INSIGHT on the Issues

Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles

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This research, based on a survey of 50 states and the District of Columbia conducted in the fall of 2012, finds that two-thirds of the states either have or will launch new initiatives to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals," over the next 2 years. To contain the growth of costs and improve care, the federal government, in partnership with many states, is exploring models to better serve duals and align the Medicaid and Medicare programs to remove adverse incentives and improve care coordination. This research also finds that some states are taking the opportunity extended by the Centers for Medicare & Medicaid Services (CMS) to test new models, but a number of states are exploring or implementing alternative approaches to dual services integration outside of the CMS models.

Overview

Roughly 10.2 million people are dually eligible for Medicaid and Medicare services; of these, 7.4 million are eligible for both Medicare and full Medicaid benefits, typically referred to as full-benefit duals.[1] Although they are a diverse group, these individuals typically are poorer and sicker than other Medicare beneficiaries, use more health care services, and thus account for a disproportionate share of both Medicare and Medicaid spending.

State and federal policy makers grapple with the means and methods to improve care delivery for duals whose health care needs frequently span acute, chronic, and long-term services and supports (LTSS) for both physical and mental health conditions. The need to integrate care across multiple delivery systems subject to different financial and regulatory requirements of two major payers—Medicaid and Medicare—presents policy makers with a complicated undertaking. States appear to be poised to take the challenge by exploring alternatives to the status quo, which frequently leaves duals to navigate a complicated system with few incentives for providers or programs to coordinate care.

Established by the Affordable Care Act, the CMS Medicare-Medicaid Coordination Office (MMCO) has provided financial incentives for states to coordinate care for the dual eligibles. Under the State Demonstrations to Integrate Care for Dual Eligible Individuals program, CMS selected 15 states—California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and

Wisconsin—to design new approaches to coordinate care in a comprehensive fashion across primary, acute, behavioral health services and LTSS for dual eligible individuals. With a goal to identify and validate delivery system and payment coordination models that can be replicated in other states, each state received up to $1 million to design and implement a duals integration program. In addition, 26 states (which include states that received up to $1 million) submitted proposals to participate in MMCO's financial alignment initiative to address the financial misalignment between the Medicare and Medicaid programs. The financial alignment initiative will test two models of care:

- A ***Capitated Model*** where the state, CMS, and a health plan enter into a three-way contract, and the plan receives set risk-based payments from Medicaid and Medicare; and
- A ***Managed Fee-for-Service Model*** where an entity receives a payment to coordinate the care of dual eligibles and achieve performance benchmarks related to improved outcomes for beneficiaries.

CMS will share the anticipated Medicare savings with states under each model. Thirty-seven states plus the District of Columbia submitted Letters of Intent to participate in the financial alignment initiative in October 2011, and 26 states—including the original 15 states that had earlier received design contracts—submitted demonstration proposals by May 31, 2012.[2] Most states are still negotiating terms with MMCO, while a few have withdrawn their proposals. When this report was going to press, four states—Illinois, Ohio, Massachusetts, and Washington state—had reached agreement with CMS and signed Memoranda of Understanding (MOUs) describing the terms and conditions of their demonstration programs.

This research is based on a survey of 50 states and the District of Columbia that was conducted in the fall of 2012. The survey asked about state dual integration initiatives for older adults and adults with physical disabilities, but not people with intellectual or developmental disabilities. A description of the research methodology is included in the appendix.

Survey Findings

The three key findings from the survey regarding state dual integration initiatives are summarized below:

- ✓ Two-thirds of all states are integrating or planning to integrate Medicaid and Medicare services for dual eligibles in State Fiscal Years (SFYs) 2013 and 2014.
- ✓ Most integration programs are broad in scope—statewide initiatives targeting all full-benefit duals and spanning most long-term services and supports.
- ✓ Most states are turning to risk-based managed care models to deliver integrated services to duals.

Two-thirds of all states are integrating or planning to integrate Medicaid and Medicare services for dual eligibles in SFYs 2013 and 2014.

Thirty-four states responded that they either have a duals integration program currently (4 states)[3] or are planning to implement a program (30 states).[4] This exceeds the number of states involved in financial alignment initiatives with the CMS Medicare-Medicaid Coordination Office (21 states currently). Fourteen states and the District of Columbia responded that they do not have or plan to have a program.[5]

Of the 34 states with dual integration initiatives, four states—Delaware, Idaho, Minnesota, and Massachusetts—indicated that they have already implemented initiatives to improve service delivery for duals. Ten states intend to implement a program in 2013, and 11 states plan to implement a program in 2014. Nine states indicated that they were in the early planning stages or were uncertain about the timing of implementation (Figure 1).

While a majority of the states pursuing duals integration also submitted Letters of Intent to participate in the financial alignment demonstration to MMCO, numerous states intend to coordinate delivery of Medicaid and Medicare services outside of the demonstration (Figure 2).

At the time of this report, 21 of the 26 states that submitted financial alignment demonstration proposals continue to negotiate with MMCO. Five states—New Mexico, Oregon, Minnesota, Tennessee, and Hawaii—have withdrawn their proposals, noting that the financial structure of the initiative does not align well with the delivery systems that currently exist in their states, and may consider alternate approaches outside the MMCO demonstration. Four states—Massachusetts, Ohio, Illinois, and Washington—have signed MOUs with CMS, which establish specific parameters of their financial alignment demonstrations.

State efforts to coordinate care for duals extend beyond the MMCO financial alignment models.

