

Designing a Medicare-Medicaid Integration Strategy: A Guide for States



Purpose of this Guide

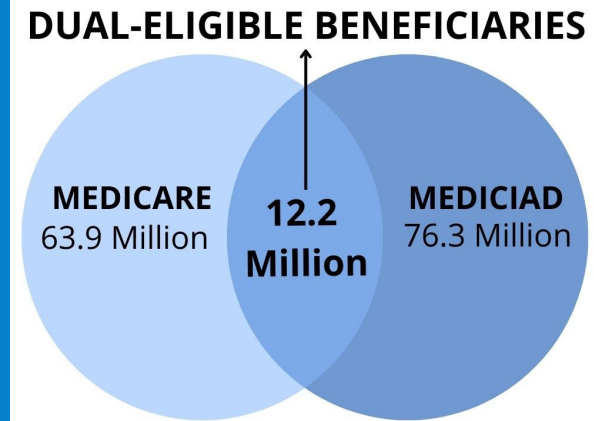
Integrated plans have the potential to improve care for beneficiaries dually enrolled in Medicare and Medicaid. This guide describes an evidence-based approach and key considerations for designing a Medicare-Medicaid integration strategy.

Informed by our experience developing [evidence-based integration options](#) for the North Carolina Department of Health and Human Services, the insights within this guide can provide direction to states that plan to develop a tailored integration strategy.

Major Sections of the Guide:

- 1. Designing a Medicare –Medicaid integration strategy**
 - Data-driven and based in evidence
 - Tailored to the state specific context
 - Guided and informed by community members
- 2. Key components of an integration strategy**
 - Principal policy and programmatic parameters
 - Core model component considerations
 - Oversight and performance measurement
- 3. Resources for strategy adoption and implementation**
- 4. Key terms**

Dual-Eligible Beneficiaries



Who are they? Nationally, there are over 12 million dual-eligible beneficiaries enrolled in both Medicare and Medicaid. Dual-eligible beneficiaries have complex health and social needs, with the average beneficiary suffering from six or more chronic health conditions. Despite the complex array of needs associated with dual status, only 18% were enrolled in integrated plans in 2021.

Why is this a problem? Medicare and Medicaid are separate programs with disparate sets of benefits, provider networks, and administrative processes. The lack of coordination across programs results in a fragmented system of care that creates additional care barriers for dual beneficiaries and their care networks.

What is the solution? To better meet the diverse needs of the dual-eligible population and promote beneficiary-centered care, recent state and federal legislative efforts have increasingly emphasized integrated plans as a solution.

Why Integrate Care?



Population Health and Improved Outcomes. Dual-eligible beneficiaries have complex health, psycho-social, and economic needs that require significant care coordination and timely access to needed services. Integration provides opportunities to deliver beneficiary-centered, equitable, and whole-person care to better meet these diverse needs.



Administrative and Financial Benefits. Dual-eligible beneficiaries are a high-cost population. Despite only comprising 19 percent of Medicare enrollees and 14 percent of Medicaid enrollees, dual-eligible beneficiaries account for more than 30 percent of spending across both programs. Misaligned financial incentives across Medicare and Medicaid result in fragmented care processes and higher spending. Integrated care plans have the potential to reduce administrative burden and reduce overall spending.

Designing a Medicare – Medicaid Integration Strategy

A systematic approach to designing an integration strategy.



Designing a Medicare-Medicaid Integration Strategy: Multi-phase, Multi-component Approach

Build

- Assemble a diverse group of advisors and partners
- Assess state readiness
- Identify evidence required to inform integration design

Analyze

- Gather and analyze quantitative and qualitative data to understand the state specific context and broader integration design considerations
- Explore opportunities for access and meaningful use of Medicare administrative data such as plan enrollment files and CMS claims data

Design

- Identify integration strategy or options:
 - Account for state readiness
 - Reflect evidence and advisor input gathered
 - Consider the State and Federal regulatory context

Disseminate

- Pressure test integration strategy/options with community members
 - Refine integration strategy based on feedback
- Identify multi-pronged dissemination strategy
- Develop mechanisms for ongoing feedback

Assemble a Diverse Group of Advisors

Advisory Panel

Before designing an integration strategy, it is important to establish an advisory panel, made up of diverse perspectives and expertise, to inform design and implementation.

