State Efforts to Integrate Care Across Medicaid Fee-for-Service Long-Term Services and Supports and Medicare Advantage Dual Eligible Special Needs Plans

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Individuals eligible for full Medicare and Medicaid benefits - full-benefit dual eligibles (FBDEs) - are a diverse population that often have multiple chronic conditions, live with disabilities, have low incomes, and experience multiple social risk factors such as housing instability, food insecurity, and inadequate access to transportation. These factors make them more likely to experience adverse health outcomes, most recently magnified by the COVID-19 pandemic. A majority of these individuals must navigate two complicated, separate sets of health care services, providers, and processes to access the care they need.

To date, most state and federal efforts to integrate Medicare and Medicaid services have relied upon the provision of Medicaid long-term services and supports (LTSS) in a managed care delivery structure. This paper highlights steps Medicaid programs can take to move forward with better coordination and integration across the two programs when a Medicaid managed LTSS program (MLTSS) is not in place. These innovative pathways can and often do lead to future implementation of MLTSS as a comprehensive approach to provide managed LTSS to eligible populations.

needs and social risk factors among the FBDE population can result in unnecessary service utilization, including emergency room visits and hospital readmissions; poorer health outcomes; and lower quality of life.

The COVID-19 pandemic magnified the need for better coordination across Medicare and Medicaid. Dually eligible individuals are more likely to contract COVID-19 and are hospitalized with COVID-19 complications at a rate of approximately 2.6 times higher than Medicare-only individuals.[10] Dually eligible individuals also make up the majority of long-term stay nursing facility residents, which surpassed 123,000 COVID-19 deaths as of May 2021.[11] Medicaid HCBS enable individuals to live and remain in the community. Communication and coordination between Medicare medical providers and Medicaid HCBS providers are critical to ensure they receive these services and avoid placement in institutional settings where they are at greater risk of infection and death.

To date, most federal and state government partnerships to create integrated Medicare-Medicaid programs or demonstrations have included some form of Medicaid MLTSS. However, there are opportunities for states that want to keep their LTSS delivery systems under FFS to proceed with coordinating and integrating care across the two programs with the creation of HIDE SNPs and use of other approaches. Some states may prefer to keep successful portions of FFS LTSS systems in place or may not yet be ready to move Medicaid FFS LTSS to managed care. CMS recently released guidance answering some of the frequently asked questions on coordinating Medicaid benefits and Dual Eligible Special Needs Plans Supplemental Benefits.[12] This guidance, in addition to existing resources and technical assistance offered by CMS, underscores the flexibility that states have to design unique integration strategies.

HMA interviewed Medicaid and Aging agency officials in the District of Columbia, Idaho, Maine, and Washington based upon known exploration and efforts to increase coordination and integration between Medicare and Medicaid. (See Appendix B ς Interview List) HMA reviewed their CY 2021 SMACs, as well as the CY 2021 SMAC for Alabama requiring provision of certain Medicaid benefits. From these interviews and SMAC reviews, HMA identified steps states can take to increase coordination across Medicaid FFS LTSS and D-SNPs for FBDE individuals. (See Appendix A ς Alabama, District of Columbia, Idaho, Maine, and Washington Medicaid Program Structure for FBDEs.) Charted paths to better coordinate and integrate Medicaid LTSS FFS and other covered benefits with Medicare services include:

- HIDE SNPs. Use of Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) covering behavioral health and other Medicaid services to support coordination with Medicaid FFS LTSS (Washington). HIDE SNP is a designated type of D-SNP. To be considered a HIDE SNP a plan must provide, either directly or through a companion Medicaid managed care plan, either behavioral health services or LTSS in addition to other Medicaid services to its dual eligible enrollees.
- Medicaid Wraparound. Inclusion of a per member per month payment for certain Medicaid services and benefits, such as the Medicaid agencèûs cost sharing obligations in SMACs óAlabamaú or the comprehensive set of Medicaid benefits, inclusive of LTSS (District of Columbia)

a total dual eligible population of approximately 24,000 are already enrolled in D-SNPs. Further, two of the District's current D-SNPs participate in capitated financial alignment initiatives (FAIs) in other geographies. The District leveraging these plans' corporate experience in designing a pathway to implement Medicaid MLTSS.

Input from state Medicaid and Aging agency officials highlighted the importance of engaging stakeholders, including D-SNP organizations, at the outset of charting steps to better coordinate and integrate Medicare and Medicaid. Both the District of Columbia and Maine issued requests for information (RFIs) to obtain stakeholder input on proceeding with Medicare and Medicaid integration that were informative and instrumental to initiating ongoing communication and tailoring an approach that meets stakeholder readiness.

