

# ENTRY POINT



**Benefits:** While raising her daughter in Braintree, Massachusetts, Crystal Evans has benefited from a health plan model specifically developed for people who are eligible for both Medicare and Medicaid. But that model is being phased out, and Evans, who serves on her program's Implementation Council, will find out whether the state's new program serves her as well.

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## The Continuing Quest To Integrate Care For Dual-Eligible Enrollees

*For people dually eligible for Medicare and Medicaid, one integrated care plan option is coming to an end. States are planning what to offer next.*

BY HARRIS MEYER

**C**ystal Evans, 43, has mitochondrial myopathy, a neuromuscular disease related to muscular dystrophy. She uses a power wheelchair to get around and is ventilator dependent as a result of respiratory failure. She is

also raising her thirteen-year-old daughter by herself, in her own home in Braintree, Massachusetts. Since 2017, she has served on the Implementation Council for One Care—a Massachusetts Medicaid program that contracts with her health plan, Commonwealth Care Alli-

ance, to serve people who are eligible for both Medicare and Medicaid. The council consists of consumers and advocates who monitor dual-eligible coordination efforts.

Evans says that there was a “drastic improvement” in her care after she joined the Commonwealth Care Alliance’s coordinated Medicare-Medicaid plan in 2016. Now she’s worried about what will happen to her and other dually eligible beneficiaries as the Commonwealth Care Alliance switches in 2026 to a new arrangement between the federally run Medicare program and the state-run Medicaid program. Under the new model, the plan will have separate contracts with the two public programs, rather than one unified contract. This new model is rolling out, or has already rolled out, among health plans in nine other states as well and will affect a total of more than 400,000 dual-eligible enrollees.

“Nobody is concretely sure what these changes would entail,” Evans fretted. “We see red flags and a lot of unanswered questions for consumers.” She’s hoping that her provider network and benefits will remain the same in 2026 under the new model.

This switch to a new model is one of the latest developments in the federal government’s long-running effort to offer coordinated, more cost-effective medical, behavioral, and long-term care and social services to the medically and socioeconomically vulnerable Americans who are eligible for both Medicare and Medicaid.<sup>1</sup> The twin goals are better care and lower total spending.

A central objective has been to try to align the financial incentives of Medicare and Medicaid so that each payer and plan prioritizes delivering the best care possible, instead of simply shifting costs to the other program. For example, how can policy makers incentivize Medicaid to cover services that keep people out of the hospital when the savings from avoiding a hospitalization largely accrue to Medicare’s bottom line?

Everyone agrees that it’s been a difficult journey.

“There is no administrative infrastructure or financial incentive to coordinate care across both programs and keep costs down,” José Figueroa, an assistant professor of health policy and management at Harvard University, said in a *Health Affairs* podcast interview last year.<sup>2</sup> “The bifurcated system is just not working. ...We know it leads to fragmentation, and we know it leads to higher costs.”

One reason that no satisfactory policy solution has yet been found may be that improving care and reducing costs aren’t always harmonious goals. “Good care coordination will lead to people getting the care they need, but it doesn’t necessarily mean it will save money, because it might increase utilization,” Figueroa said in an interview for this article.

Since 2013, Commonwealth Care Alliance has been participating in the thirteen-state Financial Alignment Initiative demonstration launched by the Center for Medicare and Medicaid Innovation (CMMI). In ten states, the demonstration introduced a new type of coordinated plan for dual eligibles, called Medicare-Medicaid Plans (MMPs), which are operated by either for-profit or nonprofit insurers. The other three states offered managed fee-for-service or alternative models. In 2022, however, CMMI announced that it would end the MMP demonstration after it produced mixed results on patient outcomes and costs.<sup>3</sup>

Surveys showed that enrollee satisfaction in MMPs was high, and the number of physician evaluation and management visits tended to increase. But plans’ performance on hospital admissions, emergency department visits, and nursing home admissions varied among the demonstration states. Importantly, per enrollee Medicare and Medicaid costs increased in most of the states. For example, in California over the course of five years, monthly costs for Medicare and Medicaid averaged \$63 and \$325 higher, respectively, relative to a comparison group.<sup>4</sup>

“The hope was that MMPs would become permanent, but they haven’t met the financial test,” said Melanie Bella, the former head of CMS’s Medicare-Medicaid Coordination Office and currently an adviser at Cityblock Health.