State Team

States also need to identify an internal team at within their Medicaid programs who will be dedicated to integration.

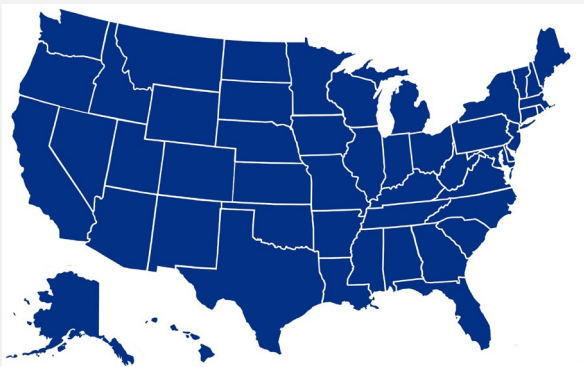


Collaborations

Building collaborative relationships with experts and academic partners to assist with developing evidence-based integration options.

Assess State Readiness for Integration

Initiating a design strategy by assessing state readiness will help leverage existing infrastructure, identify areas for development, and assist with planning for needed investments.



Assess environment to identify resources needed for integration:

Evaluate state experience with managed care

Identify D-SNP penetration and PACE coverage areas

Leverage state Medicaid staff with Medicare knowledge

Identify leadership to champion integration efforts

Build Consensus on Vision and Goals

- Identify a state-specific vision and goals for integration informed by research learnings and community member perspectives. Stakeholder engagement is vital to create a shared vision for integration.
- Establishing relationships with state, federal, and community-based partners not only provides insight into the current challenges and areas of opportunity associated with current plans and programs, but also allows for relationship building that can help mitigate concerns and challenges that may arise during implementation.

Example of Consensus Building:

We convened a core group of advisors to consider the vision and goals for NC.

- The advisory panel consisted of 5 national experts, and 10 NC stakeholders in addition to DHHS representatives and the Duke-Margolis moderators.
- We synthesized the discussion into a vision and solicited additional feedback.
- We established interrelated goals that can be actualized and measured to monitor progress.

Use Quantitative Data to Understand the State Specific Context

Leveraging quantitative data is an important component of an evidence-based integration strategy. Steps should include:

- 1. Identifying full benefit Medicaid beneficiaries who are also enrolled in Medicare who might be eligible for integration**
 1. Use national and state public use files as well as linked Medicare-Medicaid claims files.
 2. Distinguish between beneficiaries with partial Medicaid benefits (qualified Medicare beneficiaries) and Full-Benefit Dual Eligible (FBDE) beneficiaries.
 3. Aged, blind, and disabled Medicaid eligibility overlaps substantially with FBDE, but does not capture all FBDE.
- 2. Describing state-specific Medicaid and Medicare enrollment and churn among dual-eligible beneficiaries**
 1. For example, depending on the state, eligibility categories may include the medically needy and waiver beneficiaries.
 2. Describe Medicare enrollment, especially Medicare Part C enrollment, among FBDE beneficiaries.
- 3. Using analytical methods to address the questions related to integration components, including:**

Integration Mechanisms (see slide 18)

- Current landscape of integrated programs (PACE)
- Medicare Advantage plan options by region or county
- Benefits coverage and access for plans
- Geographic variation in Medicare and Medicaid program options