Prior to planning for contracting with HIDE or FIDE SNPs for CY 2022, the District of Columbia issued two informative RFIs. The first, April 2017 Medicaid Accountable Care Organization RFI gathered health plan interest in participating as a Medicaid ACO. The second, October 2019 HIDE SNP RFI soliciting input from Medicare Advantage and other health plans served as a good communication tool to:

- Build buy-in from health plans on transition to HIDE SNPs
- Educate and fill knowledge gaps among Medicaid staff about Medicare including the model of care
- Start ongoing communication with health plans resulting in quarterly calls

D-SNP organization responses also provided a look into how D-SNPs work and the way they have structured their corporate models.

Maine released an exploratory October 2019 RFI related to managed care service delivery for dually eligible members through D-SNPs, Medicare-Medicaid Plans[15] or other capitated models signaling interest in Medicare-Medicaid integration to health plans. Even though Maine does not currently operate any Medicaid managed care programs, responses indicated great health plan interest statewide, even in rural areas of the state.

Washington convened an internal workgroup to examine a move to exclusively provide SMACs to HIDE SNPs with little external communication. Washington has delayed the move to contract with HIDE SNPs following communications from providers and other stakeholders that informed the Medicaid agency about a pilot the standalone D-SNP in the state was conducting with AAAs to further Medicare-Medicaid integration. The state is moving forward aware of the importance of engaging all the AAAs as important partners. The state noted that delay also resulted from stakeholders making a case that if enrollment into standalone D-SNPs was eliminated during COVID-19 when there is less in-person

opportunity for outreach to individuals enrolled, individuals would lose their enrollment in MA if they did not choose another MA plan resulting in default enrollment in Medicare FFS.

All states interviewed underscored that dedicated state staff who have responsibility for dually eligible models of care will need to coordinate and work toward integration of Medicare and Medicaid services for FBDE individuals. Development includes engaging stakeholders to tailor approaches to the unique state landscape and establish ongoing oversight and monitoring activities going forward.

Interviewees also shared that it is essential that states have in-house staff expertise on Medicare program benefits and administrative requirements (such as Medicare marketing rules), D-SNP model of care, and MA supplemental benefits.

- Model of care. Medicare D-SNP model of care requirements support the unique needs of each enrollee through quality, care management, and care coordination processes.[16] Every person enrolled in a D-SNP receives a health risk assessment which informs their individualized person-centered care plan and is supported by their care coordinator and interdisciplinary care team. These components are essential to informing a holistic approach to supporting FBDE individuals across the two programs.
- Supplemental benefits. In recent years, Congress and CMS granted new flexibilities for MA plans to offer tailored and more innovative supplemental benefits. Medicare Advantage plans provide supplemental benefits which fall into one of two categories: 1) reductions in plan premiums and/or cost-sharing for Medicare-covered services (such as reduced copayments for certain physician office visits or hospital stays), or 2) additive benefits that are not covered under traditional Medicare.[17] Among other flexibilities introduced by CMS, plans may now offer supplemental benefits, such as in-home services and supports, and support for caregivers, that are not primarily health related.[18] State staff knowledge of the ability to provide these benefits and work with D-SNP organizations in their state can help to ensure D-SNP selection of complementary benefit offerings to Medicaid services and supports for FBDE individuals.

While states interviewed identified the need for state staff dedicated to Medicare-Medicaid integration for FBDEs, they noted that they are constrained by limited funding. State budget downturns during COVID-19 posed significant challenges to addressing staffing needs. One interviewee noted that funding for state start-up grants for Medicare-Medicaid integration, such as those provided by MMCO for some states implementing capitated FAI demonstrations (also referred to as dual demonstrations), would greatly support hiring dedicated staff responsible for Medicare-Medicaid coordination and integration efforts.

- Connecting the member to the appropriate provider(s)
- Ensuring continuity of care across services covered by different payers
- Ensuring follow-up services and appointments are scheduled within appropriate timeframes after care transitions
- Ensuring mechanisms are in place to transfer Individualized Care Plans between healthcare settings[21]

Maine CY 2021 SMACs direct D-SNP organizations to ensure timely notification of all admissions, discharges and transfers to a hospital or nursing facility . The SMAC defines timely notification as any real-time notification provided by the contracted hospitals and nursing facilities directly to the State Designated Statewide HIE. For 2021 the state allows where direct notification is not provided by the hospitals and nursing facilities to the State Designated Statewide HIE, that it may be via direct communication from the D-SNP organization to the State Designated Statewide HIE within 24 hours of the organization becoming aware of admission, transfer, or discharge. Beginning CY 2022, the state will allow only direct submission of data from the D-SNP-contracted hospitals and nursing facilities to the State Designated Statewide HIE.[22]