Eight states responding to the survey have or are developing duals integration programs, but have not pursued the financial alignment models:

- Four states—Delaware, Florida, New Jersey, and New Hampshire—are using a managed care delivery system, including managed LTSS, to coordinate dual services;
- One state—Indiana—is currently developing its program design

Figure 1

Two-thirds of States Have or Are Planning Dual Integration Initiatives

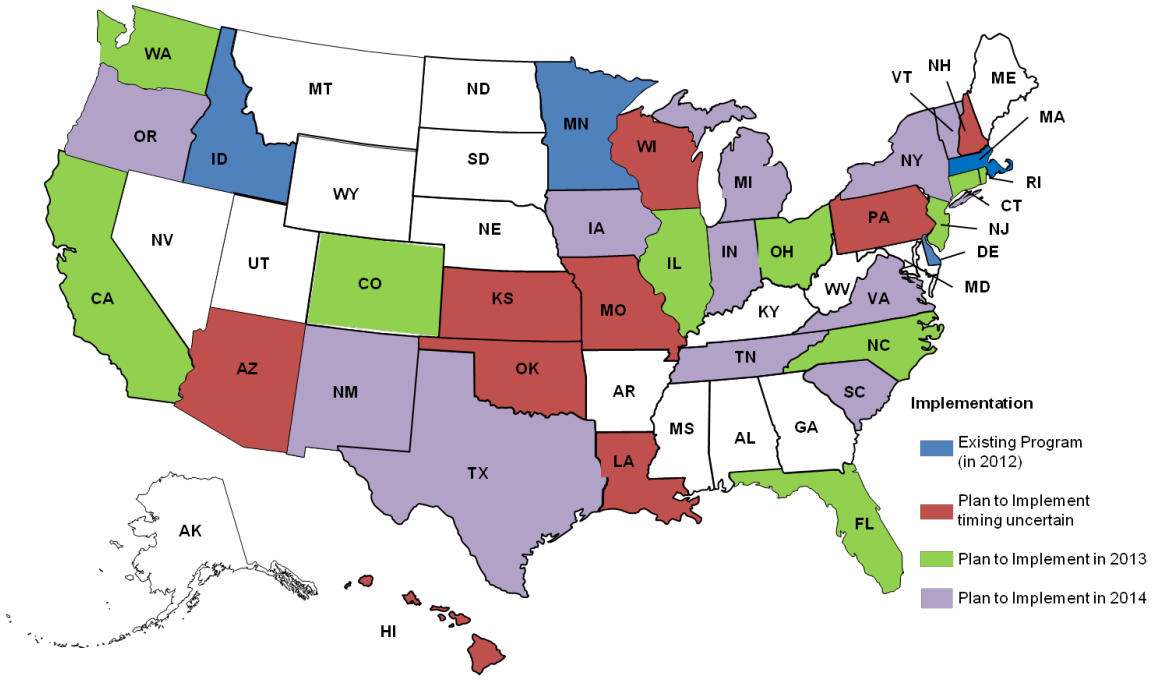
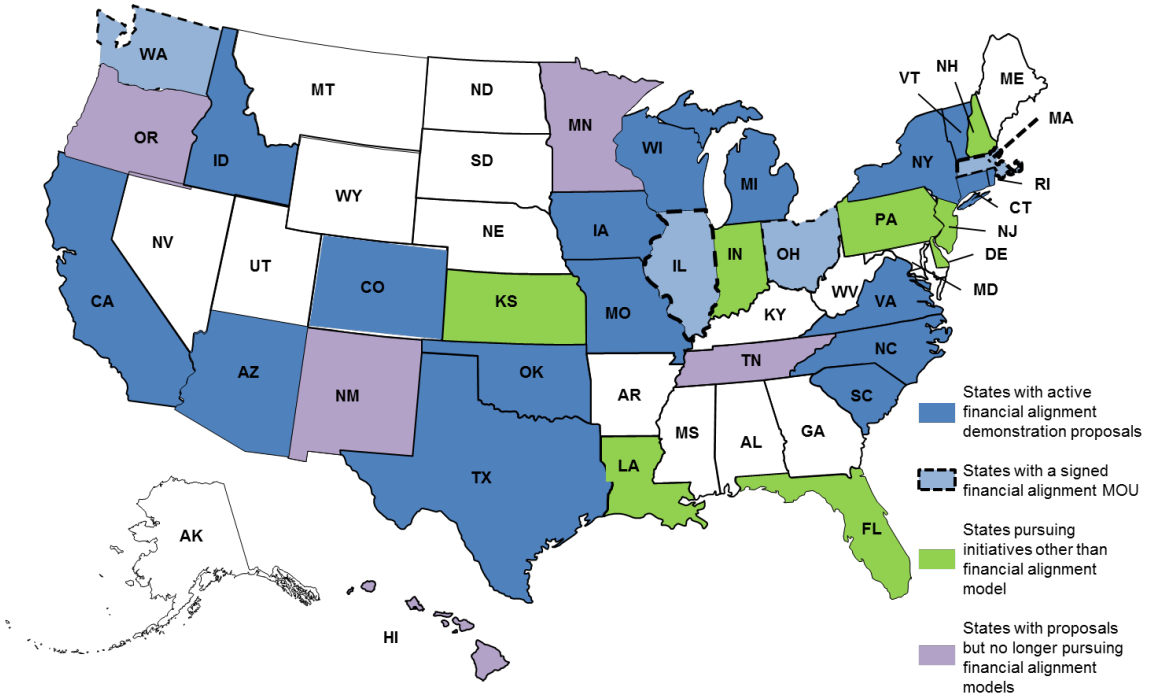


Figure 2
State Duals Integration Activity



through ongoing meetings with stakeholders; and

- Three states—Louisiana, Pennsylvania, and Kansas—are in early planning stages and have not yet defined program parameters.

Delaware moved all full duals to its §1115(a) demonstration waiver, and mandated enrollment into a managed care organization. State officials consider this move to be just an initial step in coordinating care for this population, and indicated interest in pursuing a financial alignment demonstration with CMS in the future, if the opportunity arises. ***Florida*** released an Invitation to Negotiate (ITN) for Medicaid managed care plans throughout the state in late December 2012, which will include dual eligibles.[6] ***New Jersey***'s Medicaid managed LTSS program requires managed care organizations to be Medicare Advantage Dual-Special Needs Plans (MA D-SNPs) to serve duals and to meet CMS readiness review prior to serving duals. ***New Hampshire*** will include duals as voluntary enrollees in its managed care program, and plans to include LTSS in phase 2 of implementation.[7,8]

Indiana has convened a Duals Advisory Council and is currently meeting with stakeholders to determine the structure of its dual integration initiative.[9] State officials anticipate a risk-based managed care model with potential implementation in late summer or fall of 2013.[10]

The financial alignment model is not the answer for some states.

