

Executive Summary

Rhode Island has an unprecedented opportunity to improve health care for tens of thousands of people. For many who are eligible for both Medicaid and Medicare, the current system is fragmented, difficult to navigate, and often unable to meet their needs. Because of recent changes at both the federal and state levels, Rhode Island can create an integrated program that is coordinated across settings, easier to understand, and supports staying healthy and living in the community.

Dually eligible beneficiaries are seniors with low incomes and younger people with disabilities who are eligible for both Medicare and Medicaid. Medicare is the primary payer for acute care services, such as hospital and physician services and prescription medicine. Medicaid covers a set of benefits, including long-term supports and services (LTSS), which are not included in traditional Medicare, for those who meet clinical criteria.

Rhode Island's 38,000 dually eligible beneficiaries include over 5,400 nursing home residents and 5,600 individuals who receive home and community based services. Dually eligible beneficiaries are among the nation's most chronically ill and costliest patients. Dually eligible beneficiaries often have complex medical challenges and require a high level of supports and services. Nationally, over half of the dually eligibles are under treatment for five or more conditions, have a much higher rate of hospital utilization than other Medicare members, and are more than twice as likely as other Medicare enrollees to be hospitalized for pressure ulcer, asthma and diabetes.

Although small in number, Rhode Island's dually eligible beneficiaries have extensive health, functional and cognitive needs making them expensive for both Medicaid and Medicare. In SFY 2009, the state Medicaid program spent \$761 million on care for this population, of which approximately \$367 million came from state funds¹. According to RI EOHHS, this represents "almost one half (50%) of the entire Medicaid budget spent on approximately one quarter (25%) of the total population."² Medicare spending for this group is estimated to reach \$657 million in CY2011.³

However, because the dually eligible beneficiary receives health benefits from two different programs, Medicare and Medicaid, they experience a system that is disjointed and often confounding. Medicare and Medicaid have not been aligned to meet the needs of dually eligibles, and care is typically uncoordinated, likely resulting in poorer quality and greater risk of events such as hospital admissions.

An integrated program for dually eligible beneficiaries will create an improved system, one that coordinates care across the full spectrum of settings and services. By supporting living at home, an integrated program will likely reduce preventable adverse health events, and build stronger services to help seniors and people with disabilities live with fuller freedom and dignity.

Core Elements of a Successful Integrated Program:

- An umbrella organization providing coordination across the spectrum of Medicaid and Medicare services
- Person-centered approach
- Team-based care in an integrated provider network
- A “high touch” medical management model
- Improved access to home and community based services
- Accountability for quality and improved health outcomes

Rhode Island is well-prepared to implement an integrated program for dually eligibles. Now is the time to act. Dual eligible Rhode Islanders deserve to have better coordinated care, and the state can take advantage of a new ability to share in Medicare savings while improving care for its residents.

Issue	Current Medicare and Medicaid System	Integrated Program
<p>Coordination of benefits and care</p>	<p>Coordination of providers and settings across Medicare and Medicaid does not occur; divided benefits, separate financial arrangements, and conflicting regulatory requirements makes management complex and challenging for states</p>	<ul style="list-style-type: none"> • One umbrella organization responsible for coordinating a set of benefits, managing care across the full spectrum of settings • Integrated benefits, streamlined requirements, and financial alignments ensure consumers receive the right care, at the right time and in the right settings

Consumer and caregiver supports	Members left to navigate a complex health system and be their own advocates	<ul style="list-style-type: none"> • Consistent support and customer service, including Navigators • High touch medical management model built on a “whole person” approach, with Individual Care Plans • Medical homes provide coordinated health care and improved transitional care leading to better health outcomes • Integrated acute, behavioral health and long term supports and services
Long-term care system	Unbalanced LTC in RI relies heavily on institutional care and restrictive settings	Builds new home and community based service capacity, improving access to support staying at home, in the community and with family
Quality Improvement	No systemic approach to improving health outcomes and reducing disparities	Managed care entities are accountable for measuring and improving health outcomes

Issue Brief

Integrated Program for Dually Eligible Beneficiaries

Introduction

“The majority of dually eligible beneficiaries receive their care in uncoordinated systems, which may result in poor quality, or costly care.” — CMS4

Dually eligible beneficiaries are individuals eligible for both Medicare and Medicaid. They are seniors with low incomes and younger persons with disabilities. Medicare is the primary payer for acute care services, such as hospital and physician services. Medicaid covers a set of benefits, including long-term supports and services (LTSS), which are not included in traditional Medicare, for those who meet clinical criteria. Medicare covers physician and hospital services, as well as prescription medications. For some “partial” dual eligibles, Medicaid covers the cost sharing requirements of Medicare, while for the large majority of “full” dually eligibles, Medicaid provides access to additional services necessary for their treatment and quality of life.

