manatt CHCS Center for Health Care Strategies, Inc.

Integrating Medicare-Medicaid Benefits for Dually Eligible Beneficiaries: A Strategy for Strengthening Long-Term Services and Supports

By Stephanie Anthony, Arielle Traub, Sarah Lewis, and Cindy Mann, Manatt Health; Alexandra Kruse, Michelle Herman Soper, and Stephen A. Somers, PhD, Center for Health Care Strategies

For dually eligible beneficiaries, Medicare pays for almost all hospital, physician, and prescription drug services, while Medicaid pays for most institutional and community-based long-term services and supports (LTSS) and some behavioral health services. Some services, like skilled nursing facility and home health services, are covered by both Medicare and Medicaid at different points. As a result, Medicare and Medicaid historically have had incentives and opportunities to shift beneficiaries—and costs—between care settings and the two programs. Having two separate insurers for their physical health and LTSS needs also creates tremendous confusion for dually eligible beneficiaries, who traditionally have two or three insurance cards and must navigate two distinct and complex provider delivery systems and grievance and appeals processes, among others. The fragmentation and misaligned incentives between Medicare and Medicaid may lead to discontinuity and duplication of care, poor health outcomes, and stressful beneficiary experiences.

Population characteristics and utilization patterns of the more than 12 million dually eligible beneficiaries support the need for a more coordinated system of care.[1] Dually eligible beneficiaries are more likely than other Medicare beneficiaries to experience chronic, co-morbid physical and mental health conditions—with 68 percent of dually eligible beneficiaries have three or more chronic conditions and 41 percent have at least one mental health diagnosis.[2] They also are more likely than other Medicare beneficiaries to use nursing facility services or other LTSS, and visit the emergency department.[3]

Additionally, although dually eligible beneficiaries represent only 20 percent of Medicare enrollment and 15 percent of Medicaid enrollment, they account for 34 percent and 32 percent of program expenditures respectively.[4] Dually eligible beneficiaries are more than twice as likely to use LTSS compared to other Medicaid beneficiaries, and more than five times as likely compared to other Medicare beneficiaries.[5] Notably, 62 percent of Medicaid expenditures ($91.8 billion) for dually eligible beneficiaries were for LTSS in 2011.[6] Aligning the financing and delivery of services between Medicare and Medicaid for dually eligible beneficiaries presents an opportunity to improve care and lower costs for this high-need, high-cost population by creating incentives to deliver care in the right settings and at the right time.

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million Americans to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than $154 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This LTSS reform strategy is part of a larger toolkit, ***Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment***, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.

To learn more and view the full toolkit, visit **www.chcs.org/ltss-toolkit**.

Made possible through support from The SCAN Foundation and the Milbank Memorial Fund.

Updated March 2019

Strategy Description

States are building upon their Medicaid managed long-term services and supports (MLTSS) programs to align Medicare and Medicaid service delivery for the majority of Medicaid MLTSS beneficiaries who are also Medicare-eligible. While there are a few different approaches to aligning Medicare and Medicaid, the underlying goal is to better coordinate care and streamline access to services, provider networks, and administrative processes across the programs. In addition, states are very interested in sharing any savings resulting from integrated care delivery with federal partners, which could address potential state concerns that increased access to LTSS and behavioral health interventions that help delay or prevent hospital and emergency department use would only benefit Medicare. However, opportunities for shared savings have been limited to the federal Financial Alignment Initiative ("duals demonstration") to date.

A History of Integrating Medicare and Medicaid for Dually Eligible Beneficiaries

States and their federal partners have been actively pursuing a more integrated system of care for dually eligible beneficiaries for over two decades. The Program of All-Inclusive Care for the Elderly (PACE), which became a formal waiver option for states to pursue in 1990, was the first avenue for integrating Medicare and Medicaid for dually eligible beneficiaries. Nearly a decade later, three states participated in a Medicare-Medicaid demonstration program as another early effort to integrate care outside of PACE: Minnesota (Minnesota Senior Health Options or MSHO), Massachusetts (Senior Care Options or SCO), and Wisconsin (Wisconsin Family Care Partnership).

In 2006, these demonstrations transitioned into state contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), which was a new Medicare health plan option that combined Medicare and Medicaid benefits for dually eligible beneficiaries. However, in part because health plans were required to have two separate contracts for Medicare and Medicaid, these arrangements only allowed states to achieve a certain level of integration.