**Improvement:** Crystal Evans, who has mitochondrial myopathy, uses a power wheelchair to get around and is ventilator dependent. She says that there was a “drastic improvement” in her care after she joined a coordinated plan for dual eligibles.

“We’re taking away something that’s arguably the most integrated type of plan for dual-eligible beneficiaries. Hopefully there will be something that comes back in the future, allowing more financial and clinical integration.”

By the start of 2026, Massachusetts and seven other MMP demonstration states must shift their dual-eligible residents to different integrated plans. The Centers for Medicare and Medicaid Services (CMS) hopes that the states will steer their dual-eligible beneficiaries into so-called Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), or at least Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs), a somewhat less integrated type of plan.<sup>5</sup> California and Virginia, the other two MMP demonstration states, already have made the transition away from MMPs.

Several MMP demonstration states, including Massachusetts and Rhode Island, have issued requests for bids from Medicare plans to offer FIDE SNPs that have capitated contracts with Medicaid managed care plans. The other demonstration states are expected to issue bid requests soon. They want to continue

the effort to optimize care coordination across the entire spectrum of medical care, behavioral care, institutional care, home and community-based services, and social services.

Since 2016, the Neighborhood Health Plan of Rhode Island has offered the state’s sole MMP. It currently serves 12,500 dual-eligible beneficiaries, delivering primary care through federally qualified health centers and an affiliated network of behavioral health providers and long-term services and supports providers, according to Mark Cooper, the plan’s vice president for Medicare-Medicaid integration. The plan is one of four insurers that submitted a bid in February to operate a FIDE SNP in conjunction with a contracted Medicaid plan.<sup>6</sup>

“We fully intend to move our membership to the new fully integrated D-SNP,” said Cooper, using the acronym for a Medicare Dual Eligible Special Needs Plan. “We have full long-term services and supports for members, which a new entrant into the market may or may not have. Ours is seamless to the member, with no bumps in the road where you have to go somewhere else for the service.”

## Encouraging Enrollment In Integrated Care

Meanwhile, CMS is trying to nudge a larger percentage of dual eligibles in all fifty states to enroll in more integrated D-SNPs that have state Medicaid agency contracts, as well as exclusive contracts with Medicaid managed care plans. CMS issued a final rule in April giving dual eligibles a special enrollment opportunity each month to join these plans, whereas those who choose a less integrated plan generally can only switch during the annual Medicare open enrollment.<sup>7</sup> This gives D-SNPs an incentive to contract with Medicaid plans, encouraging care coordination and financial alignment.

In addition, the new rule discourages D-SNPs and traditional Medicare Advantage plans that lack contracts with Medicaid plans from signing up dual eligibles by ending CMS contracts with these nonintegrated plans if their enrollment consists of more than 60 percent dual eligibles. Another key provision is setting a fixed amount that



insurance agents and brokers can be paid by plans; the limit is meant to encourage agents and brokers to steer beneficiaries to the plan that best meets their needs, rather than the plan that pays the highest commission.

“The changes are intended to reduce the number of D-SNP options in a market and make the remaining ones more integrated with Medicaid,” explained Christine Aguiar Lynch, vice president for Medicare and managed long-term services and supports policy at the Association for Community Affiliated Plans, a national association of nonprofit plans, many of whose members operate MMPs and D-SNPs.