There is a problem: the system is confusing and fragmented, difficult for consumers to navigate, and often results in care that does not meet the needs of patients. Families of consumers, often the primary care givers, face administrative hurdles, conflicting sets of rules, and an unclear path to obtaining the best care for their loved ones. The system promotes uncoordinated care, which may result in consumers being placed in nursing homes or other restrictive settings instead of staying at home. A lack of coordination leads to a lower quality of care.

The fractured nature of care for those enrolled in both Medicare and Medicaid has negative consequences for patients and for both state and federal budgets. MedPAC estimates that potentially preventable hospital readmissions could be reduced by 40%, with a ten-year savings of over \$100 billion.⁵ This illustrates that we are needlessly spending too much on unnecessary care, while subjecting patients to potentially harmful hospitalizations.

As the Centers for Medicare and Medicaid Services (CMS) stated, “a long-standing barrier to integration has been the financial misalignment between Medicare and Medicaid. Reforms to improve quality and reduce costs require an investment in the delivery system and care management. Because delivery of services for (dually eligibles) is split between Medicare and Medicaid, states lack the incentives to invest in such initiatives.”⁶ Recognizing this issue, as part of the ACA, the federal government created the Federal Coordinated Health Care Office in CMS, “charged with making the two programs (Medicare and Medicaid) work together more effectively to improve care and lower costs.” More recently, in July 2011, CMS released a state Medicaid directors letter encouraging states to apply for waivers in order to “integrate primary, acute, behavioral health and long-term services and supports” for dually eligibles.

Who Are the Dually Eligible Beneficiaries?

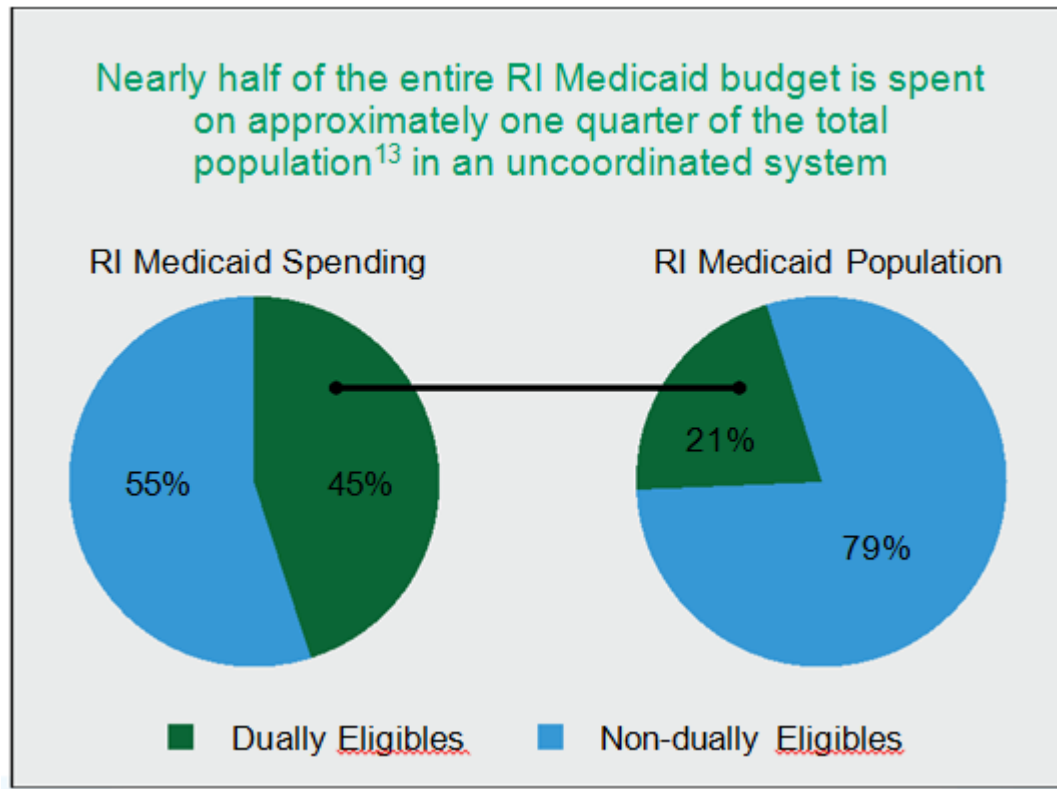
The Numbers.

