Medicare-Medicaid Dual Eligible Population Not Enrolled,” Health Management Associates (HMA), April 2020, <https://www.healthmanagement.com/wp-content/uploads/04-20-2020-Issue-Brief-1-final.pdf>

⁴ Sarah Barth, et al., “Medicare-Medicaid Integration: Integrated Model Enrollment Rates Show Majority of Medicare-Medicaid Dual Eligible Population Not Enrolled,” Health Management Associates (HMA), April 2020, <https://www.healthmanagement.com/wp-content/uploads/04-20-2020-Issue-Brief-1-final.pdf>

⁵ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps,” Medicaid and CHIP Payment and Access Commission (MACPAC), July 2019, <https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf>

⁶ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

⁷ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

⁸ Activities of Daily Living (ADLs): Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. The Medicare Current Beneficiary Survey (MCBS) Appendix B, The Centers for Medicare and Medicaid (CMS), 2008, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/2008_Appendix_B.pdf

⁹ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

¹⁰ Melony E. Sorbero, et al., “Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans Findings from Interviews and Case Studies,” U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Health Policy (ASPE), 2018, https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf

¹¹ Kevin J. Bennett, PhD, Ashley S. Robertson, JD, Janice C. Probst, PhD, “Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries,” South Carolina Rural Health Research Center, November 2014, https://sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/133characteristicsutilizationpatterns2014.pdf

¹² “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

¹³ Barth et al., “Medicare-Medicaid Integration,” HMA.

¹⁴ “Report to Congress on Medicaid and CHIP, Chapter 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options,” Medicaid and CHIP Payment and Access Commission (MACPAC), June 2020, <https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>

¹⁵ “Integrating Care,” The Centers for Medicare and Medicaid (CMS), <https://www.medicaid.gov/medicaid/long-term-services-supports/integrating-care/index.html>

¹⁶ California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas.

¹⁷ Alabama, Arkansas, California, Colorado, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming.

¹⁸ Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Tennessee, Wisconsin.

¹⁹ Arizona, Hawaii, New Mexico, Minnesota, Massachusetts, Pennsylvania, Tennessee, Texas, Virginia.

²⁰ “Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021,” The Centers for Medicare and Medicaid (CMS), April 2019, <https://www.federalregister.gov/documents/2019/04/16/2019-06822/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare>

²¹ Wayne L. Anderson, Ph.D., Z. Feng, Ph.D., and Sharon K. Long, Ph.D., “Minnesota Managed Care Longitudinal Data Analysis,” U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Health Policy (ASPE), March 2016, <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>

²² Jung, H. Y., Trivedi, A. N., Grabowski, D. C., & Mor, V., “Integrated Medicare and Medicaid Managed Care and Rehospitalization of Dual Eligibles,”

[https://ajmc.s3.amazonaws.com/media/pdf/AJMC_10_2015_Jung%20\(final%20PDF\).pdf](https://ajmc.s3.amazonaws.com/media/pdf/AJMC_10_2015_Jung%20(final%20PDF).pdf)

²³ Varnee Murugan, Ed Drozd, and Kevin Dietz, “Analysis of Care Coordination Outcomes/A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries,” Avalere, July 2012, http://avalere.com/research/docs/20120627_Avalere_Mercy_Care_White_Paper.pdf

²⁴ Note, the June 2020 reports produced by the Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC) covered chapters on the background and context for integrating care, options for integrating care for dually eligible individuals, and the transformation of Medicare toward value-based purchasing away from fee-for-service. Release of these reports occurred after producing the draft of this paper resulting in limited reference. “Report to Congress on Medicaid and CHIP, Chapter 1: Integrating Care for Dually Eligible Beneficiaries: Background and Context,” Medicaid and CHIP Payment and Access Commission (MACPAC), June 2020, <https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>, “Report to Congress on Medicaid and CHIP, Chapter 2: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options,” Medicaid and CHIP Payment and Access Commission (MACPAC), June 2020, <https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>, “Report to the Congress: Medicare and the Health Care Delivery System, Chapter 1: Realizing the Promise of Value-based Payment in Medicare: An Agenda for Change,” Medicare Payment Advisory Commission (MedPAC), June 2020, http://medpac.gov/docs/default-source/reports/jun20_reporttocongress_sec.pdf?sfvrsn=0

²⁵ Anderson, Feng., and Long. “Minnesota Managed Care Longitudinal Data Analysis,” ASPE.