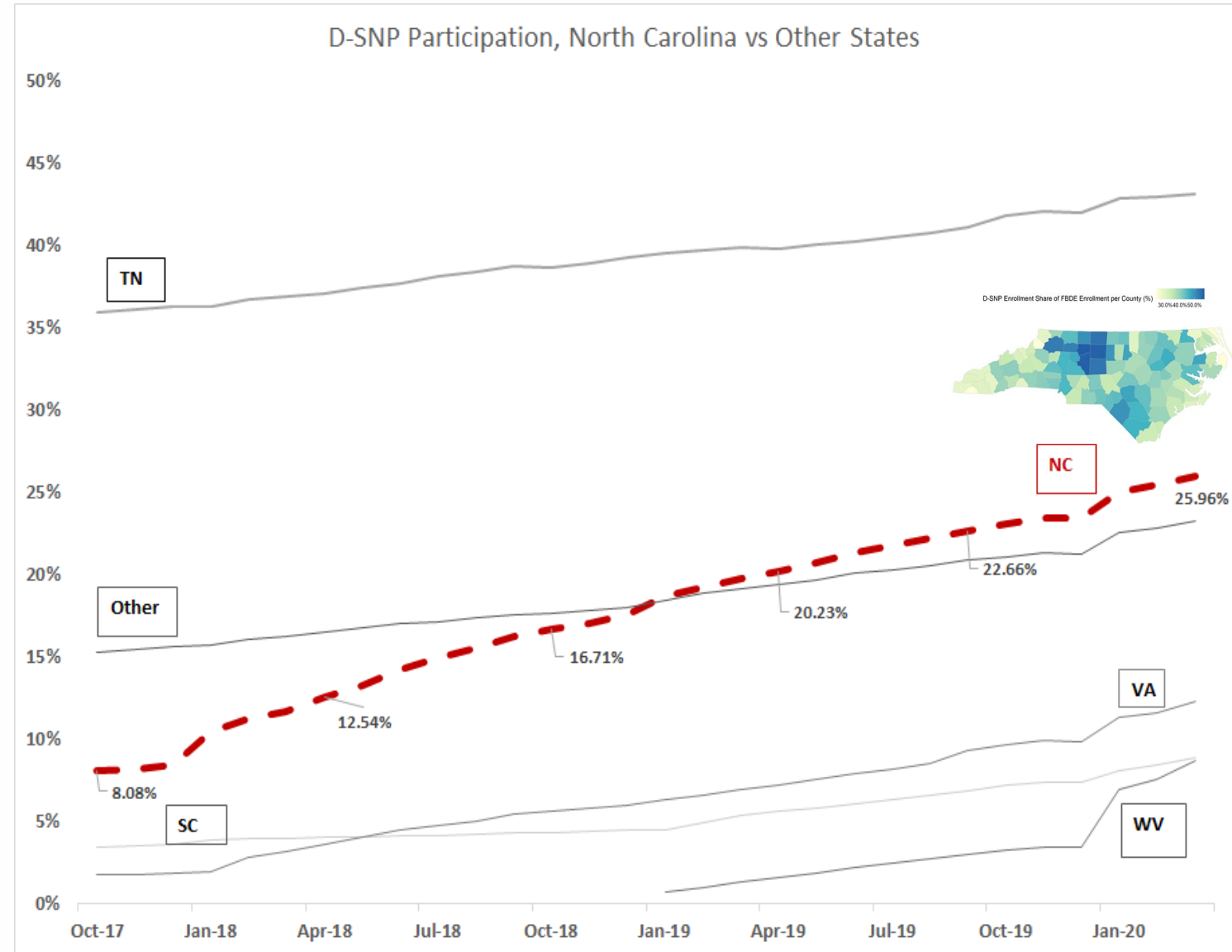
Populations and Services (see slide 19)

- Demographics and geographic variation
- Needs-based subgroups
- Waiver participants
- Medicare service use
- Medicaid service use

Case Example for Using Quantitative Data

Our North Carolina approach:

- To understand Medicare plan enrollment among dual-eligible beneficiaries:
 - We linked public use files reporting D-SNP enrollment to state Medicaid enrollment.
 - We used maps to visualize enrollment and demographic patterns.
- To understand current care and benefits for dual-eligible beneficiaries in NC:
 - We created a novel Medicare-Medicaid data linkage.
 - We described Medicaid eligibility and program enrollment and combined Medicare-Medicaid costs and use.



Use Qualitative Data to Deepen Understanding of State Context & Inform Integration Design

- As a complement to quantitative data, qualitative data can help provide a deeper, nuanced perspective on:
 - Beneficiary needs, experience, & challenges
 - State readiness
 - Vision & goals of integration
 - Integration strategy and design options
 - Implementation considerations
 - Ongoing challenges and opportunities for improvement following roll-out
- Serves as a critical mechanism to gather views and experiences of diverse perspectives in the state.
- Other sources of qualitative data, such as existing peer-reviewed and grey literature, can add further context and inform broader qualitative strategy (e.g., interviews, surveys, focus groups).

