July 2019

MEDICAID 1115 DEMONSTRATIONS

When Medicare is Unaligned: How Medicaid Managed Long-Term Services and Supports (MLTSS) Programs in Non-Integrated Models Coordinate Medicare Services for Dually Eligible Beneficiaries

Kristen Pavle, Jenna Libersky, Paul Saucier, Elizabeth Lewis, Michael Head, and Madeline Pearse

Introduction

As of 2017, 11.7 million Americans were concurrently enrolled in both Medicare and Medicaid (Medicare-Medicaid Coordination Office [MMCO] 2018). Nearly 1.3 million of these dually eligible beneficiaries receive their Medicaid benefits through managed long-term services and supports (MLTSS) plans.[1] Coordinating the benefits covered by Medicare and Medicaid for dually eligible beneficiaries is complex (see Exhibit 1), and ineffective coordination of care may lead to substandard outcomes (Health Management Associates [HMA] 2019). As national enrollment in MLTSS plans continues to grow, stakeholders are increasingly interested in how such plans can better coordinate Medicare benefits for dually eligible beneficiaries.

In response to the challenges in coordinating Medicare and Medicaid benefits, the Centers for Medicare and Medicaid Services (CMS) has developed a variety of delivery models to better integrate the two programs for dually eligible beneficiaries, including the Financial Alignment Initiative (FAI), and Medicare Advantage (MA) dual eligible special needs plans (D-SNPs), fully integrated dual eligible special needs plans (FIDE SNPs), and Programs of All-Inclusive Care for the Elderly (PACE). These models have the potential to integrate Medicare and Medicaid services, which supporters argue may reduce gaps in care and eliminate unnecessary service use, ultimately leading to higher satisfaction and better health outcomes (Medicare Payment Advisory Commission [MedPAC] 2018). However, the ability for these models to achieve these goals depends on how enrollment and program features are aligned. While these integrated models hold the promise of improving quality and reducing costs, as of 2019, only 9 percent of dually eligible beneficiaries were enrolled in them (MMCO 2019). Instead, the majority of dually eligible beneficiaries were in non-integrated, unaligned arrangements, including MLTSS plans for their Medicaid benefits[2] and for Medicare benefits, either (1) a D-SNP or MA plan operated by a different parent organization, or (2) traditional fee-for-service (FFS) Medicare.

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves low-income children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and are budget neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement—combined with contract requirements to protect enrollees – can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less costly home and community-based services as an alternative to institutional care.

In accordance with Section 523 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2020, Pub. L. No. 116-94 (Dec. 20, 2019), and extended under the Continuing Appropriations Act, 2021 and Other Extensions Act, Pub. L. No. 116–159 (Oct. 1, 2020), the public is hereby notified that this report is produced and disseminated at U.S. taxpayer expense.

Exhibit 1. How Medicare and Medicaid support dually eligible beneficiaries

Medicare and Medicaid are distinct programs created to serve different purposes. For beneficiaries concurrently enrolled in both programs, also known as dual eligibles, each program covers only a portion of a beneficiary's full array of services. Medicare is the primary payer, providing coverage for primary and acute care, prescription drugs, and post-acute care. Medicaid covers additional services, such as supplemental medical equipment, long-term services and supports (LTSS), and behavioral health. Medicaid also provides qualifying dually eligible beneficiaries with support in paying Medicare premiums and cost-sharing (Libersky et al. 2017). Among Medicaid services, LTSS is the most costly, accounting for about 80 percent of Medicaid spending on dually eligible beneficiaries who are elderly or who have a disability (Medicare Payment Advisory Commission [MedPAC] 2018).

This brief describes how MLTSS plans in three states—Florida, Kansas, and Wisconsin—coordinate care for dually eligible beneficiaries through non-integrated arrangements in which Medicaid and Medicare enrollment are unaligned.[3] The brief begins by comparing features—including the degree of alignment—between integrated and non-integrated delivery models, then compares care coordination requirements for all MLTSS plans in the three study states. The brief then describes how MLTSS plans coordinate care for dually eligible beneficiaries whose enrollment in Medicare is unaligned at several key stages: (1) initial enrollment, (2) assessment and care planning, and (3) ongoing care coordination including care transitions between hospitals, institutions, and the community. The brief concludes by describing how its findings can inform evaluations of MLTSS programs, including the national evaluation of MLTSS programs currently underway.

Comparison of Delivery Models Using Aligned Versus Unaligned Enrollment in Medicare and Medicaid

Models of care for dually eligible beneficiaries vary in their approaches to care coordination, including how they align enrollment, integrate benefits, and coordinate care across Medicare and Medicaid (see Table 1). From the least amount of integration to the most, models in which LTSS is delivered under a capitated arrangement include but are not limited to:[4]

- **MLTSS + unaligned D-SNP, MA plan, or original Medicare coverage.** In this model, dually eligible beneficiaries receive Medicaid LTSS through an MLTSS plan, and Medicare acute and primary care services through either (1) a D-SNP operated by a different parent organization than the MLTSS plan, (2) an MA plan,[5] or (3) original FFS Medicare. In this arrangement, states maintain separate contracts with the MLTSS and D-SNP plans. Though all contracts with D-SNPs must include eight minimum requirements related to coordination with Medicaid,[6] the degree to which states go above and beyond those requirements varies (Verdier et al. 2016). In unaligned arrangements, assessments and care coordination teams for Medicare and Medicaid remain separate and potentially duplicative.
- **MLTSS + aligned D-SNP.**[7,8] For this model, dually eligible beneficiaries enroll in an MLTSS plan for Medicaid LTSS and a D-SNP operated by the same parent organization as the MLTSS plan. States can create the foundation for aligned enrollment by requiring some or all of their contracted MLTSS plans and/or D-SNPs to operate "companion" plans in the same geographic area and cover the same dually eligible populations (Verdier et al. 2016). States can also require integration of the assessment and/or care coordination teams (HMA 2019), but generally integration is low (MedPAC 2018). However, CMS recently finalized updated criteria designed to increase the integration of Medicare and Medicaid through D-SNPs (see Exhibit 2).

Exhibit 2. New requirements for D-SNPs

Starting in contract year 2021, D-SNPs will be required to meet new integration criteria by (1) contracting with the state Medicaid agency to provide and coordinate LTSS, behavioral health or both; or (2) notifying the state Medicaid agency (or its designee) when certain high-risk full-benefit dually eligible enrollees have a hospital or skilled nursing facility admission. The state Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided (42 CFR 422.107). For more information on the changes for D-SNPs, see the 2020 Medicare Advantage and Part D Flexibility Final Rule, available at: https://federalregister.gov/d/2019-06822.