The analysis evaluated MSHO’s outcomes from 2010 to 2012 by comparing the experiences of similar beneficiaries inside and outside of MSHO and found that MSHO enrollees were:

- 48 percent less likely to have a hospital stay, and those who were hospitalized had 26 percent fewer stays;
- 6 percent less likely to have an outpatient emergency department visit, and those who did visit an emergency department had 38 percent fewer visits; and
- 13 percent more likely to receive home and community-based long term care services

²⁶ Murugan, Drozd, and Dietz, “Analysis of Care Coordination Outcomes,” Avalere. The results of this analysis revealed that the risk adjusted Mercy Care Plan members made higher use of preventive/ambulatory services, and had lower rates of inpatient utilization, emergency department utilization and all-cause readmissions relative to patterns of care for dual eligible beneficiaries enrolled in original Medicare fee-for-services (FFS). Mercy Care Plan is a managed care organization that focuses on integrated care for dual eligibles under contract with CMS and the Arizona Health Care Cost Containment System. It is a Medicaid, Medicare Special Needs Plan. Specifically, when compared to the total national FFS dual eligible beneficiaries, and adjusted to match the risk of the FFS dual eligibles, the total Mercy Care population exhibited:

- 3% higher proportion of beneficiaries accessing preventive/ambulatory health services
- 31% lower discharge rate (as a measure of inpatient utilization)
- 43% lower rate of days spent in the hospital (as a measure of inpatient utilization)
- 19% lower average length of stay (as a measure of inpatient utilization)
- 9% lower rate of ED visits
- 21% lower readmission rate

²⁷ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

²⁸ Edith G. Walsh, “Financial Alignment Initiative South Carolina Healthy Connections Prime: First Evaluation Report,” RTI International, August 2019, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/SCEvalReport1.pdf>

²⁹ Individuals enrolled in integrated programs are pleased with reduction in cost-sharing, improved access to medical (including durable medical equipment), behavioral, and enhanced services such as community behavioral health, as well as additional dental services, and more reliable medical transportation services. Jennie Fishman and Alexis Henry, “One Care: MassHealth Plus Medicare. Early Indicators Project: Preliminary Findings from a Focus Group with Early Self-Selected One Care Enrollees,” UMass Medical School, 2014,

<https://www.mass.gov/doc/summary-one-care-focus-group-worcester-auto-enrolled-members/download>

³⁰ Walsh, “Financial Alignment Initiative South Carolina Healthy Connections Prime,” RTI International.

³¹ Fishman and Henry, “Once Care,” UMass Medical School.

³² Walsh, “Financial Alignment Initiative South Carolina Healthy Connections Prime,” RTI International.

³³ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

³⁴ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

³⁵ David C. Grabowski, Nina R. Joyce, Thomas G. McGuire, and Richard G. Frank, “Passive Enrollment of Dual-Eligible Beneficiaries into Medicare and Medicaid Managed Care has Not Met Expectations,” *Health Affairs* 35, no. 5 (2017): 846-854 doi: 10.1377/hlthaff.2016.1082.

³⁶ “Program Update: Person-Centered Program Design & Family Caregivers;” Healthy Connections Prime, 2019, [https://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy%20Connections%20Prime%20Program%20Update%20\(Summer%202019\).pdf](https://msp.scdhhs.gov/SCDue2/sites/default/files/Healthy%20Connections%20Prime%20Program%20Update%20(Summer%202019).pdf)

³⁷ Debra J. Lipson, Erin Weir Lakhmani, Alena Tourtellotte, and Danielle Chelminsky, “The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries,” Medicaid and CHIP Payment and Access Commission (MACPAC), January 2019, <https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/>

³⁸ Barth, et al., “Medicare-Medicaid Integration,” HMA.

³⁹ Barth, et al., “Medicare-Medicaid Integration,” HMA.