From the time states responded to the survey through the release of this report, some states with financial alignment demonstration proposals determined that the financial models offered through the federal initiative were not viable options within their programs.

New Mexico withdrew its demonstration proposal in August 2012,[11] but

expressed continued interest in developing strategies to improve outcomes for duals as well as ensuring financial accountability through its Centennial Care §1115(a) demonstration waiver, which the state expects to implement January 1, 2014. Centennial Care creates a comprehensive, managed care delivery system, which includes the full array of Medicaid services including acute, behavioral health, home and community-based, and long-term institutional care. ***Minnesota*** withdrew its financial alignment demonstration proposal in June 2012, noting that Medicare financing under the financial alignment demonstration model would result in a significantly lower payment than Minnesota receives for senior Medicare beneficiaries in current programs.[12] In a letter to Coordinated Care Organizations (CCOs) and stakeholders in October 2012, ***Oregon*** officials indicated concern that the financial alignment demonstration would not be financially viable for Oregon CCOs and Medicare Advantage plans.[13] ***Tennessee*** withdrew its proposal in December 2012, also noting the financial alignment reimbursement structure as a concern.[14] Finally, ***Hawaii*** withdrew its proposal in February 2013, indicating it would continue to work with CMS to explore the possibility of implementing a financial alignment program in 2015.[15] MMCO officials have conceded "low cost states"—states with relatively low Medicaid fee-for-service reimbursement and higher Medicare Advantage reimbursement—face challenges fitting their delivery systems into the financial alignment reimbursement models.[16] Oregon, Minnesota, and Tennessee all signaled that they intend to continue discussions with MMCO, possibly submitting modified, narrower proposals that focus on administrative coordination (e.g., appeals and grievance processes).

States continue to negotiate the details of their programs with MMCO; thus, the structure of any approved initiative could vary from a state's original proposal. The information presented in this report represents state plans at the time the survey was conducted.

Most integration programs are broad in scope—statewide initiatives, targeting all full-benefit duals, and spanning most long-term care services and supports.

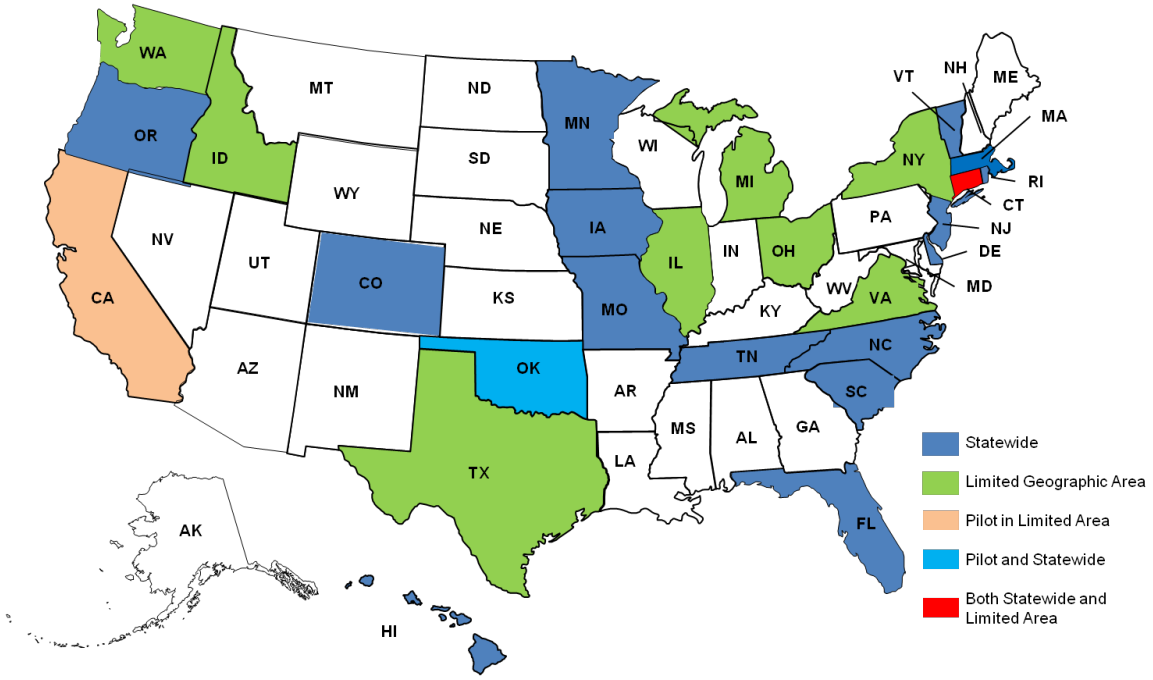
Most states plan statewide initiatives.

Twenty-six states provided information about the geographic scope of their dual integration initiative (Figure 3). About two-thirds (18 states) have or plan to implement a statewide program.[17] Oklahoma plans to implement a managed fee-for-service pilot initially, and then expand it statewide. Only nine states indicated they would implement their initiatives in a limited geographic area, and one of these states—Connecticut—also has a statewide component.[18] Only Oklahoma and California describe their initiatives as pilots. Seven states—Arizona, Indiana, Kansas, Louisiana, New Hampshire, New Mexico, and Pennsylvania—are unsure of the geographic scope at this time.

Most states are targeting full-benefit duals with a full spectrum of LTSS needs.