- **FIDE SNP.** Created by the Affordable Care Act in 2010, dually eligible beneficiaries enrolled in FIDE SNPs often receive their Medicare benefits, as well as at least some Medicaid benefits, from the plan. All FIDE SNPs must cover at least some LTSS (180 days of nursing facility care), and "substantially all" Medicaid services, but states may choose to carve certain Medicaid services out of their contracts with FIDE SNPs (for example, certain acute care, behavioral health, and/or LTSS benefits).[9] States may use a single FIDE SNP contract to define all services to be covered by the FIDE SNP, or they may execute separate contracts with FIDE SNPs and affiliated MLTSS plans. States may use a single, integrated enrollment process to enroll beneficiaries into FIDE SNPs for both Medicare and Medicaid

benefits, or enrollment may remain separate for the two programs, requiring beneficiaries to enroll first in a FIDE SNP for their Medicare benefits, then into an affiliated MLTSS plan. FIDE SNPs also have the option to coordinate the Medicare and Medicaid assessment processes or use separate assessments (Gibbs and Kruse 2016).

- **FAI capitated demonstration.** Under this federal demonstration, dually eligible beneficiaries enroll in a single Medicare-Medicaid Plan (MMP) to receive both Medicare and Medicaid benefits, the requirements of which are defined in a three-way contract between CMS, the state, and the plan (CMS 2019). MMP enrollment (for both Medicare and Medicaid benefits) is always aligned, and the process of enrolling is conducted through a single entity, typically an Enrollment Broker contracted by the state. MMPs are the most integrated form of Medicare-Medicaid coverage (with the exception of PACE), as they must cover all Medicare and Medicaid primary and acute care benefits, prescription drugs, behavioral health, and LTSS. In addition to covering all Medicare and Medicaid benefits[10], MMPs are required to integrate Medicare and Medicaid assessments and care coordination teams – a step that is optional in FIDE SNPs (HMA 2019).
- **PACE.** Established by the Balanced Budget Act of 1997, PACE is a fully integrated Medicare program and Medicaid state plan option for people who are 55 years of age or older, require a nursing home level of care, and live in a PACE service area. PACE programs cover all medically necessary care, primarily in an adult day health setting, but in-home and referral services may also be available. PACE providers enter into three-way provider agreements with CMS and the state, and they receive integrated financing that allows them to pool payments received from public and private programs and individuals (CMS 2017).

Table 1. Key features of unaligned and aligned Medicare and Medicaid models of care

Feature	MLTSS + unaligned D-SNP/ original Medicare	MLTSS + aligned D-SNP	FIDE SNP	FAI capitated demonstration	PACE
Medicare and Medicaid benefits through a single contract	No (separate Medicare and Medicaid contracts)	No (separate Medicare and Medicaid contracts)	No (separate Medicare and Medicaid contracts)	Yes (single three-way contract with CMS and state)	Yes (single three-way provider agreement with CMS and the state)
One parent organization covers Medicare and Medicaid benefits	No	Maybe	Maybe	Yes	Yes (plus medically necessary care not covered by Medicare or Medicaid)
Medicaid and Medicare enrollment is aligned initially and long-term	No (Medicare and Medicaid enrollment processes are separate)[a]	Maybe (may use an integrated enrollment process in which D-SNP enrollment triggers automatic enrollment in a companion MLTSS plan through the same parent company)[b]	Maybe (state may contract with FIDE SNP to cover all LTSS benefits or use an integrated enrollment process in which D-SNP enrollment triggers automatic enrollment in a companion MLTSS plan through the same parent company)[c]	Yes (as long as a beneficiary remains enrolled in an MMP, their MLTSS coverage will be provided by that MMP)	Yes (enrollees receive all Medicare and Medicaid benefits, including LTSS, from the PACE program)
Integrated Medicare and Medicaid assessment required	No	Maybe (states can require integrated assessment)	Maybe (assessment must be coordinated, but states can require integrated assessment)	Yes	Yes
Medicare and Medicaid Interdisciplinary Care Team (ICT)[d] required	No	Maybe (states can require ICTs)	Maybe (states can require that ICTs include Medicaid providers)	Yes	Yes

Source: Gibbs and Kruse 2016, MedPAC 2018, Weir Lakhmani and Kruse 2018.

Note: CMS = Centers for Medicare and Medicaid Services; D-SNP = dually eligible special needs plans; FAI = Financial Alignment Initiative; FIDE = fully integrated dually eligible; ICT = interdisciplinary care team; MLTSS = managed long-term services and supports; MMP = Medicare-Medicaid Plan.

[a] In MLTSS + unaligned D-SNPs or original Medicare, misaligned enrollments occur because beneficiary enrollment in FFS Medicare or a D-SNP with no affiliated MLTSS plan inherently results in MLTSS plan enrollment that cannot be aligned with Medicare enrollment.

[b] In MLTSS + aligned D-SNPs, enrollment could still become misaligned if the beneficiary changes their Medicare plan enrollment and the state has not established processes to ensure that such changes automatically trigger a corresponding change in MLTSS plan enrollment.

[c] In FIDE SNPs, enrollment could still become misaligned if the beneficiary changes their Medicare plan enrollment and the state has not established processes to ensure that such changes automatically trigger a corresponding change in MLTSS plan enrollment.

[d] Interdisciplinary care teams typically consist of the enrollee, providers, other support professionals, and family members and caregivers. These teams work collaboratively to develop and implement care plans to meet individuals' medical, behavioral, long-term services and supports, and social service needs. For more information see Barth et al. 2019, or Philip and Soper 2016.

Overview of MLTSS Programs in the Three Study States

Like MLTSS programs nationwide, those in the three study states in this brief vary in the Medicaid program authorities used, covered benefits, populations served, and approaches to the coordination and level of integration of Medicare and Medicaid (see Table 2). These programs are similar in that they are all statewide and serve full-benefit dually eligible beneficiaries. None of the programs require that the MLTSS plans offer companion D-SNPs; however, some of the MLTSS plans in each state choose to offer D-SNPs, resulting in some portion of MLTSS enrollees who were in aligned arrangements. Although our focus was on unaligned MLTSS arrangements, the state officials interviewed for this brief identified MLTSS plans that choose to offer D-SNPs as vehicles for improved coordination of Medicare and Medicaid dually eligible beneficiaries.

Table 2. MLTSS program features in three study states

MLTSS program features	Florida	Kansas	Wisconsin
Program name	Integrated Managed Medical Assistance and Long Term Care	KanCare	Family Care[b]
Medicaid authority	1915(b)/1915(c)	1115(a)/1915(c)	1915(b)/1915(c)
Start date	8/1/2013[a]	1/1/2013	1/1/1999
Statewide coverage	Yes	Yes	Yes
Inclusion of full-benefit dually eligible beneficiaries	Yes	Yes	Yes
Covered Medicaid benefits	All plans cover physical, behavioral health, and LTSS (institutional and HCBS)	All plans cover physical, behavioral health, and LTSS (institutional and HCBS)	All plans cover LTSS only (institutional and HCBS), and related long-term care state plan services
Level of care (LOC) required for enrollment	Institutional LOC	Institutional LOC	Less than institutional LOC
Included Medicaid populations	Older adults and adults with physical disabilities	Older adults, adults with physical disabilities, adults with I/DD, children with disabilities	Older adults, adults with physical disabilities, adults with I/DD
Number and percent of MLTSS plans that offer aligned D-SNP options	7 of 8 (87.5%)	1 of 3 (33%)	2 of 5 (40%)

Source: Mathematica analysis of MLTSS plans contracting with each state relative to D-SNPs reported in the CMS Special Needs Plan Comprehensive Report Plan Data, April 2019.