Who to engage:

- State Medicaid agency officials
- Medicaid and Medicare Health Plans
- Federal experts (e.g., CMS)
- Consumer groups (e.g., Area Agencies on Aging; advocates)
- Other states with integration experience
- Community-based organizations
- Providers
- Beneficiaries and their care partners

Potential options for engagement:

1. Key informant interviews
2. Focus groups
3. Public commentary

Case Example for using Qualitative Data

1

Targeted Literature Review

- We began with a literature review to establish a foundational understanding of the national policy landscape and other state experiences with integration.
- The literature review informed the design of our interview guide, including the key domains used across interviews and focus groups.

2

Interviews & Focus Groups

- We conducted interviews and focus groups with a diverse group of national experts, representatives from states with integrated models, and NC stakeholders including NC DHHS officials, providers, insurance plans, consumer groups.

3

Analyzing the Data

- We then transcribed the interviews and conducted a thematic analysis to capture key concepts that emerged through the interviews and focus groups.

Example Interview Domains:

- Defining integration: goals and key elements (e.g., administration, financing, care/benefits)
- Patient populations for integration
- Integration mechanisms
- Delivery system supports (e.g., data infrastructure, workforce)
- Contract incentives and outcomes measurement
- Beneficiary empowerment, experience, and engagement
- Strategies to address equity
- Lessons learned/best practices

Identify an Integration Strategy or Options

Design key components of the integration strategy (see “Designing Integration Strategy Components”, starting on slide 16), guided by:

State Readiness & Capabilities

- Building on state readiness assessment, identify existing programs and long-standing care delivery relationships within your state to better understand how to leverage existing infrastructure to support integration efforts; ascertain new resources and partnerships to drive integration strategy.

Evidence & Stakeholder Input

- Reflect evidence gathered through quantitative and qualitative analysis to inform the best strategy(s) for addressing different integration components.
- Consider community member perspectives gathered throughout design process.

State & Federal Regulatory Context

- State and Federal regulations are frequently updated or introduced to clarify guidance, provide additional supports to states, and, ultimately, further integration efforts.
- [Center for Health Care Strategies](#), [Integrated Care Resource Center](#), and the [Medicare-Medicaid Coordination Office](#) are valuable resources for states to learn more about current or proposed regulations.

Example

In designing integration options for NC, the following were considered and leveraged:

- Statutory requirements to integrate care for the NC FBDE population within five years of Medicaid managed care launch.
- Medicaid managed care strategy and impacts on capabilities to serve different dual-eligible subgroups.
- New federal regulations, such as the [2023 Medicare Advantage and Part D Final Rule](#), to support whole-person care and greater equity in beneficiary education and outreach.

Vet & Disseminate Integration Strategy



- After developing the initial integration strategy or options, it is important to **pressure test with an expanded group of stakeholders**, including qualitative research participants, state and community leaders, and representatives from other states with integration experience, to vet the strategy.



- Refine the integration strategy to address considerations raised by community members and experts with integration experience.



- **Disseminate finalized integration strategy via multiple avenues** (e.g., internal presentations, public webinars, educational presentations with provider groups) to raise awareness and socialize the approach.



- Establish mechanisms to **request and receive ongoing** feedback from community members (e.g., community listening sessions, beneficiary and stakeholder advisory groups).