The financial alignment demonstration specifically targets full-benefit dual eligibles; that is, people who are eligible for both Medicare and full Medicaid benefits. Some Medicare beneficiaries are not eligible for full Medicaid benefits because their assets or income are too high. Instead, they are eligible for Medicaid payment for Medicare premium and cost-sharing requirements. For example, Specified Low Income Medicare Beneficiaries (SLMBs) have income or assets too high to qualify for full Medicaid coverage, but they are eligible for Medicaid to pay their Medicare monthly premiums. Qualified

Figure 3
Geographic Scope of Duals Integration Initiatives



Medicare Beneficiaries (QMBs)—who have income or assets that are the same or less than SLMBs—are eligible for not only Medicaid coverage of their Medicare premiums, but also their Medicare cost-sharing obligations (e.g., deductibles and coinsurance).

Most states (27 states) are targeting only full-benefit duals with their integration initiatives, but three states—Kansas, New Hampshire, and New Mexico—indicated they are targeting all duals, including those that receive help only with cost sharing. California also indicated that some individuals receiving help with cost sharing will be included in their program.

The survey asked whether states would impose other eligibility criteria for their initiatives, such as age or service delivery setting. Twenty states provided additional details about populations they include (or expect to include) in their duals integration program, beyond full-benefit duals. Nineteen of the 20 states will include duals age 65 or older.

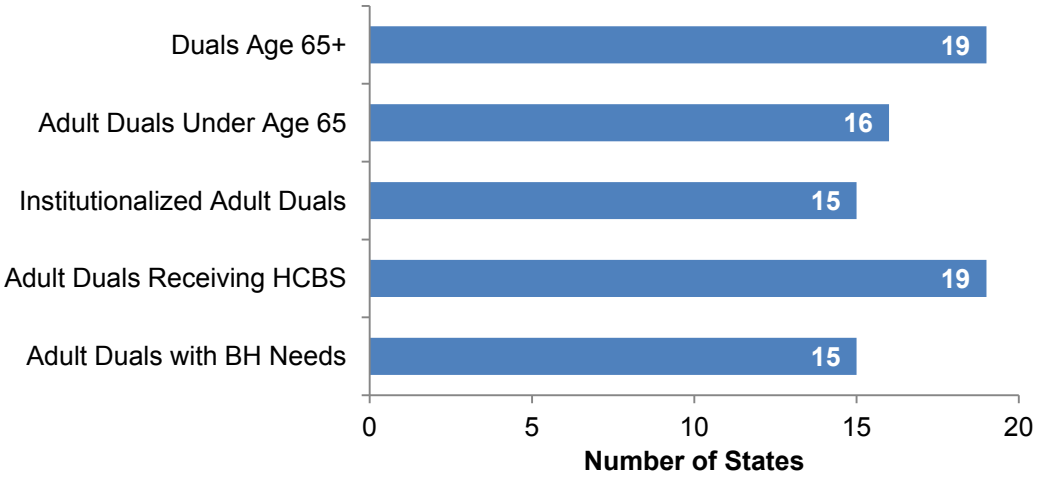
Sixteen states will include duals under the age of 65. Nineteen states will include duals receiving home and community-based services (HCBS), and 15 states will include individuals in institutions. Fifteen states indicated their program would also include individuals with behavioral health needs (Figure 4).

One state—Missouri—submitted a financial alignment demonstration proposing to share in Medicare savings for approximately 5,100 full-benefit duals currently enrolled in health homes (out of a total of 168,000 full-benefit duals). Duals must meet clinical criteria for participation in Missouri's health home program.

The vast majority of states are turning to risk-based managed care models to deliver integrated services to duals.

Of the 33 states describing duals integration initiatives, 25 described a risk-based managed care (RBMC) financial structure, 7 described a managed fee-for-service (MFFS) or

Figure 4
Populations Included in Duals Integration Programs
N=20



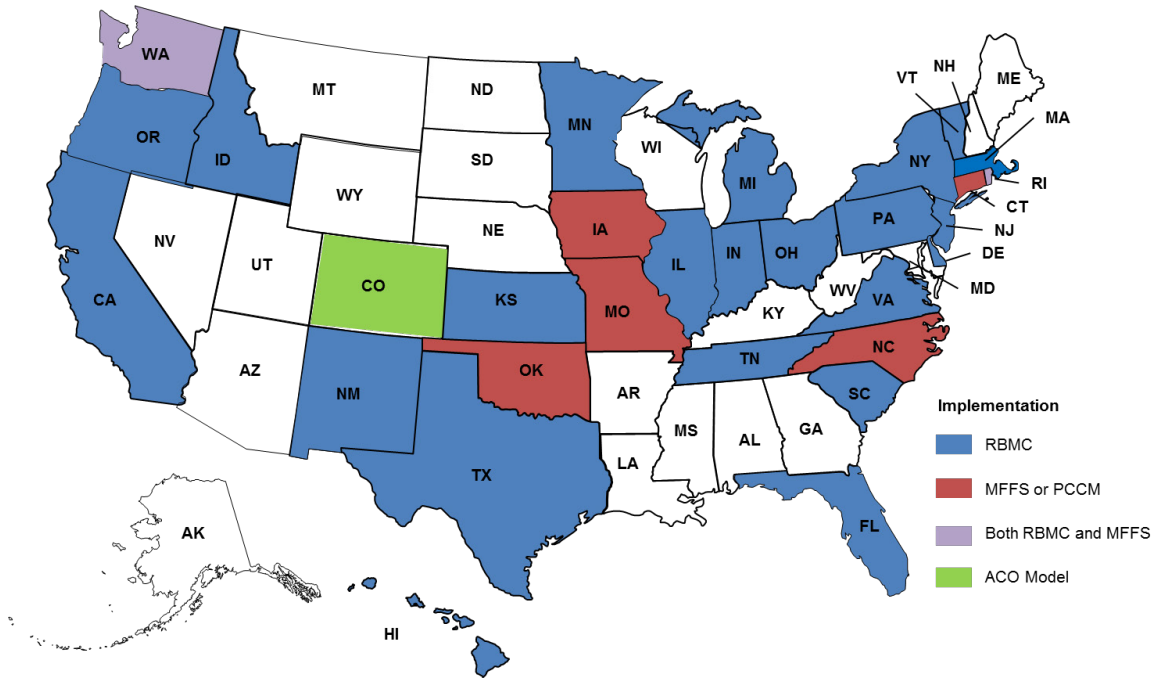
primary care case management (PCCM) structure, and 1 described an accountable care organization (ACO) structure (Figure 5).[19]

Two states—Rhode Island and Washington—indicated that they would use both RBMC and MFFS reimbursement structures within their financial alignment demonstrations. Most of the states proposing RBMC are working with MMCO to align the financing between the state Medicaid program and Medicare.