In 2010, the ACA established the Medicare-Medicaid Coordination Office (MMCO) at CMS, also referred to in statute as the "Federal Coordinated Health Care Office"). MMCO launched the federal Financial Alignment Initiative (i.e., "duals demonstrations") in 2011 to test new approaches to alignment between the Medicare and Medicaid program. In the years since the office was established, it has also supported greater state activity in expanding contracting with Medicare Advantage D-SNPs. States' managed care contracts with Medicare-Medicaid Plans (via the Financial Alignment Initiative and D-SNPs arrangements have made it easier to align many or some administrative requirements, care management models, beneficiary materials, covered benefits, and financing. In February 2018, the Bipartisan Budget Act (BBA) preserved D-SNPs as a permanent feature of the Medicare program and created new opportunities to advance integration of care dually eligible beneficiaries. The BBA included significant provisions to more effectively coordinate high-quality care, such as instituting new D-SNP integration-focused requirements (e.g., directing CMS to develop unified grievance and appeals processes and establish new minimum standards of Medicaid integration for D-SNPs), and expanding supplemental and telehealth benefits. The BBA also designates MMCO as the key point of contact for states to address Medicare and Medicaid misalignments and promote integration of D-SNPs and Medicaid managed care moving forward.

Still, there are factors that can affect growing enrollment in these integrated arrangements, including CMS' prohibition on requiring Medicare beneficiaries to enroll in managed care, challenges with provider resistance to managed care, a need for more beneficiary education about the benefits of integrated care, and challenges with setting rates that reflect a high-need, complex population. States continue to explore creative strategies for best aligning these programs for dually eligible beneficiaries.

Sources: "History." National PACE Association. Available at: https://www.npaonline.org/pace-you#History.; H.R. 1892. Bipartisan Budget Act of 2018, 1115th Congress Public Law No. 115-123. Congress.gov. Available at: https://www.congress.gov/bill/115th-congress/house-bill/1892/text.; and Integrated Care Resource Center. "Comments Invited on D-SNP provisions of the Bipartisan Budget Act of 2018." March 2018. Available at: https://www.integratedcareresourcecenter.com/pdfs/2018_03_14_Comments_Invited_on_D-SNP_provisions_of_the_Bipartisan_Budget_Act_of_2018.pdf.

Implementation Mechanisms

States are aligning Medicare and Medicaid in different ways to better coordinate care delivery for people who are covered by both programs.[7] The most integrated models used by states include the provider-led PACE program and the state-led demonstrations under the Financial Alignment Initiative; however, the opportunity for states to pursue a financial alignment demonstration is now closed. The most promising mechanism available to states at this time to better integrate the delivery of Medicaid benefits with Medicare is through D-SNP contracting, particularly for states developing an MLTSS program. All D-SNPs must have signed contracts with the state Medicaid agency in any state they operate that must meet minimum requirements.[8] However, minimum requirements do not achieve a high level of integration or alignment, and the degree to which states can achieve integrated, aligned care through the D-SNP platform depends on state investments in D-SNP contracting and program oversight. See *Dual Eligible Special Needs Plans and Fully Integrated Models* below.

Dual Eligible Special Needs Plans and Fully Integrated Models

D-SNPs are a specialized type of Medicare Advantage managed care plan that offer a higher level of integration than regular Medicare Advantage plans or traditional Medicare fee-for-service.* D-SNPs enroll dually eligible beneficiaries only, are required to have a care management model uniquely focused on meeting this population's needs, and must either arrange for or provide enrollees with Medicaid benefits.**

When Congress first authorized them in the Medicare Modernization Act of 2003, D-SNPs were not required to have any formal relationship with state Medicaid agencies. However, to facilitate coordination of Medicare and Medicaid services, the Medicare Improvements for Patients and Providers Act of 2008—as amended by the ACA—required all D-SNPs to have contracts with the states in which they operate. This D-SNP contracting authority can be used by states to control the degree of Medicare-Medicaid integration attained through D-SNPs. To launch an integrated program using D-SNPs, states must have an interest in using their D-SNP contracting authority to improve care for dually eligible individuals, and health plans need to be interested in operating these products within the state.