Note: D-SNP = dually eligible special needs plans; HCBS = home and community based services; I/DD = intellectual/developmental disability; LOC = level of care; LTSS = long-term services and supports; MLTSS = managed long-term services and supports.

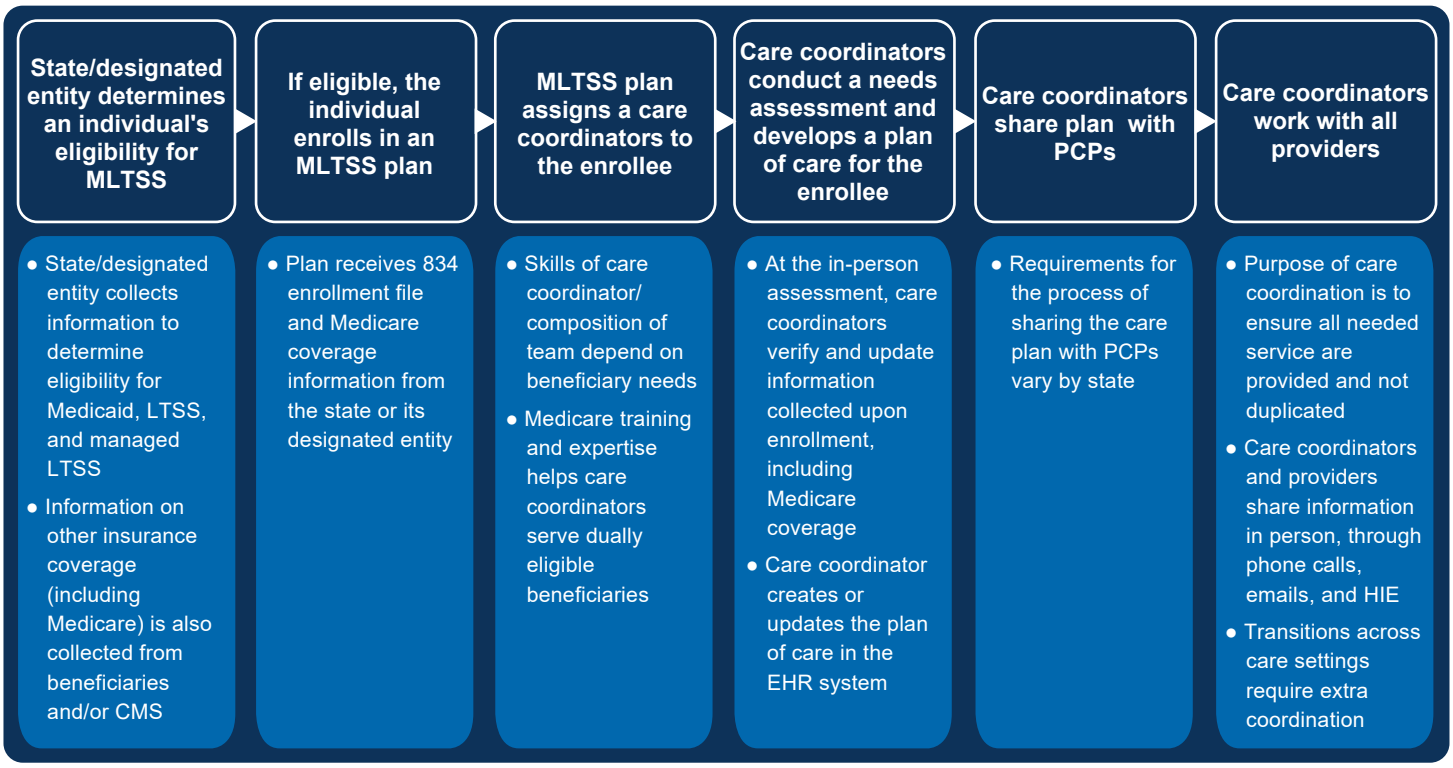
[a] Florida's MLTSS program recently transitioned from a limited benefit managed care program in which all participating plans covered only LTSS to a comprehensive program in which MLTSS plans cover Medicaid physical and behavioral health benefits for members who also receive LTSS. This transition began on December 1, 2018 and all plans were expected to complete the transition to a comprehensive plan no later than February 1, 2019. Our interviews with state officials and MLTSS plans occurred during the time of this transition.

[b] Wisconsin also operates a Family Care Partnership program that uses FIDE SNPs. This brief focuses on unaligned arrangements; therefore, it does not explore care coordination in the Partnership program.

How Unaligned MLTSS Plans Coordinate With Medicare During Eligibility Determination, Enrollment, Assessment and Care Planning, and Service Provision

In all MLTSS programs, before plans coordinate care, beneficiaries must qualify for Medicaid-covered LTSS, enroll in a plan, and receive person-centered assessments and care plans (see Figure 1). First, states, or their designated entities, review information to determine whether an individual is eligible to enroll in MLTSS. The entity that determines eligibility typically sends data files with information about eligible beneficiaries to an enrollment broker, and the enrollment broker notifies the beneficiary of their eligibility for the program and helps the individual select a plan. That entity then sends information to the MLTSS plan to help process enrollment. The MLTSS plan then assigns a care coordinator who is responsible for (1) conducting an assessment of the enrollee's needs and developing a plan of care; (2) sharing that plan of care with relevant providers; and (3) working with providers, the enrollee, and his or her family to ensure that all needed services are obtained and not duplicated. The remainder of this section describes the care coordination for dually eligible beneficiaries that occurs after MLTSS program eligibility determination, enrollment, assessment, and care planning.

Figure 1. Example of coordination that occurs between MLTSS plans and Medicare during eligibility determination, enrollment, assessment and care planning, and service provision



Note: CMS = Centers for Medicare and Medicaid Services; EHR = electronic health record; HIE = health information exchange; LTSS = long-term services and supports; MLTSS = managed long-term services and supports; PCP = primary care provider.

Using Medicare coverage information to coordinate care

Understanding how dually eligible beneficiaries receive their Medicare coverage is important for MLTSS plans because Medicare is the primary payer for many benefits, and MLTSS plans must ensure they do not duplicate Medicare-covered services. MLTSS plans must coordinate with original Medicare and MA plans, not only to ensure proper and timely Medicare crossover payments, but also to learn what Medicare services a beneficiary is receiving (see Exhibit 3). In the three study states, Medicare enrollment information is shared by the states with the MLTSS plans through a standardized enrollment file, commonly referred to as the 834 file.[11] MLTSS plans share this Medicare enrollment information with beneficiaries' assigned care coordinators to enable them to communicate with the beneficiaries' Medicare plans (when beneficiaries are enrolled in MA plans), so that they can understand the array of services and providers that an enrollee uses. One plan interviewed for this brief cross-walks enrollment information from the 834 files directly into the plan's electronic health record (EHR) system in order to ensure that care coordinators have access to timely information.