States using risk-based models plan to place a range of services under capitation.

Most states with RBMC models intend to include not only HCBS, but also some nursing facility care and behavioral health

Figure 5
State Duals Integration Finance Structure



services within a capitated rate,[20] putting managed care organizations at financial risk for the entire spectrum of LTSS.

The survey asked whether the following services would be included in capitation rates:

- Medicare Part A
- Medicare Part B
- Medicare Part D
- Nursing Facility Services
- Home and Community-based Services
- Behavioral Health Services

Twenty of the 25 states indicating a RBMC approach offered more details about the services they would include under capitation.[21] Half (11 states) intend to provide all of the services listed above through capitation rates—Idaho, Massachusetts, Michigan, Minnesota, New York, Ohio, Tennessee,[22] Texas,[23] Vermont, Virginia, and Washington. Six states include all Medicare services but carve out at least one of the Medicaid services—California, Hawaii, New Jersey, Oregon, Rhode Island, and South Carolina. Three states indicate they will only include the Medicaid services within capitation—Delaware, Indiana, and Pennsylvania (Figure 6).

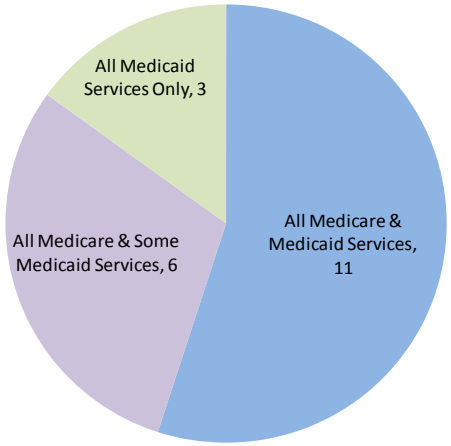
States that included *both* Medicare and Medicaid services under capitation (17 in total) have or had financial alignment demonstration proposals, except New Jersey. New Jersey plans to use MA D-SNPs and include Medicare services within capitation.

State responses reflect efforts to better coordinate medical and *behavioral health* care needs. Only two states—Hawaii and Rhode Island—specifically propose to carve out all behavioral health services from capitation. Indiana plans to carve out Medicaid Rehabilitation Option services from capitation, but include other behavioral health services. California proposes to include Medicare behavioral health within a capitation rate, but carve out Medicaid inpatient and outpatient behavioral health. Michigan and North Carolina both reported that they provide behavioral health services through Prepaid Inpatient Health Plans (PIHP) and intend to continue to operate these capitated models outside of their duals integration initiatives.

Oregon plans to include temporary skilled nursing facility services, but exclude long-term nursing facility care from capitation. Texas currently provides for 4 months of nursing facility care within its STAR+PLUS program and proposed that it would continue doing so in the context of its dual demonstration proposal. Individuals with longer stays would be disenrolled from managed care.[24] South Carolina proposes to exclude institutionalized individuals upon enrollment, but would not disenroll individuals who become institutionalized after they have enrolled in the program.[25]

Figure 6
Scope of Services Within Capitation Rates
(Number of States)

N=20



Only one state—South Carolina—plans to carve out HCBS from capitation. South Carolina has proposed that HCBS would be integrated within care coordination functions, but reimbursement would remain fee-for-service.[26]

Conclusion

Within the next 2 years, a large number of states are planning to reform the way in which they finance services for some of their most vulnerable populations: people who are dually eligible for Medicare and Medicaid services. Most of these initiatives will be broad in scale in that they will be statewide, will include duals who are age 65 and older as well as duals who receive HCBS, and will incorporate a wide range of LTSS and behavioral health services. The total number of states undertaking these efforts exceeds expectations, in part because states have historically hesitated to expend state funds implementing dual eligible care coordination programs that would benefit the Medicare Trust Fund more than state treasuries. Yet our findings confirm that numerous states are also planning to implement dual eligibles initiatives outside of the CMS financial alignment models.

Appendix

Methodology

This 2012 Survey of LTSS and Economic Trends is the third annual study of the AARP Public Policy Institute, the National Association of States United for Aging and Disabilities, and Health Management Associates. Building upon the research findings from 2010 and 2011, this 2012 survey asked questions in new areas such as eligibility and access to LTSS. As a result, findings from the 2012 survey are being released in a series of papers, including this one.

Officials from both state Medicaid agencies and the state aging and disability agencies completed an electronic survey from late August into the fall of 2012. Forty-nine states plus the District of Columbia participated. Forty-eight state Medicaid agencies responded, and 48 state aging and disabilities agencies responded.[27] Authors conducted follow-up telephone interviews with 34 state Medicaid officials and 35 state aging and disability officials to ask clarifying questions about survey responses and to gather more in-depth information. Each interview was approximately 1 hour long. In addition to the interviews, the authors made many more contacts through phone calls and emails, as needed, to ensure the accuracy and completeness of the information provided.

LTSS programs for older people and adults with physical disabilities are the subject of this report. The survey did not address LTSS programs for people with intellectual disabilities or for children.

The survey included questions about state efforts to integrate services for duals, but did not limit the response to efforts around the MMCO planning grants or financial alignment demonstration. Specifically, the survey asked states whether they currently have or are planning to implement a program to integrate delivery of Medicaid and Medicare services for duals, excluding PACE programs. Forty-seven states and the District of Columbia responded to this portion of the survey.