Historically, D-SNP contracts had to meet minimum requirements for Medicare and Medicaid coordination. On November 1, 2018, CMS published a notice of proposed new rulemaking for Medicare Advantage and Part D that would implement provisions of the Bipartisan Budget Act of 2018 related to integration of Medicare and Medicaid services and unification of Medicare and Medicaid grievance and appeals procedures by D-SNPs. The proposed regulations include significant changes to the minimum contract requirements for all D-SNPs. To meet these coordination standards once they are established, D-SNPs must:

- Contract with the state to provide Medicaid LTSS and/or Medicaid behavioral health benefits; and/or
- Share information with the state on care transitions, particularly for high-risk individuals. Examples of information sharing could include D-SNP working with the state Medicaid agency to establish a process to share information with the state or the state's designee (such as a Medicaid managed care organization) on hospital and skilled nursing facility admissions of high-risk individuals who are enrolled in the D-SNP.

*For details on D-SNPs and FIDE SNPs, and the CMS rules governing them, see the CMS Medicare Managed Care Manual, Chapter 16b (Rev.123, 08-19-16). Available at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf. CMS published the notice of proposed rulemaking in the *Federal Register* on November 1, 2018.

** See Public Law 110-275, Section 164(c)(4) and 42 CFR §422.107.

A proposed rule, which promulgates the D-SNP integration provisions of the Bipartisan Budget Act of 2018, will increase the minimum requirements for coordination to some degree.[9] States will continue to have broad discretion to add additional D-SNP requirements that can increase integration and alignment, such as care coordination, opportunities for aligned enrollment in both Medicare and Medicaid products operated by the same health plan, data sharing and reporting, and other areas that focus on integrating Medicare and Medicaid benefits and administrative processes. States may also be able to work with D-SNPs to influence product design particularly when a state is contracting with the D-SNP to also offer Medicaid benefits. Strategic D-SNP program design could include working with D-SNPs to adopt enrollment mechanisms that can help grow enrollment or assessing opportunities to tailor D-SNP benefit offerings such as cost sharing coverage or supplemental benefit offerings. For the latter, it is notable that the Bipartisan Budget Act of 2018 also expands what scope of supplemental benefits that Medicare Advantage plans can offer to chronically ill enrollees to include non-medical benefits that support functional status, that have a "reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee."[10]

The two D-SNP contracting options with the greatest degree of integration available to states today are:

1. **Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)**: FIDE SNP, a special type of D-SNP created under the ACA, is a fully integrated Medicare and Medicaid product offered by a single health plan. D-SNPs must meet certain requirements and get CMS approval to achieve FIDE SNP status — namely, the state D-SNP contract must be risk-based and cover specified Medicaid primary, acute care, and LTSS benefits to the extent required by state policy, have an aligned Medicare and Medicaid care management model, and align certain administrative functions. FIDE SNPs that serve a high proportion of frail, high-risk beneficiaries may also be eligible for an additional risk-adjustment payment, similar to PACE, to encourage plans to participate. As of December 2018, there were ten states operating FIDE SNPs, serving 181,844 beneficiaries: Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New York, New Jersey, Tennessee, and Wisconsin.[11] States may require D-SNPs that wish to operate in their state to achieve a FIDE SNP designation. The presence or absence of FIDE SNP status in a state's integrated program is dictated by many factors, including: (1) current LTSS integration status and goals for increasing integration within the delivery system; (2) desire to contract with D-SNPs to provide Medicaid benefits; and (3) potentially using FIDE-SNPs as a mechanism for promoting alignment into plans that offer all or most benefits. However, as noted below, states that focus on aligning D-SNP and Medicaid health plans as well as robust state contracting and oversight can achieve a high degree of alignment without the FIDE SNP designation.

2. **Aligned D-SNP**: States may require health plans that offer D-SNPs to offer "companion" Medicaid MLTSS products as a condition of allowing D-SNPs to participate in the state's market. Similarly, states can also require Medicaid MLTSS health plans to operate a companion D-SNP. States may make enrollment into capitated Medicaid managed care plans mandatory for all or some dually eligible beneficiaries (e.g., LTSS users), but cannot require dually eligible beneficiaries to enroll into Medicare managed care. However, having the option to enroll in the same health plan for both programs provides an opportunity for more integrated care. These models are usually most effective when a high percentage of beneficiaries enroll in the same, aligned health plans. States face challenges when beneficiaries enroll in a D-SNP

sponsored by one entity and a Medicaid plan operated by a competing entity, likely reducing care coordination and increasing administrative complexity. The extent to which these programs are aligned depends on what the state requires in its contracts including whether the state requires that the population eligible for the D-SNP matches the population eligible for the MLTSS program. Some aligned D-SNPs resemble FIDE SNPs with regard to their level of care integration, while others are much less coordinated. Under both FIDE SNP and aligned D-SNP models, state decisions regarding which populations will be enrolled have a significant impact on the level of administrative alignment that can be achieved.