Respondents from states and MLTSS plans reported that Medicare coverage information is gleaned from both CMS (for example, through Medicare crossover claims) and the dually eligible beneficiary. However, the information is often incomplete or not shared in a timely way. If an MLTSS plan does not have timely data on a beneficiary's Medicare enrollment, obtaining timely data about service use, like hospitalizations, is considerably more difficult (see "How Unaligned MLTSS Plans Coordinate with Medicare During Transitions of Care" starting on page 8).

Exhibit 3. Medicare crossover claims

About crossover claims: For low-income dually eligible beneficiaries enrolled in FFS Medicare Savings Programs (MSPs), Medicaid pays the beneficiary's Medicare premiums, deductibles, and coinsurance. For Medicare-covered services provided to dually eligible beneficiaries enrolled in MSPs, providers first submit claims to Medicare for payment, and then the claim automatically "crosses over" to Medicaid for payment of deductibles and cost-sharing amounts. These claims are referred to as "crossover claims." This crossover process is governed by a state contract with Medicare called the Coordination of Benefits Agreement (COBA), which only applies to FFS Medicare; there is no crossover process for Medicare Advantage. States can pay these claims directly or delegate the crossover claim payment responsibility to MLTSS plans. In states that delegate payment, plans must also enter into a COBA with Medicare as required by 42 CFR 438.3(t).

All three study states include Medicare cost-sharing in the capitation rates for unaligned MLTSS plans that serve beneficiaries in FFS Medicare, and require the plan to pay the crossover claims directly to providers. Across the study states, unaligned MLTSS plans reported that the crossover claim data may contain useful information about the services a dually eligible enrollee receives and their providers so long as they are enrolled in FFS Medicare. This information is shared with the care coordination team to document in the EHR and, as necessary, to identify Medicare providers to work directly with to address a beneficiary's unmet needs.

Resources for states: All states participate in the Medicare Modernization Act (MMA) File exchange (after the Medicare Prescription Drug Improvement and Modernization Act of 2003, also known as the "State Phasedown File exchange"), and have access to the accompanying ad-hoc Territory Beneficiary Query (TBQ) File. Both the MMA File and the TBQ File offer states access to real-time Medicare eligibility and enrollment data. Additionally, CMS makes available a wide array of Medicare eligibility, enrollment, claims, and assessments data to states for care coordination of dually eligible beneficiaries; as of June 2019, 29 states are receiving Medicare data. As part of the available data, states can request a timely, expanded COBA file for the purposes of coordinating care among Medicare FFS enrollees. More information on state access to Medicare data, as well as the MMA exchange and TBQ File, is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html.

Staff and training to support care coordination

Composition of the MLTSS care coordination team. In most MLTSS plans, the care coordination team is comprised of various professionals. Care coordinators are often nurses or social workers who either work for the MLTSS plan directly (an in-house model) or for a delegated entity. Beneficiaries with greater medical needs are usually assigned to a nurse care coordinator, and those with LTSS and other social needs are assigned to a social work care coordinator (Saucier and Burwell 2015). MLTSS plans, or their delegated entities, may also employ specialized care coordination staff, such as behavioral health specialists to provide expertise to assigned care coordinators as needed or directly coordinate care for enrollees with behavioral health needs (Saucier and Burwell 2015). These individuals work together as part of the care coordination team and support enrollee needs through shared record keeping and regular consultation.

In all three study states, unaligned MLTSS plans more often assign nurse care coordinators to dually eligible beneficiaries in order to communicate with Medicare providers covering their beneficiaries' medical services. The social work care coordinator is more often involved with communicating with Medicaid providers who are providing LTSS, such as personal care services or adult day services.

Even though the unaligned MLTSS plans we spoke with in the three study states do not cover Medicare services for dually eligible beneficiaries, the plans do include a variety of specialized staff on the care coordination team to help coordinate medical benefits for these enrollees. For example:

- One MLTSS plan in Florida includes behavioral health specialists as part of their team to communicate directly with behavioral health providers who deliver both Medicare and Medicaid covered services.
- One MLTSS plan in Florida also includes acute care specialists with knowledge of Medicare benefits on their team to coordinate with acute Medicare providers (for example, by supporting hospitals with discharge planning).
- Another plan in Florida relies on subject matter experts on the plan's executive team to bridge Medicare and Medicaid. The Medicare experts work closely with MLTSS care coordination teams in regional offices to share experiences and lessons learned.
- MLTSS plans in Florida and Kansas developed nursing facility transition teams that coordinate Medicare and Medicaid benefits for dually eligible enrollees who are discharged from the nursing facility to a home and community setting.

- Two MLTSS plans use specialized staff to understand and obtain information on Medicare eligibility and coverage. One plan in Wisconsin employs eligibility specialists to keep current on changes in Medicare benefits, including annual updates to MA and Medicare Part D prescription drug plan coverage. One plan in Florida contracts with a third-party vendor to obtain information on other insurance coverage beneficiaries might have, including Medicare. Care coordinators use coverage information to ensure their beneficiaries have access to all available services, regardless of payer.
- One Wisconsin plan also employs a team of durable medical equipment (DME) specialists to facilitate the process of ordering and acquiring Medicare DME. Similarly, another plan in Wisconsin employs physical therapists as rehabilitation specialists to identify rehabilitation and DME needs among enrollees and facilitate access to rehabilitation services and DME acquisition.

Medicare training for MLTSS care coordination staff. MLTSS plans in all three study states use a variety of training approaches to teach staff about Medicare eligibility and coverage so that they may better coordinate with Medicare providers on behalf of their dually eligible members. Plans in Wisconsin and Florida train care coordinators on Medicare-related topics as part of both initial orientation and continued learning. These training sessions include information about how Medicare coverage is organized (Parts A, B, C, and D), coverage of Medicare benefits compared to Medicaid benefits, and annual updates to MA and Medicare Part D Prescription Drug Plan coverage. Some plans also provide concurrent training sessions for Medicare and Medicaid providers (for example, training primary care practitioners and DME vendors together). As part of this cross-training, MLTSS plans share information about covered benefits, their utilization management and claim submission processes, and approaches to promoting quality and value. Medicare providers share information about their clinical approach to providing covered benefits and optimal ways to coordinate benefits with provider staff, such as nurses and billing teams.

Sharing the LTSS care plan with Medicare primary care providers (PCPs)

Federal regulations require that MLTSS plans share beneficiaries' care plans with the state or other managed care plans involved in the beneficiaries' care, and that each provider maintain and share health records as appropriate [42 CFR 438.208(b)(4) and (5)]. Yet states do have discretion to decide how frequently to share the plan and what the provider should do with the information they receive. In our study, states varied in their requirements for the MLTSS plans to share beneficiaries' care plans with their PCPs, who are identified through the care coordinator and/or Medicare service use data:

- Florida requires its MLTSS plans to share the beneficiary's care plan with the PCP every time the care plan is updated (that is, upon initial enrollment, annually, and with any major change in condition), but the state does not require the PCP to sign the care plan. Florida's MLTSS contract includes liquidated damages for plans that do not comply with this requirement.
- As of 2019, Kansas also began requiring MLTSS plans to share the care plan with beneficiaries' PCPs, but unlike Florida, it requires its PCPs to sign the care plan upon receipt. At least one plan in Kansas uses an electronic system to share care plans with beneficiaries' PCPs and to obtain the contractually required signatures.
- In contrast to Florida and Kansas, Wisconsin's Family Care program does not require its MLTSS plans to share beneficiaries' care plans with their PCPs.

