Key Programs Serving Dual Eligible Individuals

Descriptions, Strengths, and Limitations

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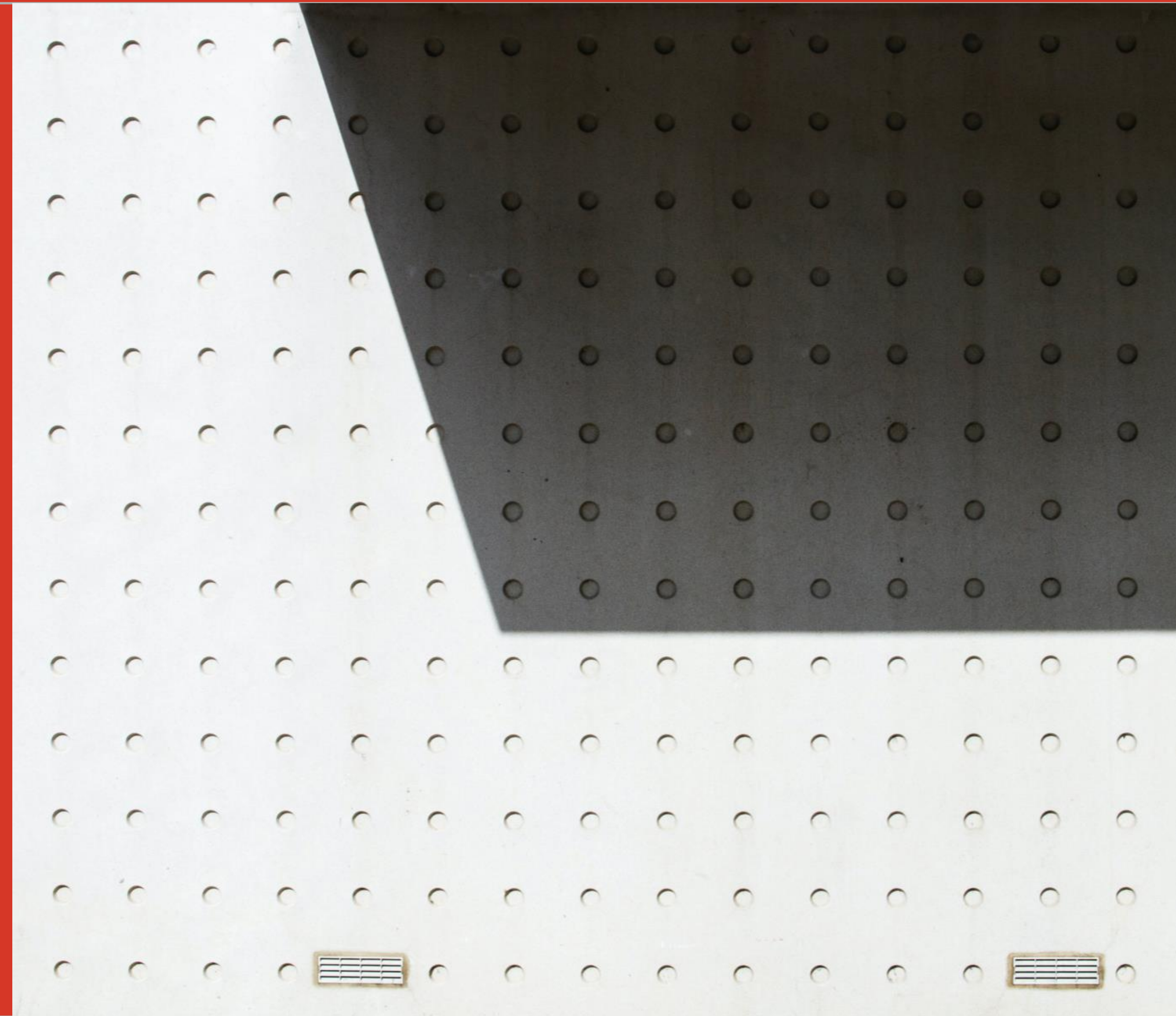
ATI Advisory



→ Background and Purpose

More than 12 million individuals are dually eligible for both Medicare and Medicaid ("dual eligible individuals"). Because Medicare and Medicaid were not initially designed to work together, dual eligible individuals often must navigate conflicting policies, provider networks, and benefit coverage between the programs. This system fragmentation leads to poor outcomes and experiences for individuals and their families, financial misalignment and shifting of costs between program payers, and program inefficiencies. To address this system fragmentation and its resulting effects, policymakers have sought solutions to integrate Medicare and Medicaid for decades.