Results to Date

Several evaluations found positive impacts on outcomes from enrollment in integrated care programs. CMS reported statistically significant improvements in certain Healthcare Effectiveness Data and Information Set (HEDIS) measures among individuals participating in D-SNPs.[12] Another study found that dually eligible beneficiaries enrolled in coordinated D-SNPs had fewer emergency department admissions, shorter hospital stays, and increased use of preventative care.[13] A 2012 independent study of Arizona's D-SNP program compared its 60,000 dually eligible beneficiaries in managed care to those in traditional Medicare fee-for-service and found that the aligned beneficiaries demonstrated a 31 percent decrease in hospitalizations, 43 percent fewer days in the hospital, nine percent lower emergency department use, and 21 percent lower readmission rate.[14] An evaluation of Minnesota Senior Health Options (MSHO) D-SNPs found that MSHO beneficiaries, when compared to dually eligible beneficiaries in a Medicaid-only program, were 48 percent less likely to have a hospital stay, 13 percent more likely to receive HCBS, and six percent less likely to have an emergency department visit. They were also more likely to access primary care services which could support state efforts to improve coordination of care and community integration for LTSS users.[15]

States engaging in Financial Alignment Initiative demonstrations reported early signs of improvements in care coordination, expanded beneficiary safeguards, and preliminary evidence of some cost savings.[16] Notably, early results from Massachusetts' financial alignment demonstration ("One Care") found that One Care beneficiaries had a lower 30-day readmission rate compared to non-beneficiaries.[17]

In November 2018, CMS released several new reports with state findings from the Financial Alignment Initiative demonstrations.[18] These reports include the first evaluation reports for the demonstrations in California, Illinois, and Ohio, and the second evaluation reports for the demonstrations in Minnesota and Washington. Despite some limitations, including timeliness (the first year reports cover 2014 to 2015) and variations in the availability of Medicare and Medicaid data, the reports describe some encouraging results. For example, demonstrations in Illinois, Ohio, and Washington showed significant decreases in inpatient utilization of 15 percent, 21 percent and five percent, respectively. Future reports will contain that information as well as additional information on enrollee satisfaction and experience of care.

Key Lessons

- **Provide ongoing, targeted beneficiary education.** States that have implemented managed care-based integrated care models report the importance of clearly articulating information to dually eligible beneficiaries about different enrollment options. Two particularly important areas to emphasize are: (1) the value to individuals who enroll of better care coordination; and (2) individuals have the option to opt out of any Medicare managed care arrangement. Some states, such as California and Massachusetts, have pilot-tested draft marketing materials with beneficiaries before release to ensure they are clear and understandable. Arizona permits D-SNPs to send marketing materials only to those individuals enrolled in the health plan's own Medicaid product to avoid confusion among beneficiaries and to attempt to prevent enrollment into different health plans for Medicare and Medicaid services. Massachusetts embarked on a comprehensive beneficiary engagement process as part of its One Care demonstration development that included: (1) focus groups with beneficiaries to identify the key impacts of Medicaid and Medicare fragmentation; (2) the creation of a One Care implementation council, an advisory group in which consumers comprise of more than half the members that monitors program implementation and serve as an early warning system for systemic issues; and (3) hiring beneficiary consultants to serve on topical design workgroups.

- **Engage providers so they understand and are trained in care philosophies and models relevant to these populations.** States recognize that provider engagement and buy-in is critical to the success of launching new, managed care-based integration models for dually eligible beneficiaries. Effective provider engagement can help to build provider network capacity and address a potential lack of provider willingness to participate in managed care. Providers are generally a trusted source of health care information for their patients, and educating them positions them to facilitate beneficiary enrollment in the program and connect beneficiaries to helpful resources and services. States can improve engagement levels by including providers in the design and implementation of the program from the outset, and offering training and technical assistance to providers.