According to CMS, there are over 9 million dually eligible beneficiaries in the United States. Of these, two-thirds are “full” dually eligible beneficiaries, meaning they receive the complete set of benefits offered by both programs.⁷ In Medicare, while constituting only 16% of all members, dually eligibles account for 27% of spending. Similarly, the 15% of Medicaid enrollees who are dually eligible account for 39% of the total program budget.⁸ Spending for dually eligibles in 2010 is estimated to have reached \$263 billion, representing 10.5% of all health care costs in the United States.⁹

Dually eligibles are a large part of our public health care coverage system. Often thought of as a subset of either Medicare or Medicaid, this population accounted for over \$263 billion in spending in 2010, a number that is almost as large as the total Medicaid spending for non-duals \$271 million, and over 2/3 the amount (\$392 billion) spent on non-dual Medicare beneficiaries.¹⁰

Rhode Island has a large and growing number of dually eligibles. According to the RI Executive Office of Health and Human Services (EOHHS), out of approximately 180,000 Medicaid enrollees, about 38,000 are enrolled in Medicare as well.

- The majority (about 31,500) of Rhode Island’s dually eligible’s reside at home
- 5,611 receive Home and Community Based Services
- 5,403 reside in institutions such as nursing homes, assisted living facilities or hospitals
- An additional 7,000 persons are at-risk of becoming dually eligible due to economic circumstance and medical conditions¹¹



In SFY 2009, the state Medicaid program spent \$761 million on care for this population, of which approximately \$367 million came from state funds.¹² According to EOHHS, this represents “almost one half (50%) of the entire Medicaid budget spent on approximately one quarter (25%) of the total population.”¹³ Additionally, Medicare spending for this group is estimated to reach \$657 million in CY2011.¹⁴

Long term supports and services (LTSS) are highly utilized by dually eligibles. Despite progress, Rhode Island’s spending on long term care remains imbalanced, with far more spent on institutional care than for services that allow residents to remain at home and in the community. According to a joint report from AARP, The Commonwealth Fund and the Scan Foundation, Rhode Island ranks 48th for its percent of Medicaid LTSS spending going to home and community based services.¹⁵ EOHHS reports “During the Fourth Quarter of SFY 2010, 84.93 percent of expenditures for elders aged 65 and over were for Medicaid long-term care institutional services and 15.07 percent were for home and community based services (HCBS). A positive sign, the latter finding (15.07 percent for

HCBS in Q-4, SFY 2010) represents an increase of almost one percent from the prior quarter (14.20 percent for HCBS in Q-3, SFY 2010).”¹⁶