Table 1
State Duals Integration Initiatives and Targeted Populations

State	Duals Integration Initiative	MMCO Financial Alignment Proposal	Expected Implementation Date	Populations Included						
				All Duals (Including Those Receiving Cost-Sharing Assistance)	Full-Benefit Duals Only	Ages 65+	Adults Under 65	Adults in Institutions	Adults Receiving HCBS	Adults with Behavioral Health Needs
	34 Yes* 15 No	**21****	**4 Implemented 10 SFY 2013 11 SFY 2014 9 Unsure**	**3**	**27**	**19**	**16**	**15**	**19**	**15**
Alabama	No									
Alaska	No									
Arizona	Yes	√	Unsure							
Arkansas	No									
California (1)	Yes	√	SFY 2013		√	√	√	√	√	√
Colorado (2)	Yes	√	SFY 2013		√	√	√	√	√	√
Connecticut	Yes	√	SFY 2013		√					
Delaware (3)	Yes		Implemented		√	√	√	√	√	√
District of Columbia	No									
Florida (4)	Yes		SFY 2013		√					
Georgia	No									
Hawaii	Yes	√	Unsure		√	√	√	√	√	
Idaho	Yes	√	Implemented		√	√	√	√	√	√
Illinois	Yes	√	SFY 2013		√	√	√	√	√	
Indiana	Yes		SFY 2014		√	√	√	√	√	√
Iowa (5)	Yes	√	SFY 2014		√	√	√	√	√	√
Kansas	Yes		Unsure	√						
Kentucky	No									
Louisiana (6)	Yes		Unsure							
Maine	No									
Maryland	No									
Massachusetts (7)	Yes	√	Implemented		√	√	√	√	√	√
Michigan	Yes	√	SFY 2014		√					
Minnesota	Yes	√	Implemented			√				
Mississippi	No									

Table 1 continued

State	Duals Integration Initiative	MMCO Financial Alignment Proposal	Expected Implementation Date	Populations Included						
				All Duals (Including Those Receiving Cost-Sharing Assistance)	Full-Benefit Duals Only	Ages 65+	Adults Under 65	Adults in Institutions	Adults Receiving HCBS	Adults with Behavioral Health Needs
Missouri (8)	Yes	√	Unsure		√					
Montana	No									
Nebraska	No									
Nevada	No									
New Hampshire	Yes		Unsure	√						
New Jersey (9)	Yes		SFY 2013		√	√	√		√	√
New Mexico	Yes	√	SFY 2014	√						
New York (10)	Yes	√	SFY 2014		√					
North Carolina (11)	Yes	√	SFY 2013		√	√	√	√	√	
North Dakota	No									
Ohio	Yes	√	SFY 2013		√	√	√	√	√	√
Oklahoma (12)	Yes	√	Unsure		√	√			√	
Oregon	Yes	√	SFY 2014		√					
Pennsylvania (13)	Yes		Unsure		√					
Rhode Island	Yes	√	SFY 2013		√	√	√	√	√	√
South Carolina (14)	Yes	√	SFY 2014		√	√			√	√
South Dakota	No									
Tennessee	Yes	√	SFY 2014		√					
Texas (15)	Yes	√	SFY 2014		√	√	√		√	√
Utah	No									
Vermont	Yes	√	SFY 2014		√	√	√	√	√	√
Virginia (16)	Yes	√	SFY 2014		√			√	√	√
Washington	Yes	√	SFY 2013		√	√	√	√	√	√
West Virginia										
Wisconsin (17)	Yes	√	Unsure							
Wyoming										

* **Wisconsin** did not respond to the survey. Wisconsin awarded contracts to MCOs in October 2012 to manage care for dual eligibles (http://www.dhs.wisconsin.gov/virtualPACE/). Wisconsin also has a financial alignment initiative pending MMCO approval. Wisconsin Financial Alignment proposal: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WisconsinProposal.pdf.

** Count does not include **Minnesota**, **New Mexico**, **Oregon**, **Hawaii**, or **Tennessee**—states that are no longer pursuing a financial alignment demonstration. MN, OR, TN, and HI continue to work with MMCO to develop alternative models or administrative opportunities. NM has indicated it will pursue integration through its Centennial Care Section §1115(a) demonstration waiver.

TABLE 1 NOTES:

(1) **California** proposes to target full-benefit duals aged 21 and older, as well as some receiving help with cost sharing.

(2) **Colorado** plans to include those in Nursing Facilities but exclude those in intermediate care facilities for individuals with intellectual disabilities (ICFs/ID).

(3) **Delaware** would like to implement a Dual Integration Demonstration in the future if CMS continues to offer opportunities, but currently is pursuing integration under its MMLTSS program. The state moved all full duals to its §1115 demonstration waiver and mandated enrollment in an MCO. The state considers this just a first step in coordinating care for this population.

(4) **Florida** released an Invitation to Negotiate (ITN) for MMLTSS December 2012. Medicare Advantage Dual SNPs can either apply to provide LTSS services for their existing dual enrollees eligible for long-term care services or competitively bid to provide long-term care services and receive new voluntary or mandatory enrollees for these services.

(5) **Iowa** has applied to use its home health model for dual integration.

(6) **Louisiana** has not yet determined target population(s), services, geographic coverage, reimbursement structure, or whether an existing care transition initiative will be used. These decisions will be addressed during planning.

(7) **Massachusetts** currently has a program, Senior Care Option (SCO), which targets duals aged 65+. The state recently received CMS approval for a financial alignment demonstration, called the State Demonstration to Integrate Care for Dual Eligible Beneficiaries, to be implemented in SFY 2013. The new demonstration will target adult duals under age 65 including those who enroll under age 65 and choose to age in place.

(8) **Missouri** has applied to share in Medicare savings resulting from duals served in the state's existing health home program.

(9) **New Jersey's** MMLTSS program requires MCOs to be MA D-SNPs to serve duals. The state's Comprehensive waiver was approved October 2012.

(10) **New York** is targeting full-benefit duals who need HCBS services for more than 120 days.