This guidebook is intended to provide a high-level summary of different approaches to integration and illuminate strengths and considerations across these approaches.

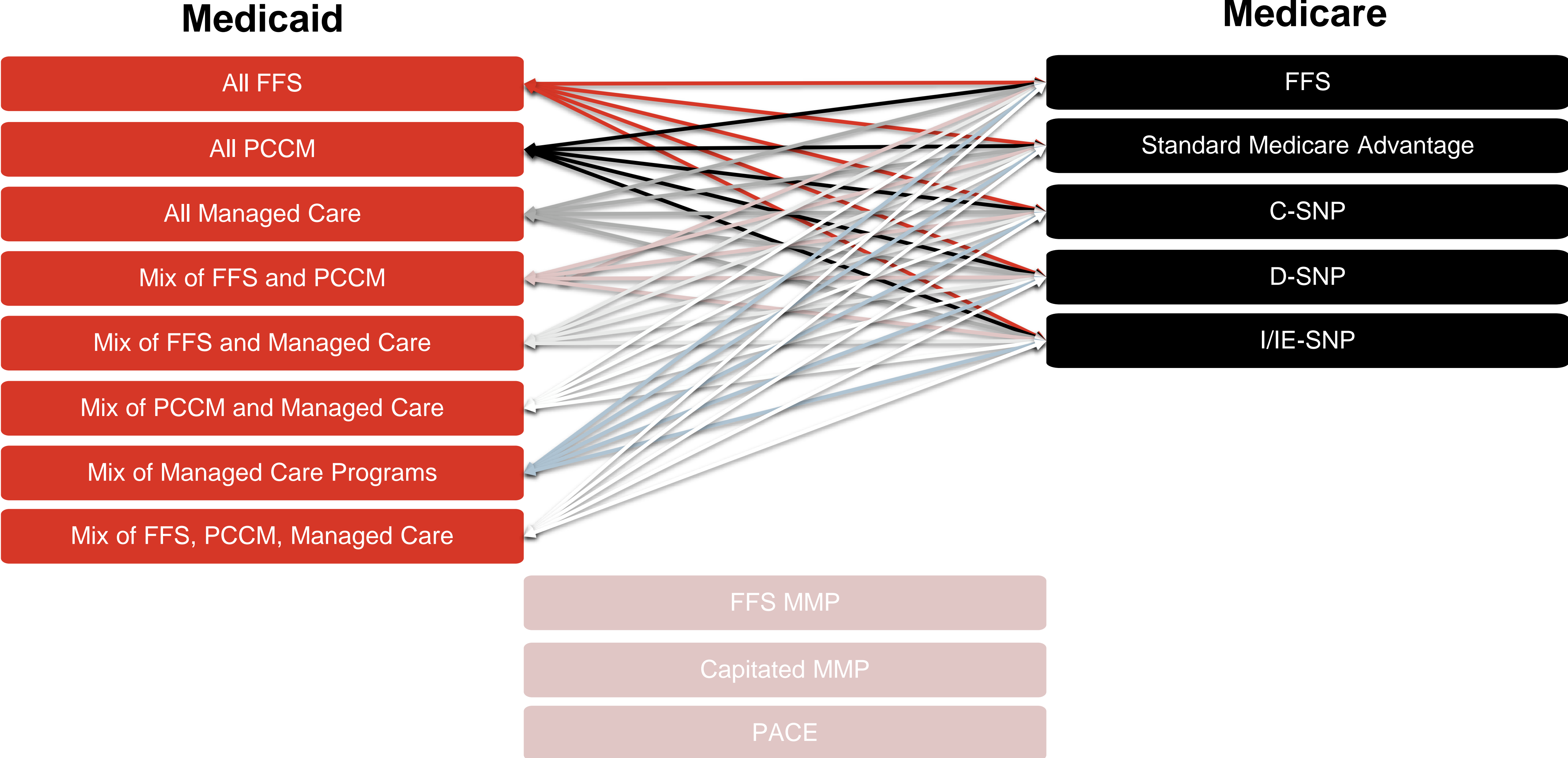
Navigate directly to a section of this guidebook:

→ Program Overviews

→ Program Strengths and Considerations

→ Additional Resources

Overview of Programs



Medicaid
All FFS
All PCCM
All Managed Care
Mix of FFS and PCCM
Mix of FFS and Managed Care
Mix of PCCM and Managed Care
Mix of Managed Care Programs
Mix of FFS, PCCM, Managed Care
Medicare
FFS
Standard Medicare Advantage
C-SNP
D-SNP
I/IE-SNP
FFS MMP
Capitated MMP
PACE