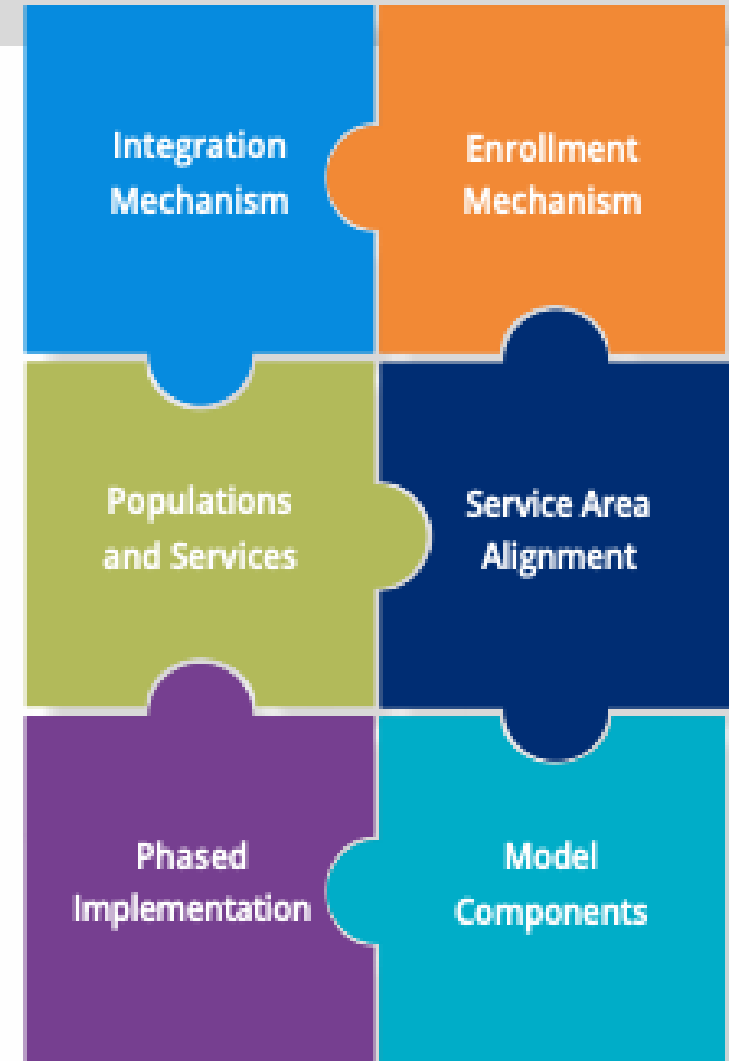
Designing Integration Strategy Components

Key considerations for designing key integration strategy components.



Integrating Strategy Components to Achieve Vision

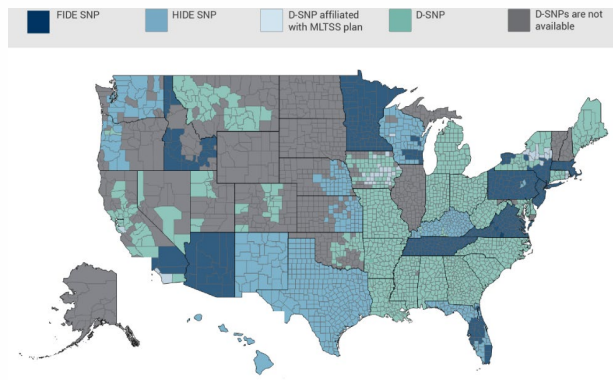
- There are six key policy and programmatic parameters that can define integration options and the degree of integration. An integrated care strategy must account for the parameters shown in the figure. The choices states make across these parameters influence the degree of integration that is possible and, in turn, the beneficiary experience.
- States should make evidence-based decisions around these parameters and tailor decisions to achieve their visions and goals, account for their state's environment, and consider the regulatory context.



1.

Integration Mechanisms

There are multiple [integration approaches](#) available to states. The majority of states have enacted integrated care models for dual-eligible beneficiaries. [45 states](#) and the District of Columbia contract with D-SNPs and [32 states](#) operate PACE programs. Many states use PACE in addition to D-SNP mechanisms. However, the choice of integration mechanism influences other decision points. For example, if a state pursues a D-SNP strategy, the state will need to consider enrollment mechanisms to enhance enrollment in D-SNPs.



Considerations for Pursuing Dual Eligible Special Needs Plan (D-SNP) Strategy

- What D-SNP infrastructure exists in your state?
- Are D-SNPs operating statewide?
- Do parent entities operating Medicaid managed care plans have companion D-SNPs?

Considerations for Pursuing Program of All-Inclusive Care for the Elderly (PACE) Strategy

- What is PACE coverage like within your state?
- Do PACE programs have the resources to operate in rural areas?
- Do your PACE programs have the capacity to expand eligible criteria?

