

State Medicaid Managed Long-Term Services and Supports Programs: Considerations for Contracting with Medicare Advantage Dual Eligible Special Needs Plans

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IN BRIEF

Many states are transforming the delivery system for Medicaid long-term services and supports (LTSS) from fee-for-service to managed care as a way to provide high-quality, person-centered, and cost-effective care to eligible beneficiaries in the settings of their choice. A subset of states are also seeking to better integrate care for their beneficiaries who are dually eligible for Medicare and Medicaid by contracting with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs). This technical assistance brief, developed with support from the Robert Wood Johnson Foundation, highlights opportunities for states to invest in Medicaid managed long-term services and supports (MLTSS) programs and align them with D-SNPs. The brief, originally developed to guide New Jersey's Medicaid program, explores considerations for requiring D-SNPs to become Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and examines the potential alignment that can be achieved through D-SNP contracting. It details key features of MLTSS, D-SNP, and FIDE-SNP programs to offer insights for states contemplating integrated programs.

To support a growing number of aging adults and individuals with disabilities, many states are transforming the delivery system for Medicaid long-term services and supports (LTSS) from fee-for-service to managed care as a way to provide high-quality, person-centered, and cost-effective care to eligible beneficiaries in the settings of their choice. As of October 2016, 21 states had a Medicaid managed long-term services and supports (MLTSS) program or were planning to launch a program—up from just eight states in 2008.^{1,2} MLTSS programs, which are designed to serve individuals with both age and disability-related long-term care needs, also serve a high-proportion of dually eligible individuals whose primary and acute care services are provided through Medicare. States are exploring options to better integrate and coordinate the care for their dually eligible populations, including contracting with Dual Eligible Special Needs Plans (D-SNPs), a special type of Medicare Advantage Plan that enrolls only dually eligible beneficiaries. As of October 2016, nearly 1.9 million individuals are enrolled in these plans in 38 states, the District of Columbia, and Puerto Rico.³

This technical assistance brief, developed with support from the Robert Wood Johnson Foundation, highlights opportunities for states with MLTSS programs to align the delivery of LTSS services to dually eligible beneficiaries receiving their medical care through a D-SNP-based platform. The information in this brief was originally gathered to guide New Jersey Medicaid officials in program decision making. Other states can use this brief to help make the case for investing in D-SNP program development to reduce fragmentation and align incentives across the Medicare and Medicaid programs.

The Case for Integrated Care

The goals of MLTSS programs include rebalancing the setting of care from institutions to community settings and reducing fragmentation between Medicaid acute and primary care, behavioral health services, and LTSS. States face additional barriers to achieving these goals for dually eligible beneficiaries enrolled in MLTSS programs because those individuals must often continue to navigate the Medicare system for primary, acute, and post-acute care services. More integrated care should reduce fragmentation, and improve quality and access to care. Programs in which a single entity is responsible for

managing acute, post-acute, and long-term care services may also reduce cost shifting and align incentives for Medicare and MLTSS providers to offer alternative home- and community-based services (HCBS) options to institutional care.

Several integrated care models are available.⁴ Twelve states are currently pursuing integrated care for their dually eligible beneficiaries through the federal Medicare-Medicaid Financial Alignment Initiative demonstrations;⁵ however, the initiative is now closed to new demonstrations. Thirty-two states have provider-driven Program for All-Inclusive Care for the Elderly (PACE) organizations, which provide highly integrated care for dually eligible beneficiaries, but PACE enrollment totals about 36,000⁶ nationally. In contrast, MLTSS programs aligned with D-SNPs provide a readily available option to align incentives and improve care for more than a million enrollees.