Some of the MLTSS plans we interviewed described challenges in sharing care plans with Medicare PCPs on behalf of enrollees in unaligned arrangements. One Florida plan shared that some Medicare PCPs do not provide services under the Medicaid program and, therefore, see the information contained in the full MLTSS care plan as unnecessary and irrelevant to the services they provide. Other Medicare PCPs who contract with the MLTSS parent company for other lines of business were confused by the MLTSS care plan because they did not understand the purpose of a care plan that includes Medicaid covered benefits. Despite provider views, one plan in Florida—which is required by the state to share the care plan with the Medicare PCP every time it is updated—views sharing the care plan as an opportunity to explain to the Medicare PCP how the MLTSS plan and the Medicare PCP can work together to meet the beneficiary's needs.

Working with Medicare providers, original Medicare, and unaffiliated MA plans

All of the MLTSS plans we interviewed emphasized the importance of establishing a collaborative relationship with the providers—including Medicare providers—involved in caring for their enrollees. Current MLTSS care coordination strategies with Medicare providers rely on personal relationships and exchange of information through phone calls, emails, and faxes. However, in two of the study states—Florida and Wisconsin—care coordinators are increasingly relying on state Health Information Exchange (HIE) systems to formalize these interactions and share information in a more efficient manner.[12]

For service types in which Medicare and Medicaid share responsibility for certain aspects of coverage and payment—such as inpatient hospitalizations, skilled nursing care, post-acute home health services, DME, and skilled therapies—coordinating services identified in the care plan requires that the MLTSS plans

work directly with Medicare providers. Each Medicare benefit type has its own specific Medicare rules and requirements that the MLTSS plan must understand to effectively coordinate with Medicare providers (Libersky et al. 2017). For other benefit types, MLTSS plans must also use information on the clinical care delivered by Medicare providers to effectively coordinate LTSS.

Staff from both of the MLTSS plans in Florida reported that it was easier to coordinate with another managed care plan offering an MA plan or D-SNP than it was with original Medicare. MLTSS plans that coordinate with D-SNPs can speak directly to the D-SNP care coordinators on behalf of the enrollee. In contrast, MLTSS plans that coordinate with original Medicare must contact the member's PCP to coordinate care or a Medicare processor to determine a beneficiary's benefit limits, which requires the plan to call a local Medicare intermediary with the beneficiary. Exhibit 4 provides examples from Wisconsin on how they collaborate with Medicare providers to support a member's need for DME, another shared benefit between Medicare and Medicaid.

Exhibit 4. Coordination with Medicare through specialized DME teams

One Wisconsin MLTSS plan developed a DME and purchasing team to help care coordinators collaborate with various Medicare providers involved in ordering and servicing DME, disposable medical supplies (DMS), or specialized medical supplies (SMS). The specialized DME team works with the Medicare PCP to obtain the DME order, share the order with DME vendors, explore the most efficient and cost-effective options for fulfilling the order, acquire additional required documentation needed to complete the order, and support the DME vendor in meeting Medicare deadlines required for reimbursement. The DME team includes a purchasing coordinator responsible for supporting the purchase of larger items, such as power wheelchairs, for which Medicare requires very specific and detailed documentation (Cinquegrani and Lawrence 2017). Similarly, the purchasing team ensures DMS/SMS vendors receive the required Medicare documentation initially and throughout the order process to ensure consistent and timely delivery.

Recognizing that many of their beneficiaries, including dually eligible beneficiaries, had DME that needed maintenance or repairs, the Wisconsin MLTSS plan also operates DME repair clinics. Repairing Medicare-acquired DME is important because Medicare limits how frequently it will pay for new DME equipment and what types of repairs can be made. These coverage limits differ from those of Medicaid. One challenge for vendors who perform DME repair is that they have to travel to beneficiaries to service the DME, and Medicare does not reimburse mileage. To facilitate the repair service, the Wisconsin plan invites DME repair professionals to their offices to staff "repair clinics." These clinics allow repair vendors to meet with multiple beneficiaries in one day without having to travel to multiple sites. There is no additional cost to the plan to provide hosting space. DME staff at the clinic also help ensure repairs are appropriate, facilitate billing Medicare, and ensure submitted claims include appropriate documentation so that repairs and reimbursement are not delayed or denied.

How Unaligned MLTSS Plans Coordinate with Medicare During Transitions of Care

Transitions across care settings carry an increased risk of adverse events resulting from miscommunication across multiple providers (Agency for Healthcare Research and Quality [AHRQ] 2018). To mitigate this risk, federal regulations require all managed care plans, including MLTSS, to establish policies and procedures consistent with state rules regarding the quality and appropriateness of care for beneficiaries transitioning between settings (42 CFR 438.62(b)). MLTSS plans are contractually obligated to ensure continuity of care for their beneficiaries during care transitions, including those who are dually eligible beneficiaries, and use a variety of care coordination approaches to meet this requirement.[13] In fact, effective in January 2021, all D-SNPs that are not capitated to provide Medicaid behavioral health or MLTSS will be required through their state contracts to provide timely notification to the state or its designee of hospital and skilled nursing facility (SNF) admissions for a group of high risk dual eligible enrollees identified by the state.[14] CMS expects that states will leverage this requirement to ensure MLTSS care managers receive timely notification of hospital and SNF admissions for members enrolled in unaffiliated D-SNPs. At the time of this brief, the MLTSS plans that were interviewed focused their transitional care coordination efforts on dually eligible beneficiaries transitioning between acute care, post-acute care, and home and community care, as described below.

Use of HIEs

Two of the study states, Florida and Wisconsin, have developed HIE systems to facilitate data exchange across the MLTSS plans and providers (see Exhibit 5). Such systems are particularly useful during transitions because they notify plans about beneficiaries who have been admitted to a hospital or visited an emergency department (ED). Utilizing an HIE system enables the Florida and Wisconsin plans to access hospital (inpatient and ED visit) admission and discharge data. However, the two systems differ in important ways. First, the Florida system receives its data in near-real time, whereas the Wisconsin system receives its data daily. Second, Florida requires its MLTSS plans to use the HIE system for acute care notifications, whereas Wisconsin's HIE notification system is voluntary. Moreover, the Florida system has 107 subscribers (including plans, providers, and accountable care organizations) and covers over 8.6 million lives (Florida HIE Services 2019);

Exhibit 5. State HIEs provide MLTSS plans timely access to Medicare data: Florida and Wisconsin

Through its Encounter Notification Services (ENS), Florida's HIE automatically pushes out an alert with information about a beneficiary's hospital encounter, regardless of payer, in near real-time. The ENS alert includes admission, discharge, and transfer (ADT) data, and subscribers have the option to receive notification in once or twice daily batches. At least one MLTSS plan in Florida automatically routes the ENS information into its EHR system. Florida requires its contracted MLTSS plans to subscribe to the HIE and contribute data to it. The fee for subscribing is based on the number of enrollees or patients assigned to the plan or provider. To date, over 200 hospitals, as well as individual providers, skilled nursing facilities, patient-centered medical homes, and accountable care organizations participate. Beneficiaries, however, must authorize the MLTSS plans and other subscribers to share their data through the system (Florida HIE Services n.d.).