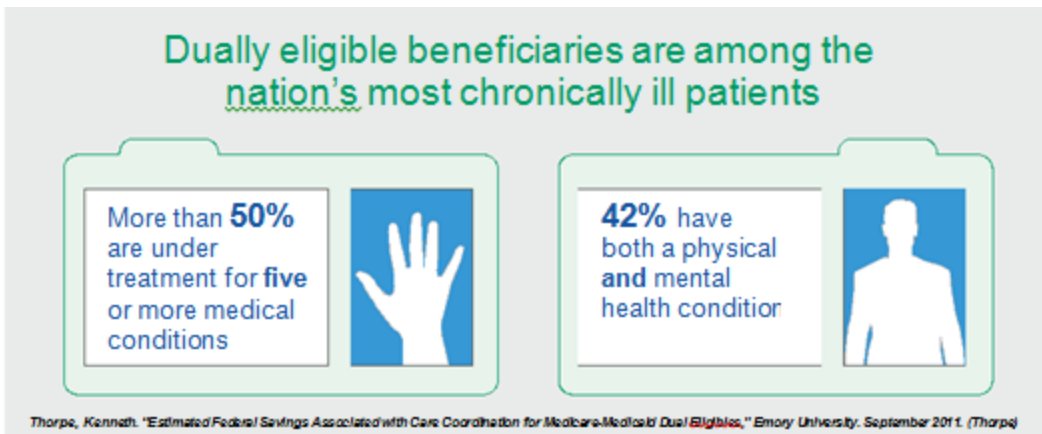
Medical Profile and Characteristics

Dually eligible beneficiaries are among the nation’s most chronically ill and costliest patients. They often face complex medical challenges and require a high level of supports and services. According to researcher Ken Thorpe, over half are under treatment for five or more conditions, including 42 percent who have both a physical and mental health condition.¹⁷ Dually eligible beneficiaries, in comparison to other Medicare members, have been found to be in poorer health, including having higher rates of chronic illness and mental/cognitive conditions.¹⁸ A closer examination of dually eligibles under 65 years of age in Massachusetts provides a deeper understanding of the medical and concomitant supports needed by this population.¹⁹ According to the Massachusetts Medicaid Policy Institute:

- 60% had a diagnosis in at least two of the three major diagnostic categories (physical illness or disability, behavioral diagnosis, developmental disability);
- 48% were diagnosed with depression (including major depression, bipolar disorder, anxiety and others);
- 38% received more than 5 prescriptions per month; and
- 18% reported hospital inpatient days as compared to 8% of all Americans.

Nationally, according to a Healthcare Cost and Utilization Project (looking at enrollees both over and under 65 years of age), dually eligible beneficiaries required hospitalization at much higher rates for certain conditions than did the rest of the Medicare population. Dually eligibles in 2008, who made up 16% of the total Medicare population, accounted for a disproportionate amount of use:

- 36% of hospital stays for Medicare patients with pressure ulcers
- 32% for those with asthma
- 32% for those with diabetes, and
- 25% for conditions including chronic obstructive pulmonary disease, urinary tract infections and bacterial pneumonia.²⁰



Dually eligible individuals are more than twice as likely as other Medicare enrollees to be hospitalized for pressure ulcers, asthma and diabetes, 52% more likely to be admitted for urinary tract infections, and 30% more likely for COPD and bacterial infections. While 20% of dually eligibles face some restriction on their mobility and daily activity, only 9% of Medicare-only individuals face the same challenge.²¹

Dually eligible individuals, in comparison to Medicare-only beneficiaries, are likely to be younger (64 vs. 71), female (68% vs. 57%), unmarried (77% vs. 53%) and less educated (only 4% with a college education). Dually eligibles are also more than twice as likely to be living in poverty (45% to 19%), as eligibility for Medicaid is based on income.²²

These medical issues, exacerbated by the challenges created by poverty such as inadequate housing, food insecurity, and ability to pay utility bills, call for creating a comprehensive and coordinated approach to meeting the health and human service needs of the population.

The Challenge

Health care for dually eligibles is often fragmented, unmanaged, uncoordinated and confusing to patients, their families and to providers. Because care for dually eligible beneficiaries is based on two different fee-for-service (FFS) payment systems, there is often little coordination of care as patient's transition between settings. Medicare and Medicaid have different sets of rules for eligibility, benefits, cost-sharing and administrative procedures. The result is a system that lacks sufficient care coordination for the comprehensive services needed by this chronically ill population.

As described by the Medicare Patient Advisory Commission, because of the current fee-for-service systems of Medicaid and Medicare, "There is a focus on procedures and services rather than on the beneficiary's total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitioning between care providers, such as at hospital discharge. Poorly coordinated care may result in patient confusion, over-treatment, duplicative service use, higher spending and lower quality of care."²³

As the aging population grows, the health care system will face numerous stressors in meeting their needs. Currently, 14.1% of Rhode Island residents are over age 65, the 11th highest rate in the nation.²⁴ Rhode Island is also ranked 8th nationally for percentage of SSI recipients with disabilities.²⁵ Both the aging demographic and proportion of disabled population in RI indicates the size of the dually eligible population is likely to continue to increase.