Benefits of D-SNP-Based Integration Models

D-SNPs are required to have contracts with state Medicaid agencies that specify, at a minimum, how they coordinate and arrange for the provision of Medicare and Medicaid benefits for enrollees.⁷ Beyond this threshold, states may pursue varying levels of Medicare and Medicaid integration, depending on their goals. The value added by state D-SNP contracting depends on the level of Medicaid benefit integration and care coordination requirements, the relationship between D-SNPs and Medicaid managed care plans, and efforts to encourage aligned enrollment between state Medicaid agencies and D-SNPs. Following is an overview of programs with increasing levels of Medicare-Medicaid alignment and integration:

Stand-Alone MLTSS Program

While MLTSS programs include incentives for rebalancing from institutional to community settings and improving access to HCBS, they do not provide incentives to MLTSS plans to influence Medicare services and cost drivers. Similarly, Medicare providers have no incentive to better manage chronic conditions to avoid nursing facility placements. In addition, MLTSS plans usually do not have access to real-time information on Medicare service utilization including hospitalizations and emergency department use that could help them better coordinate care and ease transitions between settings.

MLTSS Program and State Contracts with D-SNPs

D-SNPs may provide the opportunity to more fully integrate care and support state efforts to align incentives to provide the right care in the right setting for dually eligible enrollees, particularly when Medicare and Medicaid services are managed by the same entity. States can use their contracting authority with D-SNPs to establish a wide array of administrative, care coordination, and reporting and notification requirements for D-SNPs. The exhibit on page 4 details key program features and contractual considerations to achieve integration goals.

MLTSS Program and Contracts with Aligned D-SNPs

States can establish requirements to align their Medicaid acute care plans, Medicaid MLTSS plans, and D-SNP contractors, and develop strategies that promote enrollment into aligned plans. This results in one health plan having incentives for coordinating both Medicare and Medicaid service delivery. For example, states can require that Medicaid acute care/MLTSS plans operate a companion D-SNP product to promote enrollment in a D-SNP and Medicaid plan from the same insurer. States can make arrangements to encourage individuals to enroll in the same health plan for both Medicaid and Medicare service delivery.

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)

FIDE SNPs are a type of D-SNP authorized by the Affordable Care Act in 2010. When compared to traditional D-SNPs, FIDE SNPs provide states with additional authority and flexibility to achieve a higher degree of integration of administrative alignment and integration of Medicare and Medicaid services.⁸ FIDE-SNPs offer the highest level of benefit and administrative integration; they must be at risk for delivery of Medicaid LTSS in addition to Medicare benefits, and they must have procedures in place to promote

administrative alignment. Additionally, the FIDE SNP designation can provide a modest payment adjustment when enrollment matches the frailty level of PACE⁹ enrollees. Lastly, FIDE-SNPs may also use additional Medicare benefit flexibility to provide supplemental benefits not otherwise covered by Medicare or Medicaid.

The table on page 4 includes additional details on the key operational features in MLTSS, D-SNP, and FIDE-SNP programs and state considerations for implementing each model.

New Jersey's Integration Efforts

New Jersey is an example of a state that leveraged its MLTSS program to develop a D-SNP-based integration platform that better aligns and coordinates care for Medicare-Medicaid enrollees. The state began contracting with D-SNPs in 2012 to provide a more coordinated system of care for dually eligible beneficiaries who enroll in the same health plan for both Medicare and Medicaid service delivery. In July 2014, New Jersey launched an MLTSS program that provided an expanded platform for integrating care for the large proportion of the state's more than 200,000 dually eligible beneficiaries in need of Medicaid-covered LTSS. After assessing the comparative value of developing a fully integrated and aligned D-SNP based program along with the state's investment in MLTSS, New Jersey transitioned the responsibility for providing both nursing facility and community-based LTSS services to its aligned Medicaid/D-SNP contractors for individuals that elect to join a D-SNP. As of September 2016, three of New Jersey's current Medicaid/D-SNP contractors have obtained FIDE-SNP status and achieved a high degree of benefit integration and administrative alignment for the over 16,000¹⁰ dually eligible beneficiaries enrolled in the plans.