The Wisconsin Statewide Health Information Network (WISHIN) includes a similar service to Florida's ENS, the Patient Activity Report (PAR). The PAR provides a daily notification to payers, providers, and clinics when their beneficiary or patient has an ED or other hospital visit. The information provided includes demographic details, encounter metadata (for example, admission date and time), and high-level clinical data (for example, presenting complaint and diagnoses). The WISHIN notification system is entirely voluntary, and not all MLTSS plans in the state participate. The state is currently encouraging MLTSS plans to use the HIE notification through a forthcoming pay-for-performance program.

in contrast, Wisconsin has 1,525 subscribers (referred to as customer sites) and covers over 6 million lives (WISHIN 2019).

For unaligned MLTSS plans, HIE systems provide timely notification about Medicare acute service use among dually eligible enrollees —information that care coordinators cannot get easily through other channels. Without access to these data, the care coordinators must rely on notice of Medicare acute care service use through phone calls from providers, other insurers, and enrollees and their families, which may not be as timely as receiving notifications directly from the HIE. For example, an MLTSS plan in Florida reported that, in the absence of the HIE system, the plan might only learn about Medicare stays when enrollees or their families mention them. With HIEs, plans in Florida and Wisconsin are able to deploy staff immediately and support the acute care providers in planning for the next level of care in a timely manner.

An alternative approach to HIEs, used by one MLTSS plan in Wisconsin, is to secure data sharing agreements with high-volume providers. The Wisconsin MLTSS plan invested in data-sharing agreements with high-volume hospital systems prior to the development of the statewide HIE-driven hospital and ED visit notification service, and when that system launched, chose not to enroll. Through these data-sharing agreements, the MLTSS plan received daily lists of beneficiaries with hospital admissions or ED visits via fax, including Medicare-covered visits. Care coordination staff also had direct access the hospital's EHR systems so the MLTSS plans had real time access to their enrollee's data, including Medicare-covered hospital admissions and ED visits. The MLTSS plan pays a small fee to the hospital system to access their EHR system and is only permitted to view their plan members' charts; the plan does not have permission to print information from the hospital's EHR. The MLTSS plan staff are trained in how to use the hospital EHR system and the plan routinely undergoes auditing for Health Insurance Portability and Accountability Act compliance. As reported by the Wisconsin MLTSS plan, one major benefit of having a direct relationship with hospital systems for data sharing is that it has strengthened the relationship between the plan and their partner hospitals, which is useful as the MLTSS plan coordinates its beneficiary transition of care to and from the hospital.

State and plan-level transition of care policies

Regardless of how MLTSS plans receive information about dually eligible beneficiaries' use of Medicare services, all three states employed specific protocols for coordinating care across settings. In January 2019, Kansas enacted a new transitional care policy for its MLTSS program. The new policy requires contracted MLTSS plans to develop a transitional care plan with the beneficiary and relevant providers as their health care needs change or as they move between settings such as hospitals, ED visits, home and community settings, LTSS providers, and rehabilitation facilities (KanCare n. d.). This transitional care policy supplements the state's MLTSS contracts, which do not include specific transitional care requirements. The MLTSS plan we spoke to is complying with the policy by requiring the care coordination team to (1) complete two follow-up phone calls with dually eligible enrollees upon discharge from a Medicare-covered inpatient hospital stay and (2) meet in-person to assess the beneficiary's needs, perform a medication reconciliation, and follow-up on any unmet needs.

Similar to Kansas, Florida requires MLTSS plans to coordinate with enrollees and appropriate providers to ensure enrollees receive proper and timely care during transitions across settings, and these requirements are included in MLTSS plan contracts (Florida Agency for Health Care Administration [AHCA]

2019). One plan in Florida conducts internal, multidisciplinary rounds among care coordinators so that they can plan discharges for beneficiaries who received Medicare acute or post-acute care services. The plan also described working with the beneficiary and hospital or nursing facility discharge planners to identify the most appropriate in-network Home and Community Based Service (HCBS) providers, include details about appropriate HCBS services in the care plan, and ensure the HCBS provider delivers services as specified.

Because Wisconsin's Family Care program only covers LTSS, whereas Florida and Kansas MLTSS programs cover comprehensive physical health and LTSS, Wisconsin does not have contract language specific to transitions in care but instead generally requires that plans coordinate health care services with necessary providers and insurers (Wisconsin Department of Health Services [DHS] 2018). Even in the absence of contract language, state officials and MLTSS plans in Wisconsin reported facilitating access to in-network Medicaid HCBS providers to limit service disruption among enrollees who discharge from a hospital or nursing facility. One Wisconsin MLTSS plan also developed a regional coalition of Medicare and Medicaid providers to address discharge planning of MLTSS beneficiaries from hospital and short-term nursing rehabilitation stays in a strategic and systematic way. For example, the coalition developed a protocol on how the hospitals and nursing facilities would work together with the MLTSS plans during transitions in care that identified appropriate roles and responsibilities.

MLTSS plans in Florida and Kansas also described their use of specialized nursing facility transition teams to support beneficiary transitions in care and prevent long-term nursing facility placement following hospital discharge. In both states, nursing facility transition teams are composed of care coordinators employed by the plan who are assigned to specific in-network nursing facilities. The nursing facility transition teams offer in-person care coordination support for their beneficiaries, often providing coordination between MLTSS and Medicare benefits during discharge planning (for example, coordinating between the Medicaid-covered nursing facility and the Medicaid-covered HCBS provider to ensure dually eligible beneficiaries receive the appropriate HCBS upon discharge to the community setting)

Summary of Findings and Implications for MLTSS Evaluations

Care for dually eligible beneficiaries that is well coordinated across Medicare and Medicaid has the potential to reduce duplication in both medical services and LTSS, mitigate adverse outcomes such as potentially avoidable hospitalizations and readmissions, and result in better experiences of care. Changes in outcomes that result from care coordination may influence patterns in service use and beneficiary-reported ratings of quality of care. For this reason, any evaluation of MLTSS programs that includes dually eligible beneficiaries must consider the impact that care coordination has on outcomes.

