State Approaches to Medicare-Medicaid Integration: A Comparative Analysis of Integration Models and Healthcare Utilization Among Dual-Eligible Beneficiaries

Gugma Vidal
Emory University Rollins School of Public Health, Health Policy & Management

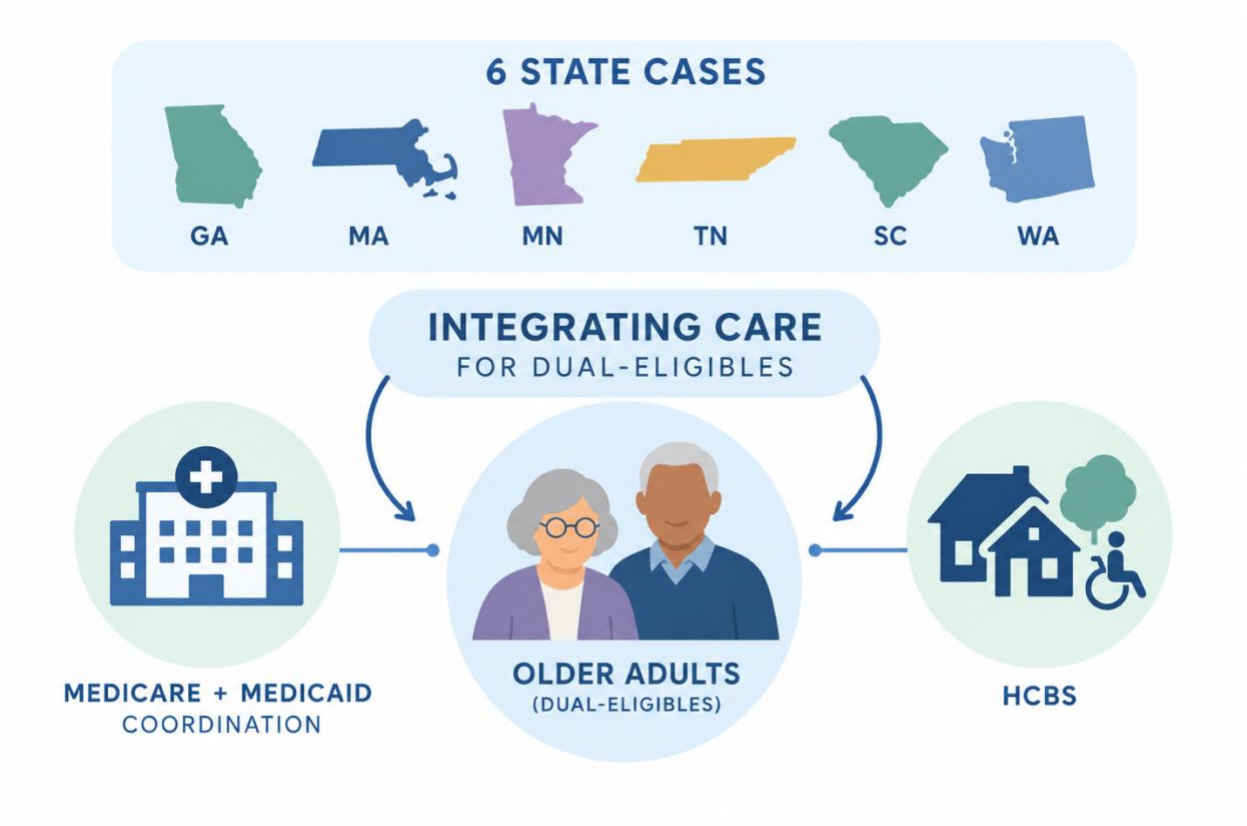


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Dual-eligibles are individuals who are covered by Medicare and Medicaid and must navigate both health insurance programs, often with little support.[i] Although dual-eligibles constitute a small part of the population who use Medicare and Medicaid benefits, healthcare spending for this population is disproportionately large due to the complexity of their medical needs and gaps in care coordination.[ii] In 2021, spending on dual-eligibles comprised about 31% of traditional Medicare spending and 29% of Medicaid spending. In comparison, dual-eligibles only account for 16% of traditional Medicare enrollees and 14% of Medicaid enrollees in the United States.[iii] In the face of rising healthcare costs and federal and state spending, there is a need to better manage health financing for this population.

The dual-payer structure of the healthcare system, in which Medicare and Medicaid pay separately for dual-eligibles, has contributed to perverse financial incentives that increase overall healthcare costs across the system.[i] It can also lead to fragmentation between payers and providers that disrupts the coordination of care for dual-eligibles.[iv] Integration of Medicare and Medicaid has been proposed as a solution, where one insurer manages Medicare and Medicaid

spending for dual-eligibles. Fully Integrated Dual Special Needs Plans, or FIDE-SNPs, are one type of integrated plan that manages Medicare and Medicaid benefits under a single managed care plan.[v] The Program of All-Inclusive Care for the Elderly, or PACE, is another type of integrated plan. These plans are not available uniformly across the United States, and there is a need for greater evaluation of these programs' effectiveness.[vi]

In 2013, the Center for Medicare and Medicaid (CMS) piloted their Financial Alignment Initiative, where states could test models aimed at addressing financial misalignment between Medicare and Medicaid. Thirteen states participated in either a capitation model or a managed fee-for-service model, including Massachusetts, Minnesota, South Carolina, and Washington.[vii] All pilot programs ended by the close of 2025, and there is now an opportunity to evaluate what is next for innovations in healthcare financing for the dual-eligible population.[viii]

This article includes a policy landscape analysis of six states, Georgia, Massachusetts, Minnesota, South Carolina, Tennessee, and Washington. A policy matrix was created by pulling together data from KFF, the Commonwealth Fund, published state government sources, and other literature. The matrix describes the status of each state across different policy dimensions and assigns a rating from one star to three stars depending on the state's level of integration. Healthcare utilization and Medicaid and Medicare spending data for the six states were compared in a cross-sectional analysis. This research found significant variation between the states in their integration of Medicare and Medicaid, unwanted healthcare utilization, and healthcare spending per dual-eligible. One key finding was that Washington state, despite having a lower level of integration than some other states, demonstrated better healthcare utilization measures for its elderly dual-eligible population in the three selected metrics during the period analyzed.

The purpose of this paper is to describe state variation in the management of dual-eligibles' care by providing comparisons across policy, healthcare utilization data, and spending data. Although there is a need for more rigorous evaluation to make causal inferences, this descriptive policy analysis makes some preliminary conclusions about the variation in state policy for dual-eligibles. Based on the research findings, policy recommendations are provided to inform the future direction of research and the application of this paper's findings. To manage spending on dual-eligibles while maintaining healthcare quality and access, states will need to learn from previous and current integrated models and more strongly align financial incentives to dual-eligible health outcomes.

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