Conclusion

As states weigh options to serve vulnerable and high-need dually eligible populations, MLTSS programs offer a starting place for the integration of Medicare and Medicaid services. By leveraging MLTSS programs, states such as New Jersey are using D- -based models as vehicles for aligning Medicare services and further coordinating benefits for dually eligible individuals. Through D-SNPs, states may be better positioned to align incentives for providers and streamline program features for beneficiaries. States have several options to use D-SNP models to increase integration, and may choose among several features to determine the configuration that will best meet their integration goals. If current trends continue, many more of the nation's dually eligible beneficiaries will be enrolled in integrated programs involving state MLTSS programs and their contracting D-SNPs.

Exhibit: Key Features of MLTSS, D-SNP, and FIDE-SNP Programs

Feature	MLTSS	D-SNP	FIDE-SNP
Level of Medicare and Medicaid Benefit Integration	<ul style="list-style-type: none"> Medicaid LTSS only Limited ability for stand-alone MLTSS plans to coordinate and influence provision of Medicare benefits 	<ul style="list-style-type: none"> Must integrate Medicare primary and acute care services May include Medicaid benefits such as LTSS and behavioral health services at the state’s discretion May offer supplemental benefits 	<ul style="list-style-type: none"> Must integrate Medicare primary and acute care services Must include Medicaid benefits with LTSS May include Medicaid behavioral health May include supplemental benefits, with more flexibility than D-SNP
Enrollment¹¹	<ul style="list-style-type: none"> Mandatory or voluntary Medicaid enrollment design Two enrollment forms to sign Misaligned enrollments between Medicare and Medicaid plans State cannot influence Medicare enrollment 	<ul style="list-style-type: none"> May use one integrated enrollment form when the same health plan offers a D-SNP and an MLTSS product May leverage Medicaid mandatory enrollment process to assign to companion D-SNPs 	<ul style="list-style-type: none"> Must use one integrated enrollment form and process May provide way for same accretion and deletion dates for all services May provide opportunity to leverage Medicaid enrollment process to assign to companion FIDE-SNPs
Care Coordination	<ul style="list-style-type: none"> Require that all members receive some level of care coordination Limited ability to coordinate across Medicare and Medicaid services No MLTSS plan access to real-time Medicare health plan data 	<ul style="list-style-type: none"> Must establish a Model of Care (MOC) to address unique needs of dually eligible enrollees Must use multi-disciplinary approach State may add Medicaid care management requirements 	<ul style="list-style-type: none"> Must establish an integrated MOC focused on provision of both Medicare and Medicaid benefits Must use multi-disciplinary approach State must add Medicaid care management requirements
Assessments	<ul style="list-style-type: none"> States require in-person, comprehensive assessment focused on Medicaid LTSS needs including social supports 	<ul style="list-style-type: none"> May (generally has) separate assessment process for Medicare and Medicaid Must complete health risk assessment (HRA) for all D-SNP enrollees 	<ul style="list-style-type: none"> Must have coordinated Medicare and Medicaid assessment processes May use integrated assessment process Must complete HRA for all FIDE-SNP enrollees
Quality Improvement	<ul style="list-style-type: none"> Quality requirements only focused on Medicaid LTSS benefits delivery Required Performance Improvement Projects (PIPs) May or may not include public reporting of LTSS process or outcomes measures 	<ul style="list-style-type: none"> May integrate comprehensive Medicare quality improvement and public reporting requirements with Medicaid requirements May integrate separate Medicaid PIPs and Medicare Quality Improvement Projects (QIPs) 	<ul style="list-style-type: none"> May integrate Medicare and Medicaid quality improvement activities, with a strong incentive to do so States may align PIP and QIP topics and/or accept Medicare QIPs Some states are considering Medicare quality information in state reporting
Utilization Data for Program Analysis/ Care Coordination	<ul style="list-style-type: none"> MLTSS plans have access to data on Medicaid LTSS service use and needs only States can obtain periodic Medicare FFS data for duals to share with plans, but data is not real-time 	<ul style="list-style-type: none"> D-SNPs must report Medicare encounter data to CMS that states may receive and use for program analysis and rate setting May use Medicare service utilization data for real-time care coordination in aligned D-SNP/Medicaid plans 	<ul style="list-style-type: none"> Same features as D-SNP with greater incentives to use Medicare data for real-time care coordination
Financial Model and Incentives	<ul style="list-style-type: none"> Stand-alone MLTSS plan receives payment for Medicaid benefits only; does not receive integrated Medicaid and Medicare payments Rate setting methodology includes incentives for rebalancing from institutional to community settings No focus on managing Medicare service use or impact to Medicaid costs and services 	<ul style="list-style-type: none"> May integrate separate Medicare and Medicaid payments by plan Incentives may exist for D-SNP/Medicaid plan to use least costly services in least restrictive settings Savings from reduced Medicare service use accrue to plan and Medicare; no mechanism for states to share in savings Subject to Star ratings; potential bonus payments 	<ul style="list-style-type: none"> Must integrate separate Medicare and Medicaid payments by plan Incentives may exist via MLTSS program design to use least costly services in least restrictive settings Plans may be eligible for frailty adjustment Savings from reduced Medicare service use accrue to plan and Medicare; no mechanism for states to share in savings Subject to Star ratings; potential bonus payments
Administrative Processes	<ul style="list-style-type: none"> Separate Medicaid and Medicare administrative processes 	<ul style="list-style-type: none"> May have integrated administrative processes when D-SNP/Medicaid plans are aligned 	<ul style="list-style-type: none"> Must have integrated administrative processes