The challenge faced by CMS and the states is that currently fewer than 10 percent, or 691,000, of all full-benefit dual eligibles—those who qualify for full Medicaid benefits rather than just cost-sharing assistance—were enrolled in tightly integrated plans such as FIDE SNPs and MMPs in 2023.<sup>3</sup> An additional 70,000 dual eligibles were enrolled in integrated Programs of All-Inclusive Care for the Elderly (PACE) plans in 2023.<sup>8</sup> Nearly two million more were enrolled in HIDE SNPs, which are somewhat less integrated.<sup>8</sup>

The remaining 71 percent of dual eligibles are typically enrolled in non-integrated options that don’t contract with Medicaid managed care plans—including traditional Medicare, D-SNPs that are not FIDE SNPs, or standard Medicare Advantage plans that market to dual eligibles. The latter are called “look-alike” plans because they market seemingly attractive benefits to dual eligibles but are under no federal requirement to contract with a Medicaid plan and thus don’t offer the full array of benefits available to them in a FIDE SNP. Other less integrated plans serving dual eligibles include Coordination Only D-SNPs, Chronic Condition SNPs, and Institutional SNPs.

In many counties around the country, dual eligibles can choose from among dozens of options;<sup>3</sup> that’s because Medicare beneficiaries have freedom of choice by law, with CMS prohibited from preventing beneficiaries from enrolling in any plan that has a Medicare contract. At the same time, traditional Medicare Advantage plans and SNPs of all types have a strong financial incentive to mar-

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ket to dual eligibles because they receive significantly higher risk-adjusted per capita payments from CMS, given dual eligibles’ higher medical acuity scores. Enrollment of dual eligibles in look-alike plans grew elevenfold, to 220,860, between 2013 and 2020.<sup>9</sup>

“In some places, the amount of choices [dual eligibles] have is completely overwhelming,” Bella said. “Some D-SNPs have pretty rigorous requirements for integration. The look-alikes don’t. It’s a real problem.”

There are a number of reasons why most dual eligibles choose non-integrated plans, experts say. For one thing, integrated D-SNPs are not offered in some counties; the most integrated option, FIDE SNPs, were available in only 18 percent of all counties in 2023.<sup>3</sup>

On top of that, providers may try to discourage their patients from joining more integrated plans because they aren’t part of the network or they mistakenly think they won’t get paid for treating enrollees of those plans, said Tiffany Huyenh-Cho, director of California Medicare and Medicaid advocacy for Justice in Aging, a national nonprofit legal advocacy organization.

Other factors include that many dual eligibles make enrollment choices without consulting with unbiased enrollment counselors, such as those with the federally funded State Health Insurance Assistance Programs, who might steer them to plans that provide better coordination of their Medicare and Medicaid benefits. And commercial insurance brokers might not direct them to D-SNPs because they don’t have contracts with those plans.

“There is a tremendous amount of complexity, and it’s even more complex for [dual eligibles], many of whom have cognitive and/or behavioral impairments and who may be targeted for

fraud,” said Gretchen Jacobson, vice president of Medicare for the Commonwealth Fund. “We need to find ways to provide unbiased, one-on-one guidance to help them sort through these options.”

Beyond those factors, dual eligibles might not even understand why they should sign up with a more integrated plan. Allison Rizer, executive vice president of payer solutions for ATI Advisory, which consults with states, health plans, and providers, said that they often pick a plan based on marketing of seemingly attractive benefits without understanding the advantages of care coordination and integration of benefits.

“Integration doesn’t sell. It’s an abstract concept that makes sense to wonks but doesn’t make sense to the typical consumer,” Rizer said. “The integrated program shouldn’t be harder for health plans or states or [dual eligibles]. It has to be an easy choice. Right now, the status quo is the easy choice.”

### Legislative Action

The issue of better coordinating care for dual eligibles has caught the attention of both Republicans and Democrats in Congress. In March, Sen. Bill Cassidy (R-LA) introduced the Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024, cosponsored by a bipartisan group of five members of the Senate Duals Working Group.<sup>10</sup> It requires all states to offer at least one integrated plan for dual-eligible people. A companion bill was introduced in the House of Representatives in May by Rep. Mike Kelly (R-PA) and Ami Bera (D-CA).<sup>11</sup>

“Patients dually eligible for Medicare and Medicaid have much worse outcomes than other groups even though there is a lot more money spent on their care,” Senator Cassidy said in a written statement. “Making Medicare and Medicaid better work together makes patients healthier and saves money for taxpayers.”