⁴⁰ Ann Hwang, MD, Letter to Demetrios Kouzoukas, “Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter,” *Community Catalyst*, March 2019, https://www.communitycatalyst.org/resources/comment-letters/document/CCEHI-Comments-on-part-2-CMS-2020-Call-Letter_FINAL_03_01_19-1.pdf

⁴¹ Nancy Archibald, Kathy Moses, and Lauren Rava “Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State’s Experiences,” *Center for Health Care Strategies*, February 2019, https://www.chcs.org/media/Washington-case-study_Final.pdf

⁴² Ann Mary Philip, Alexandra Kruse, and Michelle Herman Soper, “ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations: Innovations and Lessons,” *Center for Health Care Strategies*, 2016, <https://www.chcs.org/media/ACAP-Medicare-Medicaid-Plans-and-the-Financial-Alignment-Demonstrations.pdf>

- ⁴³ Stephanie Anthony, et al., “Integration Strategy 1: Integrate Medicare-Medicaid Benefits for Dually Eligible Beneficiaries,” Center for Healthcare Strategies and Manatt Health, December 2017, http://www.chcs.org/media/Integration-Strategy-1-Strengthening-LTSS-Toolkit_120717.pdf
- ⁴⁴ “Report to Congress: Medicare and the Health Care Delivery System, Chapter 9: Issues Affecting Dual-Eligible Beneficiaries: CMS’s Financial Alignment Demonstration and the Medicare Savings Programs,” Medicare Payment Advisory Commission (MedPAC), June 2016, <http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0>
- ⁴⁵ Edith G. Walsh, “Financial Alignment Initiative Washington Health Home MFFS Demonstration: Third Evaluation Report,” RTI International, August 2019, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf>
- ⁴⁶ “Improving Medicaid Long-term Services and Supports Key Informant Interviews and Focus Groups Executive Summary,” Public Sector Consultants (PSC), April 2018, https://www.michigan.gov/documents/mdhhs/Improving_Medicaid_LTSS_-_Executive_Summary_636886_7.pdf
- ⁴⁷ Edith G. Walsh, “Financial Alignment Initiative Massachusetts One Care: Third Evaluation Report,” RTI International, August 2019, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MAEvalReportDY3042019.pdf>
- ⁴⁸ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.
- ⁴⁹ Lee Goldberg, et al., “Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in The Financial Alignment Initiative,” The Commonwealth Fund, March 2014, <https://www.commonwealthfund.org/publications/issue-briefs/2014/mar/assessing-care-integration-dual-eligible-beneficiaries-review>
- ⁵⁰ “A Growth Spurt for P.A.C.E. ?,” Leading Age, 2015, <https://www.leadingage.org/members/growth-spurt-pace>
- ⁵¹ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.
- ⁵² “A Growth Spurt for P.A.C.E. ?,” Leading Age.
- ⁵³ Barth et al., “Medicare-Medicaid Integration,” HMA.
- ⁵⁴ Arielle Elmaleh-Sachs, MD and Eric C. Schneider, MD, MSc, “Strange Bedfellows: Coordinating Medicare and Medicaid to Achieve Cost-Effective Care for Patients with the Greatest Health Needs,” *Journal of General Internal Medicine* (2020), doi: 10.1007/s11606-020-05914-y.
- ⁵⁵ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.
- ⁵⁶ Elmaleh-Sachs, Schneider, “Strange Bedfellows,” *J Gen Intern Med*.
- ⁵⁷ “Medicare and Medicaid: Alignment of Managed Care Plans for Dual-Eligible Beneficiaries, Report to Congressional Committee,” General Accounting Office (GAO), March 2020, <https://www.gao.gov/assets/710/705345.pdf>
- ⁵⁸ Elmaleh-Sachs, Schneider, “Strange Bedfellows,” *J Gen Intern Med*.
- ⁵⁹ Elmaleh-Sachs, Schneider, “Strange Bedfellows,” *J Gen Intern Med*.
- ⁶⁰ “Passive enrollment is a process by which a beneficiary is informed that he or she will be considered to have made a request to enroll in a Medicare-Medicaid by taking no action. Under passive enrollment, dually eligible individuals are automatically enrolled in a Medicare-Medicaid plan chosen by the state Medicaid agency unless the individual “opts out” (i.e., chooses to enroll in a different plan or elects to remain in original Medicare) before the effective enrollment date.” “Medicare-Medicaid Plan Enrollment and Disenrollment Guidance,” The Centers for Medicare and Medicaid (CMS), August 2018, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/MMPEnrollmentGuidanceManual_CY2019_08022018.pdf
- ⁶¹ Default enrollment is an enrollment process that allows a Medicare Advantage (MA) organization, following approval by the state and CMS, to enroll – unless the member chooses otherwise – a member of an affiliated

