

*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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SUMMARY

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.

Funded by UnitedHealthcare, Health Management Associates (HMA) interviewed Medicaid and Aging agency officials overseeing programs that provide LTSS fee-for-service (FFS) to identify successful approaches and lessons learned through working with Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs) to better coordinate and integrate care for FBDE individuals. HMA interviewed officials in the District of Columbia, Idaho, Maine, and Washington and reviewed their, as well as Alabama's, Calendar Year (CY) 2021 state Medicaid agency contracts (SMACs) with D-SNP organizations to inform the findings in this report.

States with Medicaid LTSS FFS delivery systems can take varied approaches working with D-SNPs. Washington integrated FFS LTSS with MA Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs).¹ Alabama includes coverage of Medicaid agency cost sharing obligations under contract with D-SNPs and the District of Columbia is exploring opportunities to include Medicaid benefits, inclusive of LTSS, in the D-SNP contract. Idaho provides an example of contracting with MA Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)² prior to implementation of MLTSS. Maine is instructive as a state at the beginning stages of exploring Medicare and Medicaid integration without any Medicaid managed care programs in place.

This paper outlines approaches taken by these Medicaid programs seeking to coordinate Medicare and Medicaid services without standalone Medicaid MLTSS programs. Their approaches include the following:

- ✓ **Identifying and building upon the existing strengths of the state's Medicaid program** to increase coordination and integration of Medicare and Medicaid benefits for FBDE individuals.
- ✓ **Engaging stakeholders**, including FBDE individuals and their families, D-SNPs organizations, providers, and others, at the outset of planning for increased coordination and integration between Medicaid and D-SNPs.

- ✓ **Establishing strong state staff oversight and understanding of Medicare** program benefits and administrative requirements, D-SNP model of care, and MA supplemental benefits.
- ✓ **Establishing open, ongoing communication and building partnerships with D-SNP organizations** in the state.
- ✓ **Maximizing the new Centers for Medicare & Medicaid Services (CMS) 2021 standalone D-SNP hospital and skilled nursing facility admission data sharing requirements** to support increased coordination around care transitions.
- ✓ **Introducing D-SNP organizations to Medicaid benefits** by including coverage of certain benefits such as Medicaid agency cost sharing obligations in SMACs with D-SNP organizations.
- ✓ **Maximizing available CMS Medicare-Medicaid Coordination Office (MMCO) supports** and communicating additional supports needed going forward.

Medicaid programs can adapt these approaches to their unique state landscapes, delivery systems, and stakeholders to better coordinate Medicare and Medicaid services for FBDE individuals.

INTRODUCTION

In 2019, over 12 million individuals were dually eligible for some level of Medicare and Medicaid benefits. They are a demographically diverse group and often have co-occurring physical health and behavioral health conditions, as well as physical and cognitive disabilities. Dually eligible individuals are disproportionately younger, female, and of minority race/ethnicity, compared to other Medicare eligible individuals. Forty-eight percent of dually eligible individuals were of a racial or ethnic minority group, as opposed to 21.6 percent of Medicare-only eligible individuals.³ Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive LTSS, and 60 percent have multiple chronic conditions.⁴

Nearly nine million dually eligible individuals are designated as FBDE and may therefore receive all the services provided by the two programs for which they qualify.^{5,6} Medicare covers their medical services including physician, inpatient, and outpatient acute care, post-acute skilled level of care, and pharmacy benefits. Medicaid covers their Medicare premiums and cost-sharing as well as services not covered by Medicare.⁷ Those services are primarily LTSS, including nursing facility and home and community-based services (HCBS). HCBS include, but are not limited to, personal care services for activities of daily living such as bathing and eating; home-delivered meals; nonemergency medical transportation; adult day care for older adults; and employment services for people with disabilities.⁸ Medicaid's more expansive behavioral health benefits also wrap around Medicare's coverage of behavioral health, particularly to meet the needs of dually eligible individuals under age 65.

Most FBDE individuals must navigate two separate and confusing delivery systems of services and providers to get the care they need. They often experience poor care coordination, cost shifting, and duplication of services between the two programs. They also experience a higher prevalence of social risk factors including housing insecurity and homelessness; food insecurity; inadequate access to transportation; lower levels of education; health literacy; and poverty.⁹ The combination of higher

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.