Findings from this study have important implications for the national evaluation of MLTSS programs. First, they suggest that, even in MLTSS programs that do not have structural alignment with Medicare, many MLTSS plans are either required by state contract provisions, or are voluntarily making a concerted effort, to coordinate with MA or original Medicare providers on behalf of dually eligible beneficiaries. For example, the MLTSS plans featured in this brief try to get information on Medicare coverage during eligibility determination and after enrollment. They employ staff with specialized Medicare knowledge to help coordinate Medicare services with Medicaid LTSS and provide training to staff on Medicare coverage and requirements. They inform Medicare PCPs about their patients' Medicaid LTSS and share the LTSS care plan with the PCPs to provide a full picture of service use. They also aim to support thoughtful, collaborative transitions of care. However, it is not clear whether these efforts will affect the outcomes that are the focus of the national evaluation, such as use of HCBS relative to institutional services, avoidable hospitalizations, and minimizing length of stay in long-term care institutions. In addition, it may be difficult to distinguish the effects of the MLTSS plan's care coordination efforts from those of the state MLTSS program as a whole.

Second, MLTSS programs in the three study states are similar in that they all require MLTSS plans to make some attempts to coordinate their enrollee's Medicare and Medicaid services, yet there is considerable variation across the three state programs. For example, states vary in the degree to which they require or support HIE, and the ways in which they participate in state sponsored HIE or attempt to coordinate health information on their own. Policies regarding how often MLTSS plans must send LTSS care plans to Medicare providers, and what providers should do upon receipt, vary as well. Furthermore, state policy and contract language regarding transitions of care ranges in specificity. This finding is consistent with a 2019 Medicaid and CHIP Payment and Access Commission (MACPAC) report that asserts that the variability in contract requirements across states is greater than the variability across Medicare-Medicaid integrated care models, including aligned MLTSS and D-SNPs, FIDE SNPs, and Financial Alignment Demonstrations (Barth et al. 2019). Such variability may influence differences in MLTSS outcomes that are directly or indirectly affected by such practices, such as avoidable hospitalization and length of stays in institutional settings.

Together, these findings suggest that national and state evaluations of MLTSS programs that examine the effects of care coordination on service use among dually eligible beneficiaries must look closely at the details of each program.

Evaluators cannot assume care coordination takes a certain form based on how MLTSS is aligned with Medicare or not. Therefore, evaluators should avoid controlling for outcomes based on whether plans in a designed program are "aligned" or "unaligned"; instead, they should use qualitative information to consider the degree of alignment within each plan and understand particular aspects of care coordination, regardless of model. Such features might include the presence of electronic HIE, documented receipt of an LTSS care plan, or transition of care policies that require both Medicare and Medicaid providers to participate if enrollees are transitioning across settings paid for by different programs. Though accounting for the nuances of each MLTSS program can be resource intensive, it will lead to stronger findings on their actual impact.

Acknowledgments

We are grateful to the state officials and MLTSS managed care plans from Florida, Kansas, and Wisconsin who participated in telephone interviews, fielded follow-up questions, and provided program information and comments on earlier drafts of this brief. We would also like to acknowledge Erin Weir Lakhmani and Debra Lipson at Mathematica Policy Research who provided comments on various drafts of this brief.

METHODS AND DATA SOURCES

From December 2018 through February 2019, IBM® Watson Health™ and Mathematica Policy Research collected information for this brief through semistructured telephone interviews with key informants in three study states. Key informants included Medicaid officials and two managed care plans in Florida, Medicaid officials and two managed care plans in Wisconsin, and one managed care plan in Kansas. Medicaid staff from Kansas answered our questions via email. We selected Florida, Kansas, and Wisconsin as study states because they operate mature MLTSS programs that have had sufficient time to develop Medicare coordination strategies but do not require MLTSS plan alignment. Specifically, the study states do not participate in the Financial Alignment Initiative, do not offer FIDE SNPs, and do not require their MLTSS plans to also offer an aligned D-SNP. State officials and managed care plans were given an opportunity to review a draft of this brief for accuracy.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research and Truven Health Analytics to conduct an independent national evaluation of the implementation and outcomes of Medicaid Section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs will inform an interim evaluation report in 2018 and a final evaluation report in 2020.

References

AHRQ. "Chartbook on Care Coordination: Transitions of Care." Rockville, MD: AHRQ, July 2018. Available at: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html. Accessed April 23, 2019.

Barth, Sarah, Sharon Silow-Carroll, Esther Reagan, Mary Russell, and Taylor Simmons. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches." Washington, DC: MACPAC, March 2019. Available at: https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf. Accessed April 5, 2019.

Cinquegrani, Amy, and Scott H. Lawrence. "Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." Baltimore, MD: CMS, July 2017. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_ODF_Slides_2017-07-06.pdf. Accessed April 23, 2019.

CMS. "Quick Facts about Programs of All-Inclusive Care for the Elderly (PACE)." Baltimore, MD: CMS, December 2017. Available at: https://www.npaonline.org/sites/default/files/11341-PACE.pdf. Accessed June 4, 2019.

CMS. "Special Needs Plans." Baltimore, MD: CMS, April 1, 2014. Available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans. Accessed April 23, 2019.

CMS. "Understanding Medicare Part C & Part D Enrollment Periods." Baltimore, MD: CMS, October 2018. Available at: https://www.medicare.gov/pubs/pdf/11219-understanding-medicare-part-c-d.pdf. Accessed April 17, 2019.

DHHS (Department of Health and Human Services). "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." Washington, DC: DHHS, April 5, 2019. Available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-06822.pdf. Accessed April 23, 2019.

Florida AHCA. "Attachment II: Scope of Service – Core Provisions." Tallahassee, FL: Florida AHCA, February 1, 2019. Available at: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2019-02-01/Attachment_II-Core_Contract_Provisions_2019-02-01.pdf. Accessed April 23, 2019.

Florida AHCA. "Attachment II Exhibit II-B: Long-Term Care Program." Tallahassee, FL: Florida AHCA, February 1, 2019. Available at: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2019-02-01/Exhibit_II_B-LTC_2019-02-01.pdf. Accessed April 23, 2019. Accessed April 23, 2019.

Florida HIE Services. "Encounter Notification Services (ENS)." Tallahassee, FL: Florida HIE Services, n.d. Accessed April 23, 2019.

Florida HIE Services. "Encounter Notification Service Subscribers." March 2019. Available at http://www.fhin.net/floridaHie/docs/ENSDataSources.xlsx. Accessed June 11, 2019.

Gibbs, Stephanie, and Alexander Kruse. "State Medicaid Managed Long-Term Services and Supports Programs: Considerations for Contracting with Medicare Advantage Dual Eligible Special Needs Plans." Hamilton, NJ: Centers for Health Care Strategies, Inc., November 2016. Available at: https://www.chcs.org/resource/state-medicaid-managed-long-term-services-supports-programs-considerations-contracting-medicare-advantage-dual-eligible-special-needs-plans/. Accessed April 23, 2019.

HMA. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches." Lansing, MI: HMA, March 2019. Available at: https://www.macpac.gov/publication/care-coordination-in-integrated-care-programs-serving-dually-eligible-beneficiaries-health-plan-standards-challenges-and-evolving-approaches/. Accessed April 23, 2019.