Medicaid Managed Care, Related Programs

MCO, PIHP, PAHP, PCCM

Contract between Medicaid agency and health plan/other organization to administer Medicaid benefits; may be comprehensive or limited to specific services

→ **Managed Care Organization (MCO):** Partially or fully comprehensive benefit package; payment is capitated

→ **Prepaid Inpatient Health Plan (PIHP):** Limited benefit package with inpatient or institutional services (e.g., behavioral health); payment may be risk or non-risk-based

→ **Prepaid Ambulatory Health Plan (PAHP):** Limited benefit package without inpatient or institutional services (e.g., transportation); payment may be risk or non-risk-based

→ **Primary Care Case Management (PCCM):** Case management services (e.g., coordination) typically paid FFS

Dual Eligible Special Needs Plan

D-SNP, HIDE SNP, FIDE SNP

Medicare Advantage plan limited to dual eligible individuals and includes a contract between plan and the state (state Medicaid agency contract/SMAC); all D-SNPs must coordinate with Medicaid but not all D-SNPs bear risk for Medicaid

→ **Coordination-only D-SNP (CO D-SNP):** D-SNP that does not bear [sufficient] risk for Medicaid behavioral health (BH) or long-term services and supports (LTSS); must coordinate with Medicaid via data sharing

→ **Highly-Integrated D-SNP (HIDE SNP):** D-SNP with Medicaid risk for BH and/or LTSS, requires service area alignment with a companion Medicaid MCO, PIHP, or PAHP contract, or D-SNP capitation

→ **Fully-Integrated D-SNP (FIDE SNP):** D-SNP with comprehensive Medicaid risk for LTSS and BH, requires exclusively aligned enrollment via a managed LTSS MCO or D-SNP capitation

Financial Alignment Initiative

FAI

→ Demonstration that uses a CMS-state partnership to test financial and administrative alignment models for full dual eligible individuals; may be capitated Medicare-Medicaid Plan (MMP) model or managed FFS [capitated model sunsets December 2025]

Program of All-Inclusive Care for the Elderly

PACE

→ Provider-based program for individuals 55 years and older, residing in the community with a nursing facility level of care; includes a PACE Center and provides access to all necessary services based on individual needs

See also CY2023 Medicare Advantage Final Rule: D-SNP and Dual Eligible Impacts for additional detail on definitions, program requirements, and policy changes.

Enrollment Alignment

A state may operate an aligned Medicaid/D-SNP program, but beneficiaries may or may not receive Medicaid and Medicare services with a single organization; an organization is able to provide aligned experiences for aligned members even when the plan enrolls unaligned members

Additional Demonstration Flexibilities

States can work with CMS to deploy Financial Alignment Initiative attributes outside the capitated MMP or MFFS demonstration, for example adding certain authorities onto a D-SNP contract

Variation in D-SNP Contract Terms

States have considerable latitude in how they shape D-SNP contracts, even within each category (standard D-SNP, HIDE SNP, FIDE SNP), such as Medicare data sharing, care model engagement, and product design

Medicaid Managed Care Carve-Outs

Medicaid programs vary considerably by state often with Medicaid benefits administered across multiple Medicaid programs; Medicaid program carve-outs complicate Medicare-Medicaid integration by increasing the entities serving a dual beneficiary and creating additional vulnerability for misaligned incentives

Targeted Population

The value of integration will vary based on an individual's unique circumstances, meaning something different to those who use both Medicare and Medicaid services (e.g., BH and/or LTSS), those who rely primarily on Medicare services (physical health and acute care), those living in a community setting, and those living in a long-stay facility setting

DIFFERENT ALIGNMENT APPROACHES CAN ENHANCE MEDICARE-MEDICAID INTEGRATION

Term	Definition
Contractor Alignment	***The same organizations participate in both the Medicaid managed care program and D-SNP.*** Contractor alignment occurs when a state limits D-SNP contracts to organizations that also have a Medicaid managed care contract (or otherwise bear Medicaid risk); a state might also limit Medicaid contracts to those organizations able to offer a D-SNP. This may or may not result in aligned enrollment, described below.
Service Area Alignment	***Geographic overlap in an organization's Medicaid and D-SNP product footprint for dual eligible individuals.*** Service area alignment is required for HIDE and FIDE SNPs, where the D-SNP can be no more geographically expansive than the Medicaid service area; however, the Medicaid service area can be more expansive.
Exclusively Aligned Enrollment	***A D-SNP only enrolls individuals for whom it also has Medicaid risk.*** Exclusively aligned enrollment is required for FIDE SNPs and optional for states to require of other D-SNP types. Approaches to accomplish this include a state limiting D-SNP enrollment to individuals already served by the organization's Medicaid plan, auto-assigning D-SNP enrollees to the organization's Medicaid plan, capitating Medicaid services directly into the D-SNP, or requiring concurrent enrollment in the same organization.