- **Collect good data for planning/design, risk adjustment, resource allocation, monitoring, and evaluation purposes**. One benefit of an integrated Medicare-Medicaid platform is the potential to collect data on both Medicare and Medicaid utilization to have a complete clinical profile for each beneficiary. Many states either do not have access to or the analytic capabilities to use Medicare data, but states can use D-SNP contracts to require health plans to share data in different forms. Data can support many important functions. For example, states can use eligibility data to facilitate enrollment into integrated products. New Jersey is building the capacity needed to assess FIDE SNP impacts and help build evidence of the effectiveness of aligned D-SNP/MLTSS plans. It will use a combination of Medicare claims and health plan encounter data to measure effects on coordination and quality of care.

- **Be flexible with program requirements to the extent possible**. Beneficiaries and providers report that care management program flexibility is needed to effectively adapt the program to beneficiaries' changing needs and providers' limited availability. Several states participating in a financial alignment demonstration revised their original care management models, such as their interdisciplinary care team requirements, to better meet beneficiaries and providers' needs. In addition, states that have launched integrated or aligned health plans have considered various ways to encourage beneficiaries to enroll in the same health plan for both Medicaid and Medicare service delivery and integrating LTSS benefits into D-SNP contracts. States have been flexible in how they have approached these alignment efforts, paying attention to a number of factors including the health plan landscape in their states, and where beneficiaries currently receive care.

- **Set sufficient reimbursement rates.** Given the high needs and costs associated with this population, it is important for states to set sufficient rates that ensure health plan participation and a strong provider network and beneficiary access. Many states use rate cells or other risk stratification mechanisms to tier payments for beneficiaries based on acuity or LTSS functional needs and/or settings of care to account for the diversity of health care conditions and care needs. Note that states do not have authority over the Medicare rate component for dually eligible beneficiaries.

Case Studies

Arizona and New Jersey – Two Paths toward Alignment. Arizona has operated its MLTSS program, Arizona Long Term Care System (ALTCS), since 1989 under 1115 waiver authority, relying on competitively selected health plans to deliver all Medicaid services, including LTSS. Arizona enrolls all beneficiaries, including older adults and those with physical or developmental disabilities who need LTSS. Arizona requires all ALTCS plans to offer D-SNP products, and leverages Medicaid authority and D-SNP contract requirements to promote aligned enrollment for dually eligible beneficiaries, including those eligible for the ALTCS program.[19] To promote aligned enrollment, Arizona uses authority under its 1115 waiver to automatically assign eligible populations to Medicaid health plans. The state developed multiple pathways for beneficiary enrollment into aligned health plans, including encouraging the enrollment of ALTCS beneficiaries into the companion Medicare D-SNP operated by their Medicaid health plan. To support this, the state sends periodic mailings to ALTCS beneficiaries to inform them of the benefits of being enrolled in the same health plan for Medicare and Medicaid. Arizona also periodically reassigned beneficiaries' Medicaid acute care health plan to align with their enrolled D-SNP, thus encouraging coordination of care. This may include beneficiaries who could benefit from enhanced care coordination due to subsequent LTSS eligibility (i.e., "pre-duals"). Lastly, Arizona also limits D-SNP marketing activities by only allowing direct marketing to those individuals enrolled in the health plan's own Medicaid product.

Although New Jersey only launched its MLTSS program in July 2014, it has been successful in creating a robust FIDE SNP program in a short amount of time. The state began contracting with D-SNPs in 2012 prior to the launch of its MLTSS program. From the program's inception, New Jersey focused on improving care integration and administrative alignment.

New Jersey currently requires D-SNPs to be approved by the state as standard Medicaid health plans, and as of January 2016, the program is a fully integrated model now offering MLTSS and expanded behavioral health and substance use disorder treatment benefits. New Jersey uses its state plan and 1115 waiver authority to auto-assign beneficiaries who select FIDE SNP enrollment to the same organization's Medicaid health plan. This ensures that both beneficiaries and providers have a more seamless experience as they interact with a single health plan. The strategic design decision allows for the greatest level of clinical, financial, and administrative integration; it mirrors the approach Minnesota took with the MSHO program and draws upon the approach that CMS took with the Financial Alignment Initiative demonstrations. New Jersey's decision to invest in D-SNP contracting prior to launching MLTSS was driven by the opportunity to share in savings generated by D-SNPs as a result of enhanced Medicare quality payments available at that time, and afforded the state time to acquire experience in integrating Medicare and Medicaid services for full benefit dually eligible beneficiaries before attempting to deliver MLTSS under an integrated model.