2. Populations and Services

- A key decision point for a state's integration strategy involves deciding which populations and services should be included in their integrated care model. As previously noted, the dual-eligible population is a heterogeneous population with significant variability in needs, utilization patterns, and spending profiles. This variability underscores the importance of designing programs that account for the needs of subgroups within their unique dual population.
- We recommend that states engage with community members, particularly beneficiaries, to understand how each subgroup is currently served so the state can make informed decisions about how to best support beneficiaries. We also recommend leveraging an evidence-based approach that considers current service utilization and need.



Key Populations to Consider

- Community well
- Community-dwelling long-term services and supports users
- Population with significant behavioral health needs
- I/DD and TBI waiver populations
- Nursing home residents



Key Services to Consider

- Primary care
- Acute care
- Behavioral health care
- Long-term services and supports
- Nursing home care
- Supports for SDOH



3. Enrollment Mechanisms

- States have the ability to set enrollment mechanisms in the context of their chosen integration mechanisms and the choice of enrollment mechanism impacts the level of integration within programs. For example, pursuing a D-SNP strategy allows beneficiaries to enroll in unaffiliated Medicaid managed care and D-SNPs (unaligned enrollment), but results in continued fragmentation of care due unless there are strict requirements on model components.
- Consider administrative burden/effort related to enrollment mechanisms. For example, default enrollment allows streamlined enrollment in an integrated care model for Medicare, but the requires CMS approval and significant data infrastructure

Aligned Enrollment: Occurs when a dual-eligible beneficiary is enrolled in a D-SNP and an affiliated Medicaid managed care plan offered by the same parent entity.

Auto-enrollment: A process to automatically enroll Medicaid beneficiaries into the Medicaid plan aligned with their chosen Medicare D-SNP option.

Default Enrollment: A process that requires CMS approval to automatically enroll a Medicaid beneficiary newly eligible for Medicare in the D-SNP offered by the same parent entity as the beneficiary's Medicaid managed care plan.

Exclusively Aligned Enrollment: Occurs when the state limits enrollment in the D-SNP to Full-Benefit Dual Eligible beneficiaries who receive their Medicaid benefits from the D-SNP, or an affiliated Medicaid managed care plan offered by the same parent entity as the D-SNP.

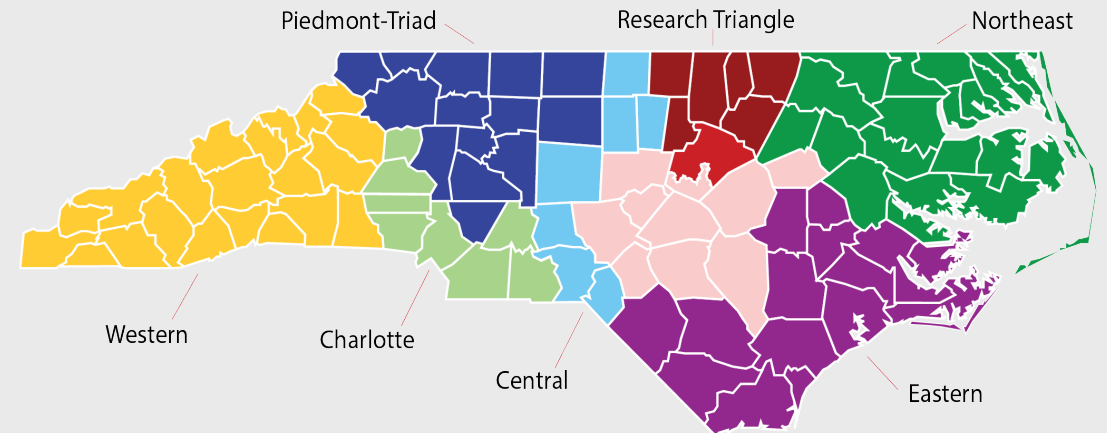
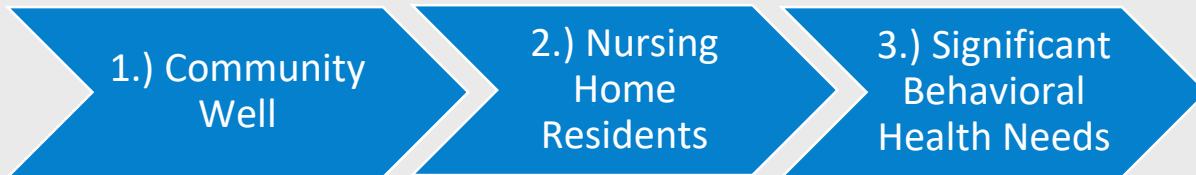
4.