KanCare "Transitional Care Requirements." Topeka, Kansas, KanCare, n.d. Available at: https://www.kancare.ks.gov/docs/default-source/policies-and-reports/mco-transition-of-care/official-kansas-transition-of-care-policy.pdf?sfvrsn=b3154d1b_4. Accessed April 23, 2019.

Libersky, Jenna, James Verdier, and Ryan Stringer. "Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees." Washington, DC: Integrated Care Resource Center, June 2017. Available at: https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicare-basics-an-overview-for-states-seeking-to-integrate-care-for-medicaremedicaid-enrollees. Accessed April 23, 2019.

MedPAC. "Report to the Congress: Medicare and the Health Care Delivery System." Washington, DC: MedPAC, June 2018. Available at: http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0. Accessed April 23, 2019.

MMCO. "Fiscal Year 2017 Report to Congress." Washington, DC: DHHS, CMS, June 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index. Accessed April 23, 2019.

MMCO. "People Dually Eligible for Medicare and Medicaid." Washington, DC: DHHS, CMS, March 2019. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf Accessed June 11, 2019.

Phillip, Ann Mary and Michelle Soper. "Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States." Hamilton, NJ: Center for Health Care Strategies, 2016. Available at: https://www.chcs.org/media/INSIDE_ICTs_for_Medicare-Medicaid_Enrollees-012216.pdf. Accessed June 13, 2019.

Saucier, Paul, and Brian Burwell. "Care Coordination in Managed Long-Term Services and Supports." Washington, DC: AARP Public Policy Institute, July 2015. Available at: https://www.aarp.org/content/dam/aarp/ppi/2015/care-coordination-in-managed-long-term-services-and-supports-report.pdf. Accessed April 23, 2019.

Verdier, James, Alexandra Kruse, Rebecca Sweetland Lester, Ann Mary Philip, Danielle Chelminsky. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options." Baltimore, MD: Integrated Care Resource Center, November 2016. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues__Options.pdf. Accessed April 23, 2019.

Weir Lakhmani, Erin and Alexandra Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." Washington, DC: Integrated Care Resource Center, April 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Aligning_Enrollment.pdf. Accessed June 11, 2019.

Wisconsin DHS, Division of Medicaid Services. "Generic Family Care Contract." Madison, WI: Wisconsin DHS, Division of Medicaid Services, January 1, 2018. Available at: https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf. Accessed April 23, 2019.

WISHIN. "Health Plans: WISHIN's Patient Activity Report for Payers." Madison, WI: WISHIN, December 2018. Available at: http://www.wishin.org/Solutions/HealthPlans.aspx. Accessed April 23, 2019.

WISHIN. WISHIN Pulse Dashboard. March 2019. Available at: http://www.wishin.org/Solutions/ProvidersandClinics/WISHINPulse/WISHINPulseDashboard.aspx. Accessed June 11, 2019.

Endnotes

[1] Mathematica analysis of 2017 Medicaid managed care enrollment report data. Source data available at: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html.

[2] Depending on the state, dual eligible beneficiaries can also receive Medicaid LTSS on a FFS basis.

[3] The MLTSS plans in Florida and Kansas interviewed for this brief offer companion D-SNPs for dually eligible beneficiaries who choose aligned arrangements. However, Medicaid and Medicare rules differ in how frequently beneficiaries may change enrollment. Medicaid rules allow states to require enrollment in MLTSS plans for a certain period of time, while Medicare rules allow dually eligible beneficiaries to change their enrollment every quarter without cause as part of special enrollment periods (CMS 2019). Therefore, some of the beneficiaries in the MLTSS plans we spoke with are enrolled in aligned D-SNP arrangements, while others are enrolled in unaligned D-SNPs run by separate organizations or in original Medicare. This brief focuses on unaligned arrangements.

[4] Within some states, Medicaid MLTSS enrollees may be distributed across multiple arrangements. That is, some beneficiaries enrolled in the same MLTSS plan can be in an aligned D-SNP while others have unaligned Medicare coverage.

[5] Because state Medicaid agencies do not contract with regular MA plans (that is, plans that do not qualify as D-SNPs), even if a single parent company offers an MA plan and an MLTSS plan in the same geographic area, those plans are not considered to be "aligned" for the purposes of this brief.

[6] As required by 42 CFR 422.107, D-SNP contracts with states must document, at a minimum: (1) the D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits; (2) the categories of dually eligible beneficiaries eligible to be enrolled under the SNP (for example, full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.); (3) the Medicaid benefits covered under the SNP; (4) the cost sharing protections covered under the SNP; (5) the requirements to identify and share information on Medicaid provider participation; (6) the procedural requirements for the verification of enrollees' eligibility for both Medicare and Medicaid; (7) the service area covered by the SNP; and (8) the contract period for the SNP.

[7] In the 2020 MA and Part D Flexibility Final Rule, CMS defined aligned enrollment as "enrollment in a dual eligible special needs plan of full-benefit dually eligible beneficiaries whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment." (42 CFR 422.2).

[8] MA plans could include but are not limited to D-SNP "look-alike" plans which offer a cost-sharing structure and supplemental benefits that target dually eligible beneficiaries; however, as conventional MA plans, they are neither required to contract with states to ensure that a minimum integration standards are met nor must they meet model of care requirements (MedPAC 2018).

[9] FIDE SNPs are required to cover at least cover 180 days of nursing facility services/year and "substantially all" Medicaid services; however, states may choose to carve out some Medicaid services from the contract (for example, behavioral health). For more information, see: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf.

[10] While states are allowed to carve certain Medicaid benefits out of three-way contracts with MMPs if desired, the practice is rare, and typically only involves carving out coverage for certain Home and Community Based Service (HCBS) waivers or specific behavioral health benefits covered through other delivery systems within the state. When a state carves a benefit out of their MMP contracts, MMPs are typically required to coordinate with the entity(ies) delivering those benefits, to ensure holistic care coordination across all service types.

[11] For more information on the 834 file, see: https://www.1edisource.com/resources/edi-transactions-sets/edi-834/?tset=old. Plans can also get information via the Beneficiary Eligibility Query (BEQ) Request File, which includes transactions submitted daily by plans to CMS' Medicare Advantage and Drug (MARx) enrollment and payment system to obtain Medicare eligibility information for prospective plan enrollees. Plans use this data received in the CMS response file to conduct initial eligibility checks for prospective enrollees.

[12] HIEs are technologies designed to exchange health data electronically between health care professionals and patients. HIEs come in many forms and offer enhanced access and security in the sharing of health data. For more information, see: https://www.healthit.gov/topic/health-it-basics/health-information-exchange.

[13] When an MLTSS plan is responsible for a dually eligible beneficiary who is also enrolled in an MA plan for their Medicare benefits, to streamline between Medicaid and Medicare, the state has discretion to determine the extent of the MLTSS plan's responsibilities in regard to assessment of beneficiary needs and corresponding care plans (42 CFR 438.208(a)(3)).

[14] For more information, see: https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.