Key aspects of Arizona and New Jersey's approaches to integrating Medicare-Medicaid benefits include:

- **Default Enrollment.** Default enrollment (referred to as "seamless conversion" prior to 2018) is a federal statutory and regulatory enrollment mechanism under the Medicare Advantage program that allows a D-SNP to facilitate enrollment into managed care arrangements in which dually eligible individuals receive all of their Medicaid and Medicare services through the same organization. With state approval and involvement, D-SNPs may automatically enroll Medicaid beneficiaries who are newly eligible for Medicare (i.e., just turning age 65, or at the end of the two-year Social Security Disability Insurance waiting period), if they are currently enrolled in that health plan's companion Medicaid product and receive adequate notice of their right to opt-out of enrollment at specific points.[20,21] Arizona required each of its D-SNPs to request CMS approval to seamlessly convert existing Medicaid health plan beneficiaries into a companion D-SNPs product. Arizona implemented default enrollment in partnership with its D-SNPs in 2016 and is successfully enrolling over 400 newly-eligible Medicare beneficiaries into aligned D-SNPs each month. To use this authority to promote aligned enrollment, Arizona provides data to D-SNPs to help them identify those enrollees in their Medicaid-only health plan who are about to become Medicare-eligible. The state also issued a letter of support for D-SNP health plans' default enrollment application proposals to CMS and found that state readiness review prior to launching of default enrollment is essential. New Jersey continues to be interested in pursuing conversations around implementing default enrollment. The state proposed requesting the authority to use default enrollment as an enrollment strategy under its 1115 Comprehensive Demonstration Waiver renewal, but removed the proposal in response to stakeholder comment and CMS' suspension of any new default enrollment proposals.[22]
- **Building Medicare and D-SNP Contracting Expertise.** After launching its MLTSS program, New Jersey made its D-SNPs incrementally responsible for the provision of both facility- and community-based LTSS. The state's pre-MLTSS investment in D-SNP contracting and its phased-in approach to carving in LTSS benefits gave it a greater understanding of complex Medicare regulations and policy, as well as the intersections of Medicare and Medicaid benefits that can be challenging to administer.

Aligning Administrative Processes for Minnesota's Senior Health Options (MSHO) Program Beneficiaries. Building on a long history of health care innovation for older adults, the MSHO D-SNP-based program was established in 1997 to serve dually eligible individuals age 65 and over and currently operates under 1915(a)/(c) combination authorities. In 2013, the state signed an agreement with CMS to operate an alternative alignment demonstration program, the *Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience* that uses MSHO's FIDE SNPs to test new approaches to integrating and aligning certain administrative functions in Medicare and Medicaid for MSHO beneficiaries.

Minnesota found the enrollment design for integrated programs to be of fundamental importance. It uses voluntary Medicaid enrollment coupled with strategic D-SNP contracting to achieve the greatest degree of administrative alignment possible. The state matches the categories of dually eligible beneficiaries enrolled in the D-SNP to those enrolled under the MSHO program, which is limited to full benefit dually eligible beneficiaries.[23] The state also developed a single enrollment process across both Medicare and Medicaid by processing enrollments for most of the D-SNPs operating in the state. This allows for streamlined enrollment and improved alignment of appeals, marketing, and beneficiary and provider notifications when one integrated set of benefits is delivered. Other states can exercise similar discretion as to which groups to include under both the Medicare D-SNP and Medicaid managed care contracts.

Minnesota's demonstration also has allowed the state to advance integration by testing new provider network standards and review methods. State and federal officials report that the joint network adequacy review process allows them to develop better, more consumer-friendly network standards. Minnesota's FIDE SNPs have noted that the trial network adequacy review process more accurately reflects the needs of dually eligible populations. Although this process is limited to Minnesota currently, other states are eager to jointly review network adequacy as well.

ENDNOTES

[1] Centers for Medicare & Medicaid Services. "People Enrolled in Medicare and Medicaid." February 2018. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

[2] *Ibid*.

[3] The Kaiser Commission on Medicaid and the Uninsured. "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS." The Henry J. Kaiser Family Foundation, August 2011. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8215.pdf.