Medicare and Medicaid Integration Efforts – Using Medicaid LTSS FFS

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 – 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 – 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 agency's cost sharing obligations in SMACs (Alabama) or the comprehensive set of Medicaid benefits, inclusive of LTSS (District of Columbia)

- **“Benchmark Model” via FIDE SNP.** Use of a Medicaid State Plan alternative benefit package with “standalone” FIDE SNP (Idaho) and without a standalone Medicaid MLTSS program. FIDE SNP is a designated type of D-SNP. FIDE SNPs provide Medicare and Medicaid benefits *under a single legal entity* that has a contract with CMS and a Medicaid contract with the state. It must provide coverage, consistent with state policy, of Medicaid benefits, including LTSS and nursing facility services for at least 180 days per plan year.¹³

These innovative pathways to integration can and often do lead to future implementation of MLTSS as a comprehensive approach to provide LTSS to eligible populations. Of note, when capitating Medicaid benefits through a wrap payment, MLTSS or other mechanism, rates need to be actuarially sound.

STATE APPROACHES TO COORDINATING AND INTEGRATING MEDICAID AND MEDICARE SERVICES WITH D-SNPS ABSENT MLTSS PROGRAMS

Interviewees and SMAC contract reviews identified successful approaches and lessons learned during the exploration, planning, and development of coordinated and more seamless systems of care for FBDEs. They are outlined below.

Identify and build upon the existing strengths of the state’s Medicaid program to increase coordination and integration of Medicare and Medicaid benefits for FBDE individuals

Interviews with state Medicaid and Aging agency officials underscored the need to identify and understand the strengths of their current Medicaid delivery system, and to lay out a clear path that builds upon what is working well, which may be outside of a strictly managed integrated care model.

Washington and the District of Columbia seek to better serve FBDE individuals while capitalizing on the strengths of their Medicaid delivery systems. Both recognize the strong delivery systems currently in place and are leveraging them to build D-SNP programs that better coordinate LTSS with physical and behavioral health services across Medicare and Medicaid.

Washington state has a high-ranking,¹⁴ cost-effective FFS LTSS system delivering services that support individuals in the community over institutional care. The state’s contracted HIDE SNPs are increasingly coordinating with its Medicaid LTSS FFS providers.

The District of Columbia is building off existing success of contracting with D-SNPs to integrate Medicaid services into current D-SNP coverage and financing responsibilities. The District plans to release a competitive bid for comprehensive Medicaid benefits, inclusive of LTSS, for FBDE. Successful bidders will receive a per member per month (PMPM) capitation payment from the District to provide these benefits through their D-SNP. The District plans to contract with HIDE and FIDE-SNPs in in CY 2022.

District of Columbia – Building on the Strengths of its Medicaid and Medicare Delivery Systems

In addition to building on the strengths of its current Medicaid delivery system, officials looked to where FBDE individuals are currently enrolled. Approximately 11,000 of their FBDE population out of

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.

Engage stakeholders, including FBDE individuals and their families, D-SNP organizations, providers, and others, at the outset of planning for increased coordination and integration between Medicaid and D-SNPs

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 Plans¹⁵ 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 *exclusively* 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.

Establish strong state staff oversight and understanding of Medicare program benefits and administrative requirements, D-SNP model of care, and MA supplemental benefits

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.

Establish open, ongoing communication and build partnerships with D-SNPs in the state

The District of Columbia, Maine and Washington officials expressed the importance of establishing regular communication venues to build relationships and establish partnerships with D-SNP organizations.

After receipt of health plan responses to its 2019 HIDE SNP RFI, the District of Columbia established regular quarterly calls with all health plans. Calls have revealed interest in learning about and communicating with each other about D-SNPs. Maine holds quarterly meetings with all D-SNP organizations, expecting them to speak with each other even though they are competitors. Washington shared its success building communication pathways with D-SNP organizations by incorporating their participation in periodic all Medicaid health plan calls with the Washington Health Care Authority. D-SNP organizations are vocal participants and their inclusion served as a catalyst to greater engagement.

Maximize the new CMS 2021 standalone D-SNP hospital and skilled nursing facility admission data sharing requirements to support increased coordination around care transitions

The new CMS CY 2021 data sharing requirements that standalone D-SNPs notify the state Medicaid agency or its designee of hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk enrollees¹⁹ positions states to put processes in place to share critical information with LTSS FFS providers and HCBS waiver program care managers to support care transition planning.

Interviewees reported that the new data sharing requirements present an opportunity in support of a move forward with Medicare-Medicaid integration. Washington started its Medicare-Medicaid integration efforts with an FAI managed FFS demonstration integrating care for FBDEs individuals using Medicaid Health Homes.²⁰ The state updated SMACs with D-SNP organizations on an annual basis as required but did not view D-SNPs as a model to integrate care. The new CMS data sharing requirements were a catalyst to strengthen care coordination language in SMACs and take the next steps forward to partner with D-SNP organizations to better coordinate and integrate care for FBDE individuals.

States can include D-SNP SMAC provisions outlining processes for required data sharing with Medicaid to help ensure needed Medicaid HCBS services are in place and necessary medical appointments and follow-ups occur. These may include directing use of health information exchanges and sharing and coordinating information with Medicaid LTSS FFS providers and care managers.