Rhode Island is well-positioned to take on this new challenge. The Rhode Island Executive Office of Health and Human Services (EOHHS) understands the problems presented by fragmented care and the deleterious effects this confusion has on the well-being of patients. For the past several years, they have been dedicated to improving the system. In January 2009, Rhode Island won approval from CMS for the innovative Global Consumer Choice Compact Waiver, a unification of the various Medicaid programs in the state which provides for administrative flexibility in rebalancing the long-term care system. Progress is underway. In a June, 2010 report to the Rhode Island Senate, ²⁶ EOHHS reported:

- 1,754 Level of Care (LOC) assessments had been completed;
- 741 individuals safely transitioned to community settings; and
- 92 individuals met the Preventive Level of Care and received home and community based services as opposed to entering a nursing facility (in Q3, 2010).

In February 2011, EOHHS applied for a demonstration grant from CMS to integrate Medicare and Medicaid.²⁷ Though not selected, EOHHS clearly identified the challenge: “The current fragmented financing system, with Medicaid and Medicare operating as separate and distinct programs, not only leads to uncoordinated care for the state’s most vulnerable citizens, but results in a spending trend that is unsustainable in the short and long-term.”

The General Assembly passed Article 16 of the state FY2012 budget which directs that, “By July 2012, the department of human services shall establish a contractual agreement between the Medicaid agency and a contractor (e.g., managed care entity) to manage primary, acute and long-term care services for Medicaid-only beneficiaries and for individuals dually eligible for Medicaid and Medicare.”²⁸ Most recently, the EOHHS submitted a letter of intent to CMS in response to the July 8, 2011 state Medicaid directors about “Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.”

Additionally, in 2005, the Program for All-Inclusive Care for the Elderly (PACE) Organization of RI was formed (see sidebar) and in 2008, Rhody Health Partners enrolled 12,200 disabled adults into Medicaid health plans with an emphasis on care management and coordination across LTSS community-based services. Rhody Health Partners creates a solid infrastructure of plans, providers and HCBS organizations upon which to create the best possible system for the state’s 38,000 dually eligible beneficiaries.²⁹

However, like many states, Rhode Island has room to improve. In an AARP survey, Rhode Island placed 34th in the nation for overall long-term supports and services system.³⁰ In specific areas, we ranked 41st for Affordability & Access, 32nd for Choice of Setting and Provider, and 30th in Support for Family caregivers. Our best showing was ranking 15th for Quality of Life & Quality of Care. The AARP estimated if RI improved to the level of the best-performing state, we would see dramatic improvements in metrics of long-term care. For example, 1,504 new Medicaid long-term care members would receive services in home and community based settings instead of being placed in nursing homes, 1,348 nursing home residents would be able to transition to care in the community and at home, and 198 unnecessary hospitalizations of people residing in nursing homes would be avoided.

PACE Organization of Rhode Island – An innovative model for frail elders at nursing home level of care

The State of Rhode Island has a fully integrated program for frail elders who are dually eligible beneficiaries – the Program of All-inclusive Care for the Elderly organization of RI (PORI). PORI is a provider-based Medicare and Medicaid managed care program that currently provides acute, chronic and long-term care for approximately 200 people.

PORI serves the entire state, providing a continuum of care and services to frail seniors with chronic care needs, including medical care provided by a PACE physician, prescriptions medications, hospital and nursing home care when necessary, specialty care, home health care and personal care, adult day care, and social services. An interdisciplinary team of professionals assesses the patient's needs and works together with the client and their family (if appropriate), to develop an effective plan of care.

Under federal rules, to be eligible for PACE, participants must be age 55 or older, meet a nursing facility level of care, and live in the PACE organization service area. The PACE program features a comprehensive medical and social service delivery system in an adult day health center that is supplemented by in-home and referral services in accordance with participants' need. By coordinating and delivering a full spectrum services, PACE helps frail seniors remain independent and in their homes for as long as possible.

The Solution: An Integrated Program for Dually Eligible Beneficiaries

CMS defines an integrated program as one that “encompasses all the medical, behavioral health and long-term services and supports needed by an individual eligible for both Medicare and Medicaid.”³¹ As Rhode Island moves forward in designing an integrated program for dually eligible residents, we must ask ourselves: What program design features need to be included in order to ensure that the 38,000 Rhode Island residents who are dually eligible receive the most appropriate care, in the least restrictive setting, and at the right time? An integrated program for dually eligible beneficiaries must be based on care management strategies that meet the needs of enrollees,

improves quality of care, effectively builds provider capacity and puts the individual at the center of the system. A review of the literature offers evidence for the elements that work best and have the potential to save money.³²