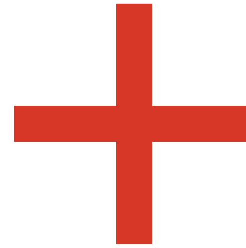
Program Strengths and Considerations

	Aligned member experience	Maximized enrollment	Integrated financing	Medicare savings for state	Ease of implementation
Standard D-SNP	Typically Not, None, Never	Often, Very Much	Minimal, Limited, Difficult	Minimal, Limited, Difficult	Always, Nearly Complete, Easiest
Capitated D-SNP	Always, Nearly Complete, Easiest	Often, Very Much	Minimal, Limited, Difficult	Some, Moderate	Some, Moderate
Medicaid MCO aligned with D-SNP	Often, Very Much	Some, Moderate	Minimal, Limited, Difficult	Some, Moderate	Minimal, Limited, Difficult
FFS MMP	Often, Very Much	N/A	Typically Not, None, Never	Some, Moderate	Some, Moderate
Capitated MMP	Always, Nearly Complete, Easiest	Minimal, Limited, Difficult	Some, Moderate	Often, Very Much	Minimal, Limited, Difficult
PACE	Always, Nearly Complete, Easiest	Typically Not, None, Never	Often, Very Much	Typically Not, None, Never	Minimal, Limited, Difficult

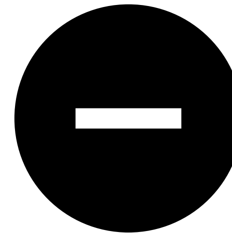
Typically Not, None, Never | Minimal, Limited, Difficult | Some, Moderate | Often, Very Much | Always, Nearly Complete, Easiest

What it is:

A D-SNP without comprehensive Medicaid risk BH or LTSS that, at a minimum, must share information with a state or other entity to facilitate transitions of care when an enrollee is admitted to a hospital or skilled nursing facility



- → Expands access to Medicare duals products that might not otherwise be available, allowing for a targeted care model and Medicaid coordination
- → Data sharing requirements can facilitate transition from a Medicare stay into the community via Medicaid supports
- → Creates a stairstep approach to more robust methods of integration and alignment
- → Can enroll full and partial dual beneficiaries

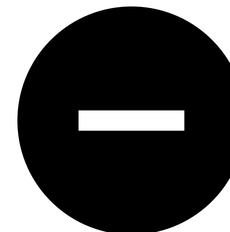


- → D-SNP often has limited or no line of sight into Medicaid experiences
- → D-SNP may not have relationship with Medicaid providers
- → Minimal alignment in financial incentives
- → Minimal alignment in beneficiary experience

What it is:

Single D-SNP contract with a state and CMS into which the state capitates certain Medicaid services, often mutually exclusive from a separate Medicaid managed care contract or procurement in the state

- Easier to implement than comprehensive Medicaid managed care and can transition into formal, mandatory Medicaid managed care program (e.g., via 1915(a) authority that transitions to 1915(b) or 1115(a))
- Exclusively aligned enrollment for Medicaid services capitated in D-SNP
- Aligned materials, customer service
- Eliminates/reduces reprocurement volatility
- Allows program to focus exclusively on duals (versus broader programs that include non-dual Medicaid populations)

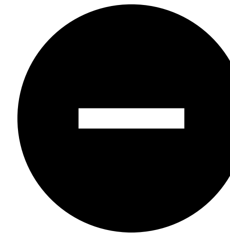


- States unable to mandate Medicaid enrollment
- State-specific legislative barriers may exist around capitating Medicaid services
- LTSS and BH providers may be unaccustomed to managed care initially

What it is:

Organization has Medicaid managed care contract with a state and a separate D-SNP contract with the state and CMS; covered Medicaid services vary based on what a state "carves-out" to FFS or a separate Medicaid managed care program