That said, there is currently a dearth of solid research evidence to confirm that integrated models of care provide better care for dual eligibles or reduce total costs.

During the *Health Affairs* podcast, Harvard’s Figueroa said that it makes sense that financial alignment and better care coordination improve outcomes

and reduce costs. But, he acknowledged, “there is not a lot of data out there showing which integrated care programs work or what [are] the specific features of the integrated programs that might actually make care better for dual eligibles.”<sup>2</sup>

CMS declined to make any officials available for an interview for this article.

Dual eligibles are an expensive and challenging population to serve. In 2021, there were 12.8 million people enrolled in both programs, with about 9.3 million eligible for full Medicaid benefits, rather than just cost-sharing assistance. Of the total, 64 percent were age sixty-five or older, and 36 percent were younger than age sixty-five.<sup>12</sup>

These are among the nation’s sickest and most socially and economically vulnerable adults. Spending for their care totaled \$493.4 billion in 2021, with Medicare spending at \$312 billion and state Medicaid programs spending at \$181.5 billion. Although just 14 percent of Medicare enrollees and 10 percent of Medicaid enrollees in 2021 were full-benefit dual eligibles, they accounted for 26 percent of all Medicare spending and 27 percent of all Medicaid spending.<sup>12</sup>

The dual-eligible population is also disproportionately diverse. Of the total number of dual eligibles in 2021, 53 percent were non-Hispanic White and 47 percent were Black, Hispanic, Asian, or from other racial and ethnic groups.<sup>12</sup> Adding to the challenge of serving them, dual eligibles have lower incomes than most Medicare beneficiaries; 87 percent had an income of less than \$20,000 in 2020.<sup>13</sup> That means that plans and providers serving them must address daunting social determinants of health, including food security, housing, and transportation.

Dual eligibles who are age sixty-five or older have high rates of multiple chronic health conditions, dementia and other cognitive impairments, mental health and substance use issues, and physical disabilities than other Medicare beneficiaries.<sup>13</sup> Some live in their own homes, whereas others reside in nursing homes and mental health facilities. Still others are homeless. Dual eligibles younger than age sixty-five often have a severe physical or behavioral disability and may receive long-term services and supports or live in an institution.

## The issue of better coordinating care for dual eligibles has caught the attention of both Republicans and Democrats in Congress.

The federal effort to improve care for dual eligibles while reducing spending began in earnest with the Affordable Care Act and its creation of the Medicare-Medicaid Coordination Office in 2010.<sup>1</sup> Under Bella, its first director, that office announced the ambitious Financial Alignment Initiative in 2011 to harmonize Medicare and Medicaid. The goal of the demonstration was to develop models of seamless and cost-effective care for dual eligibles through capitated managed care plans or managed fee-for-service arrangements.

In 2013, CMMI launched the Financial Alignment Initiative to provide integrated benefits under a capitated contract. MMPs were offered in ten states that agreed to participate in the demonstration (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia), with Colorado, Minnesota, and Washington State participating through noncapitated models.

Unlike other integrated plans for dual eligibles except for PACE plans, MMPs are paid through a capitated, per person per month rate combining Medicare and Medicaid payments, with a payment withhold contingent on quality performance, and with state and federal savings factored in. As of September 2022, about 428,000 dual eligibles were enrolled in MMPs.<sup>14</sup>

In MMP demonstration markets, dual eligibles initially were signed up through passive enrollment and then could opt out into a different plan or traditional Medicare. Or they could choose to sign up directly in an MMP. They received a single membership card for all of their Medicare and Medicaid benefits, along with a single set of membership materials.