Care Coordination and Integration of Benefits: Proper care coordination provided through experienced Medicaid managed care organizations can result in significantly better quality of life and health outcomes for individuals. By integrating acute, behavioral health, pharmacy, and long-term supports and services, consumers will receive the right care, at the right time and in the right setting. According to Ken Thorpe, “By coordinating different health care providers across the continuum of care, health plans can work to ensure beneficiaries receive the most clinically appropriate, cost-effective services. These activities provide the foundation for cost savings and improved health outcomes for dual eligibles.”³³ AARP, in assessing the role of care coordination, recommends a “many touches” approach. They define this as repeated contacts – via phone or in person – that “allow(s) the (health) plan to take a more proactive approach to care management, to stay ahead of the game, and to prevent avoidable acute care events whenever possible.”³⁴

“Whole Person” Focus with Comprehensive Needs Assessment and an Individual Care Plan (ICP): A focus on “whole person” care through an Individual Care Plan can help reduce disease and improve management of chronic conditions. Proactive outreach to patients with chronic conditions - either in a care setting or telephonically – is a promising strategy to improve care, self-management and adherence of patients to ICPs. Several studies help validate this whole person focus. In one, successful medication adherence resulted in a 23% reduction in overall medical costs for Medicaid patients with congestive heart failure.³⁵ Others indicate that medication management resulted in significantly fewer hospitalizations, meaning overall better health outcomes and reduced costs.³⁶ With adherence rates hovering at 50-65%³⁷, increased medication management through an integrated program for dually eligibles holds the promise of great improvements in the quality of life and health outcomes of patients.

Patient Centered Medical Homes with Team Based Care and Integrated Provider Networks: Coordinated multidisciplinary teams have shown the ability to reduce hospitalization (medical and behavioral), readmissions, and nursing home admissions. In Massachusetts, a pioneering program of Senior Care Organizations (SCOs) resulted in fewer people entering nursing homes (8.7% compared to 12% among Medicare-only individuals) and a large improvement in the number of people who remain in nursing home care for more than 4 months (15.4% vs. 30%).³⁸ A study in Texas found that members with complex needs enrolled in a Medicaid health plan that integrated networks and managed member care between settings experienced lower rates of inpatient and emergency room admissions.³⁹ Rhode Island’s Community Health Centers, who are early leaders in creating Patient Centered Medical Homes, are experienced in coordinating team based care and working with Medicaid managed care organizations.

Transitional Care Management: Transitional care, when a patient moves from one setting to another, is central to reducing possibly preventable hospital readmissions, disruptions in care and

potential declines in health status for individuals. Improved outcomes at these key moments in a patient’s care is an area that demonstrates the success of care coordination. Ken Thorpe cites several studies on this topic. “One analysis of 18 studies showed that comprehensive discharge planning coupled with post-discharge support for those hospitalized with congestive heart failure reduced readmissions nearly 25%.” Other studies concluded nurse-led transition care programs can reduce preventable readmissions by up to 56%.⁴⁰ “There is a growing body of evidence that has identified the key functions performed by health plans and successful comprehensive team based care coordination models in managing chronically ill patients,” according to Thorpe.⁴¹

Improved Home and Community Based Services Capacity: There is a need to expand innovative services to help more people who want, and are able, to stay at home. An integrated program will need to develop new HCBS services expanding upon current options such as personal attendants, provision of certain durable medical equipment, and homemaker services. As an example, Tennessee in the first 8 months of implementing a managed care system for its LTSS population, saw the number of beneficiaries receiving HCBS care (as opposed to residing in a nursing home or other institution) grow by over 50%.⁴² Rhode Island’s nursing home providers can play a vital role in creating new and innovative services including HCBS.

Case Study: The Value of Care Coordination and the Fragmentation of the Current System

Mrs. B is a 64 year old, low-income woman living in Rhode Island. Recently diagnosed with ovarian cancer and released from the hospital, she faces a challenging medical future. Cared for at home by her son, she had been taking the bus to her medical appointments, and the complexity of her condition means she has four different doctors involved in her care. A care manager from a Medicaid managed care organization visited Mrs. B at home, and discovered that Mrs. B had been prescribed several new medications, and was weak and thin and still in pain from surgery.

Working with Mrs. B, the care manager created an Individual Care Plan, which included additional support services. Through the care manager, Mrs. B. gained access to homemaking and personal care assistance, transportation services for medical appointments, and a peer navigator to assist with navigating the health care system and daily activities.