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

¹ States operating or developing comprehensive MLTSS programs: AZ, CA, DE, FL, HI, IL, KS, MA, MI, MN, NJ, NM, NY, OH, PA, RI, SC, TN, TX, VA, WI.

² P. Saucier, J. Kasten, B. Burwell, and L. Gold. "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Truven Health Analytics, July 2012. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf.

³ J. Verdier, A. Kruse, R. Lester, A. Philip, and D. Chelminsky. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options." Integrated Care Resource Center. (forthcoming).

⁴ N. Archibald and A. Kruse. "Snapshot of Integrated Care Models to Serve Dually Eligible Beneficiaries." Center for Health Care Strategies, December 2015. Available at: <http://www.chcs.org/media/INSIDE-Snapshot-of-Integrated-Care-12-14-15-FINAL.pdf>.

⁵ States taking part in the Financial Alignment Initiative: CA, CO, IL, MA, MI, MN, NY, OH, RI, SC, TX, VA and WA. For more information see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>.

⁶ Integrated Care Resource Center. "Programs of All Inclusive Care for the Elderly (PACE) Enrollment by State and Organization." October 2016. Available at: http://www.integratedcareresourcecenter.com/PDFs/PACE_Enroll_by_State_Oct_2016.pdf.

⁷ Verdier et al., op. cit.

⁸ Centers for Medicare & Medicaid Services. "Medicare Managed Care Manual." Chapter 16b (Rev.123, Issued 8-19-16). Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>.

⁹ Section 1853(a)(1)(B)(iv) of the Affordable Care Act (ACA) provides the authority to apply a frailty adjustment payment under the rules for Program of All-Inclusive Care for the Elderly (PACE) payment, for certain FIDE SNPs, to reflect the costs of treating high concentrations of frail individuals. Frailty scores are calculated using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) from the year previous to the payment year. For a SNP to be eligible to receive frailty payments pursuant to section 1853 of the Act, the SNP must: (1) satisfy the FIDE SNP definition under 42 CFR 422.2(3); (2) participate in the HOS; and (3) have similar average levels of frailty as PACE organizations as described in the Advance Notice for the given year. Centers for Medicare & Medicaid Services. "Medicare Managed Care Manual." Chapter 16b (Rev.123, Issued 8-19-16). Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>.

¹⁰ Centers for Medicare & Medicaid Services. SNP Comprehensive Report. September 2016. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2016-09.html>.

¹¹ For Medicare, dually eligible beneficiaries may choose to enroll in D-SNPs, other Medicare Advantage plans, or Medicare fee-for-service (FFS), and states cannot limit month to month changes between Medicare Advantage plans or Medicare FFS.