Phased-In Approach

Population and geographic phasing are two potential options for scaling an implementation strategy.

1 Implementation that initially focuses on specific **population(s)** may provide the state and community members with additional time to learn from implementation before including the entire population. A possible drawback is the exclusion of some groups during the scaling process.

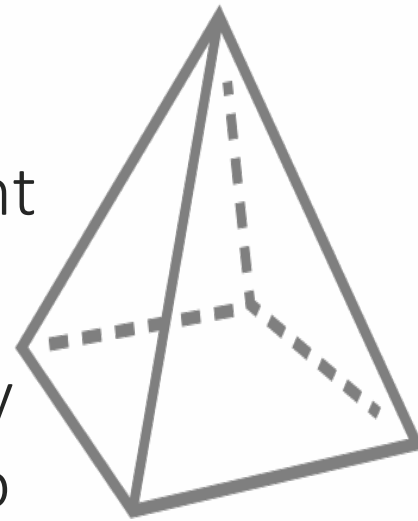
2 States can phase-in by **geographic** areas, such as counties or pre-determined regions. A possible drawback of geographic phasing is that it may result in inequitable access for dual-eligible beneficiaries residing in the regions not initially selected.





5. Service Area Alignment

- Service area alignment is a key consideration for states that pursue a D-SNP integration strategy and involves requiring aligned Medicaid managed care plans and D-SNPs to operate in the same geographic service areas when they are operated by the same parent entity.
- Service area alignment serves to enhance an integration strategy by ensuring all dual-eligible beneficiaries in the state have the option to enroll in aligned plans for integrated coverage.



CMS recently updated regulations in the [2023 Medicare Advantage and Part D Final Rule](#) (CMS-4192-F) to require service area alignment for Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs).

Enhance an integration strategy through programmatic components

State choices regarding the five [policy and programmatic parameters](#) have implications for the degree of integration possible and may require states to design customized model components to meet the needs of beneficiaries and enhance their experience.

Example scenario:

A state pursues a D-SNP strategy with exclusively aligned enrollment (using default enrollment and auto-enrollment mechanisms) and service area alignment, and plans to phase-in needs-based subgroups beginning with the community well. The state will need to:

- Assess their data infrastructure and ensure they have the analytic capacity to attribute beneficiaries,
- Build adequate networks of LTSS and behavioral health providers,
- Align, to the extent possible, Medicaid bidding and procurement timelines with Medicare timelines.

6.

Considerations for Core Model Components

Organizational Supports



Care Delivery



Administrative Processes



- Does your state have leadership to champion integration efforts and staff dedicated to integration, including staff with Medicare knowledge?
- What is the status of your state's workforce to support integration and deliver care?
- How can your state invest in a robust data infrastructure and analytic capabilities needed to advance integration?

- How can your state leverage community-based organizations to support care coordination and deliver whole-person care?
- Does your state have the adequate provider networks to ensure beneficiary have timely access to quality care?