(11) **North Carolina** already has a program to integrate primary and behavioral health (BH) services, so BH is not included in the duals integration initiative.

(12) **Oklahoma** proposes a PACE-like model. Institutionalized individuals would not be eligible, but if members entered an institution after enrolling, they would not be disenrolled.

(13) **Pennsylvania** is in early planning stages but anticipates a program for full duals over the age of 18.

(14) **South Carolina** HCBS services will be integrated as part of the coordination of care, but carved out of the capitated rate. The implementation excludes those dual eligibles who are institutionalized or enrolled in the PACE program. If institutionalized after enrollment, they remain in the program.

(15) **Texas** would include duals enrolled in the STAR+PLUS managed care program. Individuals with longer than 4 months' stay in a nursing facility are disenrolled from STAR+PLUS.

(16) **Virginia** excludes those duals in PACE, intermediate care facilities for individuals with mental retardation (ICF/MRs), those who spend down for Medicaid eligibility, and those in a state mental health/mental retardation (MH/MR) Institution. The demonstration includes those older adults and adults with disabilities with consumer direction HCBS waivers. It excludes people with mental retardation/intellectual disabilities/developmental disabilities (MR/ID/DD), Alzheimer's waivers, and those in hospice at the time of implementation, but will include those who go into hospice after they are in the duals initiative.

(17) **Wisconsin** did not respond to the survey, but has a financial alignment demonstration proposal pending MMCO approval.

TABLE 2
Duals Initiatives Geographic Coverage and Financial Structure

State	Geographic Scope			Financial Structure	Services Included in Capitation					
					Medicare Services			Medicaid Services		
	Pilot	Limited Area	Statewide		Part A	Part B	Part D	BH	NF	HCBS
33	2	9	18	**25 RBMC 7 PCCM/MFFS 1 ACO 1 Unsure**	17	17	17	17	18	18
Arizona										
California (1)	√	√		**RBMC**	√	√	√		√	√
Colorado			√	**ACO**						
Connecticut (2)		√	√	**MFFS**						
Delaware (3)			√	**RBMC**				√	√	√
Florida (4)			√	**RBMC**						
Hawaii			√	**RBMC**	√	√	√		√	√
Idaho			√	**RBMC**	√	√	√	√	√	√
Illinois		√		**RBMC**						
Indiana (5)				**RBMC**				√	√	√
Iowa (6)			√	**MFFS**						
Kansas				**RBMC**						
Louisiana (7)				**Unsure**						
Massachusetts			√	**RBMC**	√	√	√	√	√	√
Michigan		√		**RBMC**	√	√	√	√	√	√
Minnesota			√	**RBMC**	√	√	√	√	√	√
Missouri (8)			√	**MFFS**						
New Hampshire (9)				**RBMC**						
New Jersey (10)			√	**RBMC**	√	√	√	√		√
New Mexico				**RBMC**						
New York		√		**RBMC**	√	√	√	√	√	√
North Carolina (11)			√	**MFFS**						
Ohio		√		**RBMC**	√	√	√	√	√	√
Oklahoma (12)	√		√	**MFFS**						
Oregon (13)			√	**RBMC**	√	√	√	√		
Pennsylvania (14)				**RBMC**				√	√	√
Rhode Island			√	**RBMC PCCM**	√	√	√		√	√
South Carolina (15)			√	**RBMC**	√	√	√	√	√	
Tennessee (16)			√	**RBMC**	√	√	√	√	√	√
Texas (17)		√		**RBMC**	√	√	√	√	√	√
Vermont (18)			√	**RBMC**	√	√	√	√	√	√
Virginia		√		**RBMC**	√	√	√	√	√	√
Washington (19)		√		**RBMC MFFS**	√	√	√	√	√	√

TABLE 2 NOTES:

(1) **California** proposes to include Medicare BH within capitation. Medicaid BH inpatient and outpatient would be carved out. Medicaid county-based BH services would be coordinated between the Plan and County.

(2) **Connecticut** plans to implement administrative services organizations (ASOs) statewide and Health Neighborhoods in 3 to 5 limited areas (information from Kaiser Commission on Medicaid and the Uninsured: *State Demonstrations to Integrate care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS;* October 2012. Accessed January 2013 at http://www.kff.org/medicaid/8369.cfm.

(3) **Delaware** is pursuing duals integration under its MMLTSS program, which launched in April 2012.

(4) **Florida** has proposed including duals in its MMLTSS program. Information is from the state's website.

(5) **Indiana** plans to carve out Medicaid rehabilitation option (MRO) services but include other BH services under capitation. State anticipates a statewide program. See Stakeholder Meeting and Agenda Minutes, November 11, 2012 (http://www.in.gov/fssa/files/Dual_Eligibles_Integrated_Care_Meeting_Minutes_111912.pdf).

(6) **Iowa:** The state plans to use its home health model and incorporate disease management, ACO, and PACE (based on financial alignment proposal submitted to CMS). Information is from the state website and MMCO Financial Alignment Demonstration proposal.

(7) **Louisiana** has not yet determined target population(s), services, geographic coverage, reimbursement structure, or whether an existing care transition initiative will be used. These decisions will be addressed during planning.

(8) **Missouri:** Information is taken from the state website and MMCO Financial Alignment Demonstration proposal.

(9) **New Hampshire** proposes to include duals as voluntary enrollees in its existing managed care program and plans to include LTSS in managed care in the future.

(10) **New Jersey** requires Medicaid MCOs to operate MA D-SNPs. The state's Comprehensive §1115(a) demonstration waiver was approved by CMS in October 2012.

(11) **North Carolina:** BH services are provided through Local Management Entities/MCOs which is a Prepaid Inpatient Health Plan capitated model outside of the duals integration initiative. Information is from the state website and MMCO Financial Alignment Demonstration Proposal.

(12) **Oklahoma:** The program would start as a pilot and eventually expand statewide. Oklahoma's financial alignment demonstration proposal also included two smaller programs limited to full-benefit duals in the Tulsa, Oklahoma City, and Lawton areas. These programs would have an RBMC financial structure.