Most importantly, her medical care became more fully coordinated between her four physicians. As an example of an improvement of care, her home visiting nurse began to work with Mrs. B. on the importance of medical therapy compliance, about what to expect with upcoming chemotherapy treatments and what to look for as she recovers from surgery.

Soon after developing and engaging in her care plan with a Rhody Health Partners care manager, Mrs. B turned 65 and transitioned to Medicare fee-for-service and lost her care manager. Under an integrated program, the disruption to her care could be minimized and she would be able to retain a care manager.

Consumer Satisfaction and Protection: Perhaps most importantly, experience from other states that have implemented managed LTSS demonstrates that consumers are satisfied with the care and service they receive. In Arizona, beneficiaries had a 90-95% satisfaction rate with their health plans, and an overall satisfaction rate of 93% with the managed LTSS program itself. Additionally, states must protect access to current providers as beneficiaries enroll into a new integrated program. An Integrated Program should be designed to protect consumer rights. Options include creating an easy to navigate grievance and appeals process, enacting marketing protections, protecting the consumer’s voice in health care decisions, and implementing an ombudsman program to help beneficiaries with any difficulties they encounter.

Quality and Improvement: Continuous quality improvement driven by linked Medicare and Medicaid data, robust data-sharing, inter-provider communication and data analysis is best accomplished in a managed care program. A Medicaid health plan can use data to align financial incentives and implement payment reform models to reward quality and invest in preventive health care. Accurate data allows a managed care program to “identify opportunities for streamlining and/or improving care for dual eligible beneficiaries. These types of analyses can be used to help make the case for further integration of Medicare and Medicaid services.”⁴³

Medicaid health plans can play a crucial role in implementing a new integrated program for dually eligible beneficiaries. In Rhode Island, these health plans have experience with complex and medically needy populations, the care management infrastructure to best meet the needs of consumers, comprehensive provider networks, capacity to develop new services, and the ability to use data to drive quality improvement. The plans are dedicated to a robust process of including stakeholders - including patients, caregivers, providers, community agencies and advocates – in the development of inclusive, person-centered care management programs and provider networks.

Rhode Island should consider these elements in order to design an integrated program for dually eligible beneficiaries that puts consumers in the center of a new responsive, high-quality and cost-effective system of care.

Conclusion

Rhode Island’s 38,000 dually eligible beneficiaries need a new integrated program based on care management strategies that meet the needs of enrollees, improves quality of care, builds provider capacity and puts the individual at the center of the system. The current system is confusing and fragmented, difficult for consumers and their families to navigate, and often results in care that does not meet the needs of patients. Uncoordinated care may result in lower quality of care, unnecessary placements in nursing homes or other restrictive settings instead of staying at home, or avoidable hospital readmissions because of poorly managed transitional care.

In an integrated program for dually eligible beneficiaries, consumers will experience an improved system, one that coordinates care across the full spectrum of settings and services, supports living at

home with family and in the community, reduces preventable adverse health events, and builds a stronger infrastructure to help seniors and people with disabilities live with fuller freedom and dignity.

Working together, consumers, providers, advocates, policy makers and the families of dually eligible individuals can create an integrated program that will bring higher quality care, better health outcomes, and an increased ability for individuals to remain at home, with their families and in their communities. Given the new opportunities at the federal level to integrate Medicaid and Medicare, now is the time to act.

Notes

1. The Medicaid budget is shared between the state and federal governments; roughly, for every \$1.00 the state spends, the federal government adds \$1.13: [http:// aspe.hhs.gov/health/fmap11.htm](http://aspe.hhs.gov/health/fmap11.htm)
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6. SMDL
7. SMDL
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9. Menges and Batt
10. CMS data; Menges and Batt
11. Includes 2,000 Medicare patients who currently receive home and community based services (HCBS) from RI Department of Elderly Affairs (RI DEA), along with about 5,000 Medicaid-only disabled adults: from DHS Demonstration.
12. The Medicaid budget is shared between the state and federal governments; roughly, for every \$1.00 the state spends, the federal government adds \$1.13: [http:// aspe.hhs.gov/health/fmap11.htm](http://aspe.hhs.gov/health/fmap11.htm)
13. DHS Demonstration
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