The District of Columbia requires timely notification to a D-SNP member's Medicaid Health Home, elderly and physically disabled (EPD) waiver case manager, or other primary care provider within a designated timeframe for all planned and unplanned inpatient admissions to hospitals and SNFs and emergency department visits. The notification is to be facilitated by health information technology (HIT) or the DC health information exchange (DC HIE), as appropriate. The SMAC specifies that discharge planning and care transition protocols must be developed to maintain continuity of care including, but not limited to:

- 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 settings²¹

Maine CY 2021 SMACs direct D-SNP organizations to ensure timely notification of all admissions, discharges and transfers to a hospital or nursing facility *for all plan enrollees*. 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 2021 HIDE SNPs. HIDE SNPs report hospital and nursing facility 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 (AL TSA), if the member receives HCBS services. The state specifies coordination will include appropriate discharge planning for short-term and long-term hospital and institutional stays with services the individual receives from any other Medicaid MCO and in Medicaid FFS, including LTSS.²⁴

Introduce D-SNP organizations to Medicaid benefits by including coverage of certain benefits such as Medicaid agency cost sharing obligations in SMACs with D-SNPs

States can use the SMAC to require D-SNP organizations to provide Medicaid covered benefits. Alabama’s CY 2021 SMAC refers to these services as “wrap-around benefits.” They are Medicaid benefits or services included in the SMAC for Medicaid payment to and provision by the D-SNP. Alabama pays D-

SNPs a PMPM payment, and D-SNP organizations cover the Medicaid agency'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 individuals' positive experience having 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.

Maximize available CMS MMCO supports and communicate additional supports needed going forward

CMS MMCO provides technical assistance to states through the Integrated Care Resource Center (ICRC) to share best practices, facilitate peer training, and develop solutions to advance new care coordination models.* State officials interviewed indicated they benefited from receiving technical assistance through MMCO to advance their integration efforts. Washington engaged in multiple calls with the ICRC followed by monthly calls with MMCO staff. The District Columbia also has monthly calls with ICRC. Interviewees noted that calls with MMCO provide time to ask questions and receive validation of approaches to coordination and integration, which has been reassuring. One interviewee noted that in addition to these calls, although each state is proceeding with Medicare-Medicaid integration in their own way, they still recommend connecting with other states, particularly those that may be similarly situated in geography, population, and proceeding without MLTSS at the outset. MMCO may be able to help coordinate these calls.

*<https://www.integratedcareresourcecenter.com/>

As noted above, interviewees indicated the need for dedicated state staff. One interviewee noted MMCO technical assistance is very helpful, but their state is still in need of dedicated staff - states would benefit from federal assistance to support funding for devoted staff positions.

LOOKING FORWARD

States without separate Medicaid MLTSS programs have proceeded with increased Medicare-Medicaid coordination and integration with D-SNPs. Recent federal requirements support activities for all states to advance holistic and coordinated care for FBDE individuals. However, states need supports going forward. States can continue to work with and develop partnerships with D-SNP organizations to identify supports needed and move this important work forward.

APPENDIX A – ALABAMA, DISTRICT OF COLUMBIA, IDAHO, MAINE, AND WASHINGTON MEDICAID PROGRAM STRUCTURES FOR FBDEs

State	Medicaid Program Structure for FBDEs		
	<i>Acute/Primary Care</i>	<i>Behavioral Health</i>	<i>LTSS</i>
Alabama*	FFS	FFS	FFS
District of Columbia>	FFS	FFS	FFS
Idaho	MC in certain geographic areas where FIDE SNPs operate, otherwise FFS	MC in certain geographic areas where FIDE SNPs operate, otherwise FFS	MC in certain geographic areas where FIDE SNPs operate, otherwise FFS
Maine	FFS	FFS	FFS
Washington*^	MC	MC	FFS

FFS = fee for service

MC = managed care

*Program of All-Inclusive Care for the Elderly (PACE) is an option in limited geographic area(s). PACE is a capitated payment, provider-based program that uses a nationally recognized model of care that integrates Medicare and Medicaid benefits for eligible beneficiaries

>PACE Program in planning and development stage

^Washington operates a financial alignment initiative (FAI) managed FFS model demonstration program based on Medicaid Health Homes for FBDEs with certain chronic conditions in limited geographic areas. For this demonstration Washington and CMS entered into an agreement by which the state is eligible to benefit from a portion of savings from the demonstration designed to improve quality and reduce costs for both Medicare and Medicaid.