Medicaid Managed Care Organization (MCO) into its Medicare Dual Eligible Special Needs Plan (D-SNP) when that member becomes newly eligible for Medicare. This process is only permissible in circumstances where the member remains enrolled with the Medicaid MCO upon Medicare eligibility. “Default Enrollment Frequently Asked Questions,” Integrated Care Resource Center, February 2019, <https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default%20Enrollment%20FAQs%202-25-19.pdf>

⁶² Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁶³ “Key Consumer Provisions in the Dual Demonstrations: Findings from a Survey of ACAP Plans,” Association for Community Affiliated Plans (ACAP) & Community Catalyst, 2015, <https://www.communitycatalyst.org/resources/publications/document/Key-Findings-from-Survey-of-ACAP-Plans-on-Duals-Demonstrations.pdf>

Association for Community Affiliated Plans (ACAP) represents 61 not-for-profit Safety Net Health Plans.

⁶⁴ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁶⁵ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

⁶⁶ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁶⁷ Kaitlyn McBride, et al., “Healthcare Decision-Making Among Dual-Eligible Immigrants: Implications from a Study of an Integrated Medicare-Medicaid Demonstration Program in California,” *Journal of Immigrant and Minority Health* 22, no. 3 (2019): 494-502, doi: 10.1007/s10903-019-00922-5.

⁶⁸ Kimberly Proctor, Shondelle M. Wilson-Frederick, and Samuel C. Haffer, “The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries,” *Health Equity* 2, no. 1 (2018): 82-89, doi: 10.1089/heq.2017.0036.

⁶⁹ Carrie Graham, et al., “Evaluation of Cal MediConnect: Results of Focus Groups with Beneficiaries,” Health Research for Action, UC Berkeley; Institute for Health and Aging, UC San Francisco; and Community Living Policy Center, UC San Francisco, March 2016, https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/cal_medicconnect_focus_group_report_march_2016.pdf

⁷⁰ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁷¹ Proctor, Wilson-Frederick, Haffer, “The Limited English Proficient Population,” *Health Equity*.

⁷² “Program Update,” Healthy Connections Prime.

⁷³ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁷⁴ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁷⁵ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁷⁶ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.

⁷⁷ Grabowski, Joyce, McGuire, and Frank, “Passive Enrollment of Dual-Eligible Beneficiaries into Medicare and Medicaid Managed Care has Not Met Expectations,” *Health Affairs*.

⁷⁸ Kate McBride, et al., “Cal MediConnect Enrollment: Why Are Dual-Eligible Consumers in Los Angeles County Opting Out?,” UCLA Center for Health Policy Research, 2017, <https://europepmc.org/article/med/28990748#impact>

⁷⁹ Philip, Kruse, Herman Soper, “ACAP Medicare-Medicaid Plans and the Financial Alignment Demonstrations,” Center for Health Care Strategies.

⁸⁰ “Key Consumer Provisions in the Dual Demonstrations,” ACAP and Community Catalyst.

⁸¹ Brooke Hollister, et al., “Integration of Medicare and Medicaid in California: Provider Perspectives of Cal MediConnect,” University of California San Francisco and Berkeley, January 2018, http://www.caads.org/pdf/pdf/ucb_ucsf_%20cmc_provider_perspectives_final_010818.pdf

⁸² Hollister, et al., “Integration of Medicare and Medicaid in California,” UCal San Francisco and Berkeley.

⁸³ Hollister, et al., “Integration of Medicare and Medicaid in California,” UCal San Francisco and Berkeley.

⁸⁴ Hollister, et al., “Integration of Medicare and Medicaid in California,” UCal San Francisco and Berkeley.

⁸⁵ Hollister, et al., “Integration of Medicare and Medicaid in California,” UCal San Francisco and Berkeley.