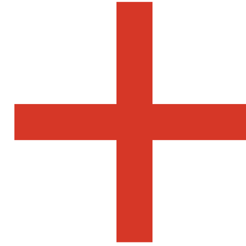
- States can mandate Medicaid enrollment if coupled with specific Medicaid authorities
- Contractor alignment provides opportunity for enrollment alignment in a single organization, particularly important for duals using Medicaid services
- Plans can offer aligned materials and customer service



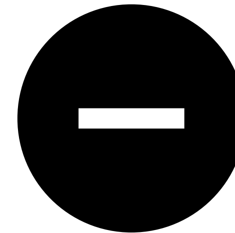
- Managed care programs take years to implement and can have considerable political and financial implications
- Reprocurement can cause significant disruption to dual beneficiaries
- Limiting D-SNP contracts and/or enrollment to Medicaid contractors can push duals to non-dual Medicare products (particularly "community-well" duals)

What it is:

Managed FFS demonstration program under the Financial Alignment Initiative that includes an agreement between a state and CMS and allows the state to share in Medicare savings; currently a single state operates a FFS MMP program and uses a Medicaid Health Homes program as the infrastructure



- May be easier to implement than comprehensive managed care program
- Allows state to share in any Medicare savings with CMS
- Creates a seamless beneficiary experience at a program and clinical level

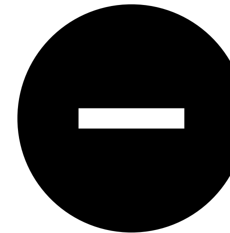


- Best if coupled with an existing Medicaid infrastructure that some states might not have (e.g., health home)
- State Medicare savings are retrospective, which does not align with annual budget balancing requirements
- Limited to full duals who are not enrolled in Medicare Advantage or PACE programs, and approach may not work with lower-complexity duals

What it is:

A Financial Alignment Initiative demonstration that includes a three-way contract between a state, CMS, and a health plan, that allows a state to share in Medicare savings with CMS and creates an aligned beneficiary experience

- Allows state to share in any Medicare savings with CMS
- Allows for aligned materials, customer service, and beneficiary experience
- Able to passively enroll into Medicaid and Medicare (with opt-out)
- Facilitates integrated/pooled financing

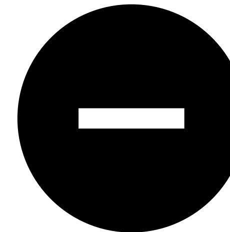


- Sunsetting December 2025
- Lower Medicare payment coupled with quality withholds increase program opt-outs and reduce plan/provider interest
- Plans may have less robust benefit packages than non-MMP plans
- Implementation costs are significant for states and plans
- Limited to full dual eligible individuals

What it is:

Capitated/risk-based Medicaid State Plan program that integrates preventative, acute care, and LTSS through a combined Medicare and Medicaid prospective payment (and premium payments for certain individuals), coupled with a PACE Adult Day Center

- Of all current models, offers the highest degree of financial integration
- Able to meet needs of individuals regardless of standard Medicare or Medicaid limits
- Combined funding and flexibility allows for coverage of certain social services



- Expensive to implement
- Limited to LTSS level-of-need older adults
- Requires a brick-and-mortar location
- Limited geographic availability

Additional Resources

Resources

- Retaining the Successes of the MMP Model
- Advancing Medicare-Medicaid Integration Through Medicaid Programs: A Policy Roadmap
- Enhancing Medicare-Medicaid Integration: Bringing Elements of the FAI into DSNPs
- Fixing the FIDE-SNP – Redefining "Fully Integrated"
- Access to Medicare-Medicaid Integrated Products
- Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections when Enrolled in Medicare Advantage
- Is Too Much Choice a Bad Thing?
- Key Beneficiary Protections in Medicare-Medicaid Integrated Programs
- Advancing the Policy Environment to Address the Unique Needs of Partial Dual Eligible Beneficiaries
- Transportation Access, Dual Eligibility, and COVID-19
- Left Behind in the Era of Internet: Yet Another Challenge Facing Dual Eligible Beneficiaries
- Making Sense of Medicare-Medicaid Integration Models
- Medicaid-Capitated DSNPs: An Innovative Path to Medicare-Medicaid Integration
- State Approaches Will Shape the Successes (and Failures) of New Supplemental Benefits in DSNPs

ATI has a library of resources on the current landscape of programs serving dual eligible beneficiaries, the unique needs and experiences of dual eligible beneficiaries, as well as recommendations to improve policy to better serve dual eligible beneficiaries.

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