APPENDIX B – INTERVIEW LIST

<i>Name, Title</i>	<i>Organization</i>	<i>Interview Date</i>
District of Columbia		
Katherine Rogers, <i>Program Manager</i> katherine.rogers@dc.gov DaShawn Groves, <i>Lead Project Manager</i> Dashawn.groves@dc.gov	Department of Health Care Finance	11/5/20
State of Idaho		
Matt Wimmer, <i>Administrator</i> <i>Division of Medicaid</i> Matt.wimmer@dhw.idaho.gov	Idaho Department of Health and Welfare	3/18/20
State of Maine		
Paul Saucier, <i>Aging and Disability Director</i> <i>Office of Aging and Disability Services</i> Paul.saucier@maine.gov	Maine Department of Health and Human Services	11/23/20
State of Washington		
Alice Lind, <i>Manager,</i> <i>Grants and Program Development</i> alice.lind@hca.wa.gov Kelli Emans, <i>Integration Manager</i> Kelli.emans@dshs.wa.gov	Washington Health Care Authority	11/6/20

REFERENCES

¹ A D-SNP may meet the criteria for designation as a HIDE SNP if it covers, consistent with state policy, either (1) LTSS; or (2) Medicaid behavioral health services, under a state contract either directly with the legal entity providing the D-SNP; with the parent organization of the D-SNP; or with a subsidiary owned and controlled by the parent organization of the D-SNP. Sharon Donovan, Dual Eligible Special Needs Plans, Additional Guidance on CY2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs), Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, Memorandum, January 17, 2020.

² A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization to provide Medicaid benefits, including long-term services and supports (and behavioral health benefits, consistent with state policy. Sharon Donovan, Dual Eligible Special Needs Plans, CY2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs), Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, Memorandum, October 7, 2019.

³ Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019, Prepared by the Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, November 2020.

⁴ People Dually Eligible for Medicare and Medicaid, Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, Fact Sheet, March 2020.

⁵ Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019, Prepared by the Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office, November 2020.

⁶ Eligibility for the federal Medicare program is usually tied to age (65 and older) or long-term disability. Eligibility for Medicaid, a joint federal-state program, is generally tied to income and additional functional criteria for receipts of LTSS. Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches, S. Barth, et. al., Health Management Associates Report to the Medicaid and CHIP Payment and Access Commission, March 2019.

⁷ Partial-benefit dually eligible individuals qualify for Medicaid assistance limited to payment of Medicare premiums and in some cases, Medicare cost sharing. Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches, S. Barth, et. al., Health Management Associates Report to the Medicaid and CHIP Payment and Access Commission, March 2019.

⁸ Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches, S. Barth, et. al., Health Management Associates report to the Medicaid and CHIP Payment and Access Commission, March 2019.

⁹ Ibid.

¹⁰ Centers for Medicare & Medicaid Services, Medicare and Medicaid Coordination Office, Preliminary Medicare COVID-19 Data Snapshot, April 2021, <https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>

¹¹ Based upon data submitted to Centers for Medicare & Medicaid Services May 9, 2021. Data.CMS.Gov, COVID-19 Nursing Home Data, [Link to CMS Data](#)

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 Services and Supports State Scorecard ranks Washington’s LTSS system number 2 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 2019 RFI indicates “MMP health plans operating under the Capitated Model of CMS’ Financial Alignment Initiative deliver an integrated set of services for dually eligible individuals and incentivize more person-centered models of care.” 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, Narda, Jonathan Blum, Eric Hammelman, and Mary Hsieh. *Medicare Advantage Supplemental Benefit Flexibilities: Adoption of and Access to Newly Expanded Supplemental Benefits in 2020*, Issue Brief #1, Health Management Associates, May 2020.

¹⁸ MA plans may tailor these benefits to enrollees with specific chronic diseases and/or conditions. They may offer these benefits in a non-uniform approach to a subset of enrollees and tailor offerings to address gaps in care and improve overall healthcare outcomes in a target geography.

¹⁹ States are given flexibility to:

- Identify group(s) of high-risk full-benefit dual eligible individuals
 - Outline the manner of notification
 - Designate what entity receives the notification
- CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs), Medicare-Medicaid Coordination Office Memorandum to Dual Eligible Special Needs Plans, October 7, 2019.

²⁰ Section 2703 of the Affordable Care Act of 2010 created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. Using a whole person philosophy, Health Homes providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Medicaid.gov: <https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html>

²¹ Cooperative Agreement for MA Organizations Offering D-SNPs in the District of Columbia, CY 2021. (District of Columbia SMAC for CY 2021)

²² Memorandum of Understanding Between the Department of Health and Human Services and D-SNPs, CY 2021. (Maine SMAC for CY 2021)

²³ Ibid.

²⁴ State Medicaid Agency Contract between Washington State Health Care Authority and D-SNPs, CY 2021.

²⁵ Alabama calendar year 2021 SMAC.