- ⁸⁶ Sarah Barth, et al., “Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries—Health Plan Standards, Challenges and Evolving Approaches,” Health Management Associates (HMA), March 2019, <https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf>
- ⁸⁷ Fishman and Henry, “One Care,” UMass Medical School.
- ⁸⁸ Fishman and Henry, “One Care,” UMass Medical School.
- ⁸⁹ Lipson, Lakhmani, Tourtellotte, Chelminsky, “The Complex Art of Making It Simple,” MACPAC.
- ⁹⁰ Molly O’Malley Watts, “Early Insights from Ohio’s Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries,” The Henry J. Kaiser Family Foundation (KFF), May 2015, <http://files.kff.org/attachment/issue-brief-early-insights-from-ohios-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries>
- ⁹¹ Sarah Barth, et al., “Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries,” HMA.
- ⁹² Edith G. Walsh, “Alignment Initiative Washington Health Home MFFS Demonstration: Third Evaluation Report,” RTI International, December 2019, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf>
- ⁹³ Walsh, “Alignment Initiative Washington Health Home MFFS Demonstration,” RTI International.
- ⁹⁴ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.
- ⁹⁵ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.
- ⁹⁶ Edith G. Walsh, “Report on Early Implementation of the Demonstrations Under the Financial Alignment Initiative,” RTI International, October 2015, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>
- ⁹⁷ Edith G. Walsh, “Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience: Second Evaluation Report,” RTI International, November 2018, <https://innovation.cms.gov/fai-mn-secondevalrpt.pdf>
- ⁹⁸ Hwang, Letter to Demetrios Kouzoukas, Community Catalyst.
- ⁹⁹ Walsh, “Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience,” RTI International.
- ¹⁰⁰ James Verdier, et al., “State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options,” Integrated Care Resource Center (ICRC), November 2016, https://www.chcs.org/media/ICRC_DSNP_Issues_Options.pdf
- ¹⁰¹ Laura Summer and Jack Hoadley, “Early Insights from Commonwealth Coordinated Care: Virginia’s Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries,” The Henry J. Kaiser Family Foundation (KFF), June 2015, <http://files.kff.org/attachment/issue-brief-early-insights-from-commonwealth-coordinated-care-virginias-demonstration-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries>
- ¹⁰² Walsh, “Financial Alignment Initiative South Carolina Healthy Connections Prime,” RTI International.
- ¹⁰³ Edith G. Walsh, “Financial Alignment Initiative Texas Dual Eligible Integrated Care Demonstration Project: First Evaluation Report,” RTI International, April 2019, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXEvalReportDY1042019.pdf>
- ¹⁰⁴ Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid,” Bipartisan Policy Center, April 2020, https://bipartisanpolicy.org/wp-content/uploads/2020/04/BPC_Health_WhitePaperPt2_Final1.pdf
- ¹⁰⁵ “Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid,” Bipartisan Policy Center.
- ¹⁰⁶ Nancy Archibald, MHA, MBA, Michelle Herman Soper, MHS, Camille Dobson, MPA, “Starting from Square One: Considerations for States Exploring Medicare Medicaid Integration,” MLTSS Institute, Advancing States, and Center for Health Care Strategies, 2019, <http://www.advancingstates.org/sites/nasuad/files/State%20Considerations%20Starting%20from%20Square%20One%205-27-20.pdf>

¹⁰⁷ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

¹⁰⁸ Sabiha Zainulbhai, Lee Goldberg, Weiwen Ng, and Anne H. Montgomery, “Assessing Care Integration for Dual-Eligible Beneficiaries: A Review of Quality Measures Chosen by States in the Financial Alignment Initiative,” The Commonwealth Fund, March 2014, <https://www.commonwealthfund.org/publications/issue-briefs/2014/mar/assessing-care-integration-dual-eligible-beneficiaries-review>

¹⁰⁹ “Development of the Financial Alignment Demonstrations for Dual Eligible Beneficiaries: Perspectives from National and State Disability Stakeholders,” The Henry J. Kaiser Family Foundation (KFF), July 2013, <https://www.kff.org/wp-content/uploads/2013/07/8461-development-of-the-financial-alignment.pdf>

¹¹⁰ O'Malley Watts, “Early Insights from Ohio’s Demonstration to Integrate Care and Align Financing for Dual Eligible Beneficiaries,” KFF.

¹¹¹ “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

¹¹² “Evaluations of Integrated Care Models for Dually Eligible Beneficiaries,” MACPAC.

¹¹³ Zainulbhai, Goldberg, Ng, and Montgomery, “Assessing Care Integration for Dual-Eligible Beneficiaries,” The Commonwealth Fund.