Benefits and provider networks were aligned. Each enrollee was assigned a care coordinator. A unified process was

established for member grievances and appeals of benefit decisions. State Medicaid programs were offered a way to share Medicare savings for reduced utilization on services such as hospital and emergency department admissions.

The MMPs were required to establish a streamlined, one-step approval process for beneficiary services to avoid any delay between the request and delivery of a service, said Dennis Heaphy, a sixty-two-year old dual-eligible member of Commonwealth Care Alliance in Massachusetts. He also chairs the One Care Implementation Council, as well as serving on the Medicaid and CHIP Payment and Access Commission.

For example, Heaphy said, an MMP is authorized to approve a prescription drug if it’s listed in the state Medicaid drug formulary, even if it’s not in the Medicare formulary. “That didn’t always happen, but in theory it should have happened,” said Heaphy, who is quadriplegic because of a spinal cord injury and needs personal care attendants.

Dual-eligible beneficiary Evans recalls her experience in 2015, before joining the Commonwealth Care Alliance’s MMP, when she had a combination of private employer coverage, Medicare, and Medicaid. She needed to have a ventilator covered by insurance, but her three insurance programs disputed which one should pay, thus delaying the procedure. “It became a big fight with a lot of finger pointing,” she said.

Since joining Commonwealth Care Alliance, which participates in Massachusetts’s One Care demonstration program, Evans has had a quite different experience. She needed oxygen to manage respirator or equipment emergencies, such as a ventilator failure. In general, Medicare only covers oxygen for chronic, long-term use, not for emergencies. But Commonwealth Care Alliance, with its integration of Medicare and Medicaid benefits, had the flexibility to provide it.

“Combining the two insurances avoids the complications,” she said. “It’s not all put on the consumer to sort through which policy covers what. It’s all done internally by the plan. One Care gives you case management. They’ve been coordinating all those things.”

Even so, Evans says that she and other dual eligibles enrolled in the state’s

three MMPs have struggled with certain systemic issues. From her time on the One Care Implementation Council, she's learned that people with rare conditions such as dwarfism have trouble finding in-network specialists. She also believes that plans and providers need to improve their communications strategies with enrollees who have language barriers or cognitive disabilities. And she has seen the care coordination role become increasingly divided among multiple individuals, a trend that can lead to more fragmented care.

"I'm concerned about how this [upcoming] change to the D-SNP model will affect care coordination, which we've fought so hard for," Evans said.

Heaphy agrees with that observation. "The elegance of the MMP model, with just one contract where you had both CMS and the state working together to ensure that plans were carrying out their responsibilities, will be gone," he lamented. "It's a big concern that misaligned requirements might lead to confusion among members or reduced access to services."

### Transition Planning

Still, patient advocates hope the transition from MMPs to new integrated models goes smoothly and that enrollees are served as well or better in the new plans.

In California, nearly all of the 112,000 dual eligibles enrolled in MMPs in seven participating demonstration counties were automatically transitioned into integrated D-SNPs, called Medi-Medi Plans, by January 1, 2023.<sup>15</sup> The new plans are operated by the same companies that ran the MMPs, including Anthem, Blue Shield of California, HealthNet, Molina, and Santa Clara Family Health Plan.

The California Department of Health Care Services facilitated the smooth transition through intensive education and stakeholder engagement to prepare health plans, enrollees, providers, advocates, and State Health Insurance Program counselors, said Huyenh-Cho of Justice in Aging. A key part was educating provider groups that they could continue to see their patients under the new plans. What helped, she added, was that the agency has staff who are expert in Medicare rules, which most state Medicaid agencies lack.

## Although advocates of greater care coordination for dual eligibles praise aspects of the bill, some worry that it would leave in place the same confusing array of other plans.

The state agency encouraged the plans to call enrollees, instead of just sending a letter, to notify them about the transition, because many dual eligibles are hard to reach, have cognitive impairments, or have low health literacy. The agency also maintained the same robust consumer protections in the new plans, including an ombuds program, which is no longer required by CMS in the new D-SNP program, Huyenh-Cho said.