Maine also requires that when a D-SNP member receives Maine Medicaid or state-funded HCBS LTSS, the D-SNP organization must ensure coordination with the State's designated Service Coordination Agencies (SCAs). D-SNP organizations must have a memorandum of understanding with each SCA to identify dually eligible individuals served by the D-SNP and to collaborate to ensure effective coordination of service needs.[23]

States have the authority through issuing SMACs to extend the standalone D-SNP data sharing requirements to HIDE SNPs and FIDE SNPs. Washington extended data sharing requirements to its new CY нлнм HIDE SNPs HIDE SNPs report hospital and nursing facilitè admission data to Washington's Aging and Long-Term Support Administration weekly which is distributed to regional staff in the FFS LTSS system. Their SMACs also require HIDE SNPs to identify their plan care coordinators to support coordination and care transition planning. The plan is to coordinate services between settings of care, and include all relevant parties involved in discharge or transition planning, including Home and Community Services (HCS), a division of the State's Aging and Long Term Support Administration (ALTSA), if the member

SNPs a PMPM payment, and D-SNP organizations coØer the Medicaid agencè℩s cost sharing obligations including co-payments, coinsurances and deductibles, except any due under Medicare Part D. [25]

Alternatively, Idaho introduced D-SNP members to Medicaid services including LTSS in a comprehensive approach through D-SNP organizations contracting with health plans to meet designation as a FIDE SNP. The state did not have a separate Medicaid MLTSS program upon launch of the FIDE SNP model. It uniquely used the Medicaid state plan Alternative Benefit Plan option as authority to provide Medicaid services, including LTSS, through D-SNPs.

Idaho – Proceeding First with a FIDE SNP Charting a Path to MLTSS

Prior to 2010, Idaho first proceeded using Alternative Benefit Plan benchmark authority to set up managed care for FBDE individuals. The state proceeded with a FIDE SNP program to provide Medicare and Medicaid services, including LTSS. Idaho noted the benefit of using an application process for health plans rather than a competitive request for procurement process. They observed FBDE indiØiduals℩ positiØe eÈperience haØing a care manager℗

The state currently has approximately six staff who oversee the program and reported that it benefited from staff who had some Medicare background. Staff devoted time to extensive outreach to stakeholders by engaging FBDE individuals and providers, holding events in different locations including senior centers and town halls.

Over time, Idaho benefited from implementation of a voluntary enrollment program and gaining program experience. After years of overseeing the voluntary enrollment program through FIDE SNPs, the state moved to implement a complementary mandatory Medicaid MLTSS program for FBDE individuals. In 2018-2019 Idaho proceeded with a county-by-county roll-out in geographic areas in which FIDE SNPs operate.

State	Medicaid Program Structure for FBDEs

District of Columbia		
Katherine Rogers, katherine.rogers@dc.gov DaShawn Groves, Dashawn.groves@dc.gov	Department of Health Care Finance	11/5/20
State of Idaho		
Matt Wimmer, Matt.wimmer@dhw.idaho.gov	Idaho Department of Health and Welfare	3/18/20
State of Maine		
Paul Saucier, Paul.saucier@maine.gov	Maine Department of Health and Human Services	11/23/20
State of Washington		
Alice Lind, alice.lind@hca.wa.gov Kelli Emans, Kelli.emans@dshs.wa.gov	Washington Health Care Authority	11/6/20

[12] Centers for Medicare & Medicaid Services, Medicare and Medicaid Coordination Office, Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits, May 2021, https://www.cms.gov/files/document/dsnpmedicaremedicaidcoordbenefitsfaqs.pdf

[13] Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) for Contract Year 2021, CMCS Informational Bulletin, Centers for Medicare & Medicaid Services, November 17, 2019.

[14] The Long-Term SerØices and Supports State Scorecard ranks Washingtonῼs LTSS sѐstem number н in the country. Ranking is a composite of rankings on different dimensions of the LTSS delivery system including affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and effective transitions. Long-Term Services and Supports State Scorecard - A State Scorecard for Long-Term Services and Supports for Older Adults, People with Disabilities, and Family Caregivers, AARP Foundation, The Commonwealth Fund, and The SCAN Foundation, 2020.

[15] The October нлмф RFI indicates άMMP health plans operating under the Capitated Model of CMSῼ Financial Alignment Initiative deliver an integrated set of services for dually eligible individuals and incentivize more person-centered models of careΰέ Request for Information Related to Managed Care Services Delivery for Dually Eligible Members, State of Maine, Department of Health and Human Services, October 2019.

[16] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC

[17] Ipakchi,