[4] Medicaid and CHIP Payment and Access Commission. Medicare Payment Advisory Commission. "Beneficiaries Dually Eligible for Medicare and Medicaid." January 2018. Available at: https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf.

[5] Congressional Budget Office. "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies." June 2013. Available at: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf.

[6] The Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long-Term Services and Supports: A Primer." The Henry J. Kaiser Foundation, December 15, 2015. Available at: https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[7] State of North Carolina, Department of Health and Human Services, Division of Health Benefits. "Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries." N.C. Sess. Law 2015-245, § 5(11). January 31, 2017. Available at: https://files.nc.gov/ncdhhs/documents/files/DHHS-NC-Dual-Eligibles-JLOC-Report_SL2015-245_2017-01-31.pdf.

[8] 42 CFR §422.107. Centers for Medicare & Medicaid Services. U.S. Department of Health and Human Services. Available at: https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec422-107.pdf.

[9] 42 CFR § 422. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021". Centers for Medicare & Medicaid Services. Federal Register Proposed Rules. November 1, 2018. Available at: https://www.govinfo.gov/content/pkg/FR-2018-11-01/pdf/2018-23599.pdf

[10] Bipartisan Budget Act of 2018, Pub. L.115- 123(2018).

[11] Better Medicare Alliance. "Medicare Advantage Special Needs Plans." July 2017. Available at: www.bettermedicarealliance.org/sites/default/files/2017-07/BMA_SNP_IssueBrief_2017_07_17.pdf.

[12] National Committee for Quality Assurance. "Medicare Special Needs Plans Performance Results: HEDIS 2015." Centers for Medicare & Medicaid Services, November 30, 2015. Available at: https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/2015-HEDIS-Report.pdf.

[13] V. Murugan, E. Drozd, K. Dietz. "Analysis of Care Coordination Outcomes / A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries." Avalere Health, July 2012. Available at: http://avalere.com/research/docs/20120627_Avalere_Mercy_Care_White_Paper.pdf.

[14] *Ibid*.

[15] W. Anderson, Z. Feng, and S. Long. "Minnesota Managed Care Longitudinal Data Analysis." Office of the Assistant Secretary for Planning and Evaluation. March 31, 2016. Available at: https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis.

[16] B. Chernof. "Perspectives: Good Start, Now Get to Goal—Lessons Learned from California's Duals Demonstration." The SCAN Foundation, August 2016. Available at: http://www.thescanfoundation.org/perspectives-good-start-now-get-goal-lessons-learned-californias-duals-demonstration.

[17] "Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare". Prepared for Centers for Medicare & Medicaid Services. September 1, 2016 (Updated July 18, 2017), Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf

[18] For more information about the evaluation reports, refer to: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html.

[19] Arizona also integrates physical and behavioral health care for Medicaid beneficiaries with serious mental illness through contracts with Regional Behavioral Health Authorities (RBHAs). To support the state goal to further integration of service delivery for dually eligible individuals including those with serious mental illness, the RBHA contractors are also required to operate companion D-SNPs.

[20] See 42 CFR 422.66 for regulatory guidance related to coordination of enrollment and disenrollment through MA organizations. CMS lifted a temporary moratorium implemented on October 21, 2016 on approval of new requests to conduct seamless enrollment from all MA health plans, including D SNPs, in August 2018 under 42 CFR 422.66(c)(2). . "Seamless enrollment of individuals upon initial eligibility for Medicare," (10-21-16 memo). Retrieved from https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/HPMS_Memo_Seamless_Moratorium.pdf

[21] In October 2016, following inquiries about how health plans are using this mechanism and related beneficiary protections, CMS placed a temporary moratorium on new health plan approvals for seamless conversion while it reviews current policies, although already-approved health plans were allowed to continue. In August 2018, CMS lifted the moratorium for eligible D-SNPs pending CMS approval under 42 CFR 422.66(c)(2), effective October 1, 2018. "Default Enrollment Option for Newly Medicare Advantage Eligible Medicaid Managed Care Plan Enrollees (formerly known as "Seamless Conversion Enrollment")". CMS. August 31, 2018. Available at: https://www.integratedcareresourcecenter.com/sites/default/files/CY%202019_Default%20Enrollment%20Transition%20Guidance_8-29-18.pdf.

[22] Interview with New Jersey, October 12, 2017

[23] State Medicaid agencies are required to specify which dually eligible beneficiaries can be enrolled in D-SNP contracts.