Even with the successful transition, only about 8 percent of California's 1.6 million full-benefit dual eligibles are enrolled in plans that tightly integrate their Medicare and Medicaid benefits and services.<sup>16</sup> That means that most are not necessarily receiving care coordination to help them navigate the two complex systems and get the services they need. Even in a D-SNP, they might or might not get that help, Huyenh-Cho said.

"So many people are losing out on coverage because they don't realize they could have asked for that service under the Medicare or Medicaid benefit," she said. "Care coordination should be a model where folks don't have to know that Medicare covers this, Medicaid covers that, and they have to chase different phone numbers."

In contrast to California, Illinois delayed the transition of its 84,000 MMP enrollees until January 2026.<sup>17</sup> There currently are no D-SNP plans operating in the state. The Illinois Department of Healthcare and Family Services is expected to issue a request for bids by fall 2024.

"Because we don't have any D-SNPs operating now, the state can build this new model just as they want," said Elizabeth Durkin, manager of healthcare education and counseling at Age-Options, an Area Agency on Aging that

trains professionals who work with older and disabled adults throughout Illinois. "The flip side is there's no experience with D-SNPs in Illinois, so we'll be implementing something brand new."

Durkin hopes the new D-SNPs will be as tightly integrated as the MMPs, with a unified grievance and appeals process and close alignment with Medicaid managed care plans. She also would like to see gaps filled in the plans' provider networks, particularly for non-English speakers; stronger care coordination; greater use by the plans of home and community-based care and long-term services and supports; and more transportation assistance for beneficiaries.

### A Small Step Toward Integrated Care

It remains to be seen how well the multistate transition from MMPs to D-SNPs goes, how many dual eligibles the new plans enroll and retain, how well they serve their enrollees, and whether they succeed in lowering costs. The broader challenge for CMS and the states is how to encourage more dual eligibles in all of the states to move into plans with stronger care coordination and close financial alignment between Medicare and Medicaid.

Some experts and policy makers think that CMS and the states lack the tools they need to achieve more without congressional action.<sup>18</sup> This is why the DUALS Act would require CMS and the states to develop at least one integrated health plan for dual eligibles in each state, although beneficiaries would be able to opt out after initially being automatically enrolled. In many ways, the proposed integrated plans resemble the MMPs that are being phased out. One big difference is that every state would have to offer them.

Similar to MMPs, the proposed plans would receive a single pooled payment combining Medicare and Medicaid contributions.<sup>10</sup> Each beneficiary would be assigned a single care coordinator. A standardized health risk assessment would be performed for each enrollee, leading to the development of a comprehensive care plan including medical, functional, behavioral, social, and caregiving needs and goals.

Although advocates of greater care coordination for dual eligibles praise as-



pects of the bill, some worry that it would leave in place the same confusing array of other plans, including all of those less integrated and nonintegrated SNPs and look-alike Medicare Advantage plans. That multitude of other plans is a major reason why such a small percentage of dual eligibles have joined MMPs.

“The DUALS Act has a lot of strengths—particularly that it would require all states to have a meaningfully integrated option, which many don’t have now,” ATI Advisory’s Rizer said. “But you want to make sure everyone is incentivized to choose the best pro-

gram.” She recommends giving CMS the authority to apply similar requirements to any organization serving dual eligibles, whether or not they are in an integrated program.

Even with the uncertain state of knowledge about what works best, Heaphy, who both receives care in the dual-eligible system and monitors it as an advocate, argues that everyone should be moving toward more integrated models. But he favors greater openness to different models, not just D-SNPs, that could better serve beneficiaries. He envisions mental health providers and other entities contracting

with medical providers, instead of offering the sole model of health plans and medical providers in charge of beneficiaries’ care.

“The system is broken,” he said. “We need to have integrated care to fix the misalignment that exists between Medicare and Medicaid. But we shouldn’t allow insurers to define what that is. [Dual eligibles] are hexagons, circles, triangles, and so many shapes. They just don’t fit into that square hole.” ■

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