(13) **Oregon** plans to include temporary skilled nursing facility only under capitation. LTSS long-term nursing facility and HCBS would be carved out.

(14) **Pennsylvania** has not yet determined the design for its program.

(15) **South Carolina** has proposed providing HCBS in a fee-for-service reimbursement arrangement.

(16) **Tennessee:** ICF/ID and HCBS for persons with ID would remain carved out, but the population is included for Medicare Parts A, B, and D and for other Medicaid services.

(17) **Texas'** proposal is limited to those enrolled in the STAR+PLUS MMLTSS program, which does not operate in all counties.

(18) **Vermont:** The State Department of Vermont Health Access serves as the Managed Care Entity and would receive a per member per month payment.

(19) **Washington** intends to use a health home model of care.

Endnotes

[1] Medicare-Medicaid Coordination Office. *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011*. February 2013. Dual eligible populations are discussed later in the paper.

[2] For a summary of each state's financial alignment initiative proposal, see Kaiser Commission on Medicaid and the Uninsured: *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS*; October 2012. Accessed January 2013 at http://www.kff.org/medicaid/8369.cfm.

[3] It should be noted that even in the four states that already have some form of duals integration program, none have yet fully implemented financial alignment.

[4] Findings in this report are based on research results as of a point in time. For ongoing information about states' dual integration initiatives and other state actions to modernize long-term services and supports, see the State Medicaid Integration Tracker© published online monthly by the National Association of States United for Aging and Disabilities at http://www.nasuad.org/medicaid_integration_tracker.html.

[5] West Virginia, Wisconsin, and Wyoming did not respond to dual integration survey questions. Wisconsin has a financial alignment demonstration proposal pending CMS approval.

[6] AHCA ITN-017 12/13 Attachment D; for example, see Region 1. Accessed January 2013 at http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=104487.

[7] New Hampshire DHHS Medicaid Care Management Info Meeting Final Report; August 2012. Accessed January 2013 at http://www.dhhs.nh.gov/ocom/care-management.htm.

[8] New Hampshire Medicaid Information Meeting presentation; January 2013. Accessed January 2013 at http://www.dhhs.nh.gov/ocom/care-management.htm.

[9] Indiana Family and Social Services website. Accessed January 2013 at http://www.in.gov/fssa/ompp/4347.htm.

[10] Ibid.

[11] Julie Weinberg, Director New Mexico Human Services Department; Letter to Melanie Bella, Director Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services; August 17, 2012. Accessed January 2013 at http://www.naela.org/app_themes/public/PDF/Advocacy%20Tab/Health%20Care%20Reform/LettertoMelanieBella_NewMexico.pdf.

[12] Minnesota Department of Human Services website. Accessed January 2013 at http://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=141378.

[13] Susan Otter, Project Director CMS Design Contract for Integrating Medicare/Medicaid for Individuals Dually Eligible; Memorandum to Coordinated Care Organizations and Stakeholders; October 30, 2012. Accessed January 2013 at https://cco.health.oregon.gov/Documents/MEMO-CCOs-Stakeholders-Medicare-Medicaid-Alignment-Final.pdf.

[14] Letter to stakeholders; January 4, 2013. Accessed January 2013 at http://www.thearctn.org/Assets/Docs/TennCare-Memo-Stakeholders-0113.pdf.

[15] Reported by Insidehealthpolicy.com; February 2013.

[16] During the U.S. Senate Finance Committee hearing on December 13, 2012, MMCO Director Melanie Bella acknowledged challenges for "low cost states" such as Oregon and Minnesota and indicated that alternatives are being considered. Hearing proceedings are available at http://www.finance.senate.gov/hearings/hearing/?id=44840579-5056-a032-52c9-034b7663dc1e.

[17] Michigan proposed a statewide initiative, but on January 13, 2013, the Michigan Department of Community Health announced it is proceeding with a regional approach. Press release accessed January 2013 at http://www.michigan.gov/documents/mdch/Integrated_Care_Regions_PR_408757_7.pdf.

[18] In its original response to the National Association of States United for Aging and Disabilities–AARP survey, officials from Texas indicated that they planned to implement their duals integration initiative on a statewide basis, but in subsequent communication, Texas reported that "the duals demonstration in Texas will not be implemented statewide; instead, it will be limited to the 19 counties with the most populous number of

dual members." Source: Email communication from Kelsey Letcher, Policy Advisor / Project Management, Medicaid/CHIP Division at the Texas Health & Human Services Commission, February 28, 2013.

[19] Louisiana is unsure about the reimbursement structure and Arizona did not respond to questions about reimbursement structure.

[20] The survey did not request detail from states about the structure of capitation rates. For instance, the survey did not ask whether the state plans to use a single blended rate using Medicaid and Medicare funding, or whether the program would use multiple rates.

[21] Florida, Illinois, Kansas, New Hampshire, and New Mexico provided no additional detail.

[22] Tennessee excludes Intermediate Care Facilities for Intellectual or Developmental Disabilities (ICF/IDD) services and HCBS for persons with intellectual disabilities from capitation.

[23] Texas's proposal would limit the program to duals enrolled in the STAR+PLUS Medicaid Managed LTSS program. STAR+PLUS covers only the first 4 months of a nursing facility stay.

[24] Texas Health and Human Services Commission; STAR+PLUS Handbook, December 3, 2012. Section 3632.3. Accessed January 2013 at http://www.dads.state.tx.us/handbooks/sph/3000/3000.htm#sec3111. To participate in the state's dual eligible integration initiative, an individual must be enrolled in STAR+PLUS.

[25] New Jersey did not indicate its plan for nursing facility reimbursement.

[26] Oregon did not indicate how it plans to treat reimbursement for HCBS.

[27] State Medicaid agencies in North Carolina, South Dakota, and Wisconsin did not participate. State aging and disabilities agencies in Florida, West Virginia, and Wisconsin did not participate.

Insight on the Issues 80, April, 2013

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