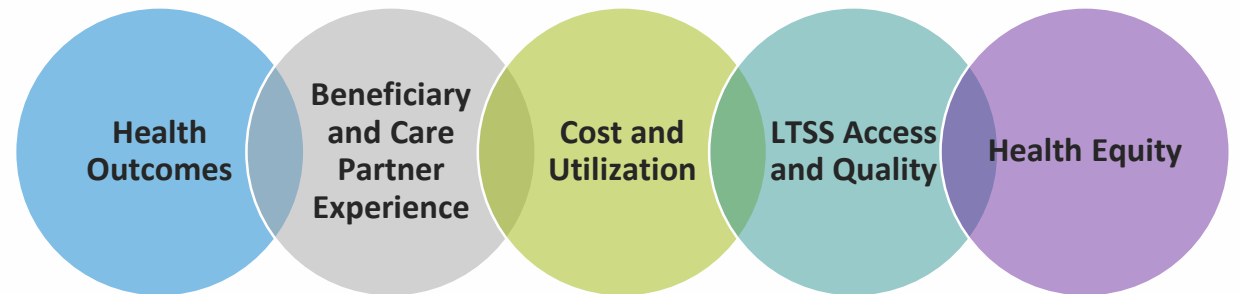
- How can your state leverage contracting mechanisms (E.g., State Medicaid Agency Contracts for D-SNPs) to support an integration strategy?
- What needs to happen to align Medicare and Medicaid bidding timelines to simplify and align administrative process?

Conducting Oversight and Performance Measurement

In addition to leveraging model components to advance integration, it is important to evaluate progress by developing a plan for oversight and measurement.

- Quality measurement strategies should be beneficiary centered, easy for plans to execute, and offer flexibility.
- Evaluating implementation should be prioritized. Over time, measurement strategies can be adjusted to accommodate state specific areas for improvement, including gaps in care and cost inefficiencies.

Begin with a self-assessment: Review any existing state-level strategy documents regarding quality measurement (e.g., those for Medicaid lines of business) and consider how the state's current approach aligns with Medicare reporting requirements, and where there may be gaps relevant to the dual-eligible population. The five domains below can help guide this process.



Key Resources



- [Congress Considers Strategies To Improve Medicare And Medicaid Integration For Dual-Eligible Individuals](#) (Keohane, L. and Hwang, A)
- [Contract Year 2023 Policy and Technical Changes to the Medicare Advantage](#) (CMS)
- [Dually Eligible Individuals - Categories](#) (CMS)
- [Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment](#) (Integrated Care Resource Center)
- [Medicare Advantage Proposed Rule: D-SNP and Dual Eligible Proposals](#) (ATI Advisory)
- [Medicare & Medicaid Integration](#) (Center for Health Care Strategies)
- [Opportunities for States](#) (CMS Medicare-Medicaid Coordination Office)
- [Washington Health Home MFFS Demonstration: Fifth Evaluation Report](#) (RTI International)
- [Working with Medicare: Using D-SNPs to Integrate Care for Dually Eligible Individuals](#) (Integrated Care Resource Center)

Key Terms

1. **Aligned Enrollment:** Occurs when a dual-eligible beneficiary is enrolled in a D-SNP and an affiliated Medicaid managed care plan offered by the same parent entity.
2. **Auto-Enrollment:** A process to automatically enroll Medicaid beneficiaries into the Medicaid managed care plan aligned with their chosen Medicare D-SNP option.
3. **Default Enrollment:** A process that requires CMS approval to automatically enroll a Medicaid beneficiary newly eligible for Medicare in the D-SNP offered by the same parent entity as the beneficiary's Medicaid managed care plan.
4. **Dual Eligible Special Needs Plan (D-SNP):** Medicare Advantage plans serve dual-eligible beneficiaries that are required to contract with states.
5. **Exclusively Aligned Enrollment:** Occurs when the state limits enrollment in the D-SNP to Full-Benefit Dual Eligible beneficiaries who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent entity as the D-SNP.
6. **Financial Alignment Initiative (FAI):** Centers for Medicare and Medicaid [demonstration model](#) that aligns financing of Medicare and Medicaid and integrates care for dual-eligible beneficiaries.
7. **Full-Benefit Dual Eligible (FBDE):** A person who qualifies for Medicare and the full set of Medicaid benefits.
8. **Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP):** Exclusively aligned plans that receive capitated payments from Medicare and Medicaid covering behavioral health and MLTSS.
9. **Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP):** D-SNP plans that receive capitated payments for some Medicaid benefits—covering behavioral health, MLTSS, or both.
10. **Program of All-Inclusive Care for the Elderly (PACE):** Model that provides comprehensive medical and social services to community-dwelling adults aged 55 and older who require nursing home-level care.
11. **State Medicaid Agency Contract (SMAC):** Contracts between state Medicaid agencies and D-SNPs that outline integration [requirements](#).

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