BRIEF

RESOURCES FOR INTEGRATED CARE
Resources for Plans & Providers for Medicare-Medicaid Integration

Preparing to Support Long-Term Services and Supports (LTSS) Needs

Long-Term Services and Supports (LTSS) encompass a broad range of services and supports designed to help older adults and people with disabilities with everyday activities in institutional settings, such as nursing facilities, or in home and community-based settings. Due to the predicted growth in the population eligible for LTSS, states continue to explore ways to reduce budget risk, improve the delivery of services, and meet individuals' preferences to live in their homes and communities.[1] Increasingly, states are looking to health plans to shoulder the responsibility to manage the administration and delivery of LTSS. This opportunity presents challenges for health plans unfamiliar with the LTSS landscape – a landscape that includes the ever-growing provision of home and community-based services (HCBS). HCBS may include services, such as chore or homemaker services, personal care, meals, or transportation. Health plans will need to contract with these providers and many others, to ensure that the full range of Medicaid services covered in the state are available to the plan's members. Provider contracting is just one of many factors a health plan would need to evaluate as they look to support a state's LTSS population. This brief provides key considerations for understanding a state's LTSS program priorities, assessing plan members' LTSS needs, and ensuring the delivery of person-centered care.

Key Considerations

Understand the State's Priorities

As of 2021, 24 states operate MLTSS;[2] each with their own unique system based on federal regulations, state goals, and strategies. Any state that pursues MLTSS will build their system in accordance with their own priorities. For example, states may carve out institutional care, specific services like behavioral health, pharmacy, and dental services, or HCBS for Intellectual and Developmental Disabilities (I/DD) from managed care organizations' (MCO) contracts.[3] Additionally, the state may choose a non-MLTSS model to achieve its LTSS program goals. It is important for health plans to understand their state's priorities and policies (e.g. the use of in-lieu-of services, value-added opportunities, the role of Electronic Visit Verification (EVV) to help the health plan understand their role in the state's goals and priorities.

[1] Davis, M. R. (2021). Despite Pandemic, Percentage of Older Adults Who Want to Age in Place Stays Steady: New AARP Survey Reveals Older Adults Want to Age in Place. AARP. Retrieved from https://www.aarp.org/home-family/your-home/info-2021/home-and-community-preferences-survey.html.
[2] Medicaid and CHIP Payment and Access Commission. (2022). *Managed Long-Term Services and Supports*. Retrieved from https://www.macpac.gov/subtopic/managed-long-term-services-and-supports/.
[3] Rudowitz, R., & Hinton, E. (2020). 10 Things to Know about Medicaid Managed Care. Retrieved from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

Understand the Intersection with Medicare

In 2021, there were more than 12 million individuals dually enrolled in Medicare and Medicaid.[4] Individuals that are enrolled in both Medicare and Medicare are referred to as dually eligible individuals. Dually eligible people tend to report having worse health status and more complex medical and social needs than Medicare-only members.[5] The negative health outcomes that dually eligible members face are exacerbated by the fragmented experience members can undergo from enrollment in two systems (Medicare and Medicaid) that were not designed to work together.[6] To better serve dually eligible members, health plans can identify which members are dually eligible, understand what type of dually eligible coverage is outlined in their contract with the state Medicaid agency, develop communication and engagement strategies for helping members navigate Medicare-Medicaid systems, ensure providers understand the needs of the dually eligible population, and understand the state's priorities in Medicare-Medicaid integration. For a brief overview of the different Medicare-Medicaid programs, see the Key Programs Serving Dual Eligibles Guidebook.

Understand the Populations You Serve

The LTSS needs of members vary depending on factors such as age, physical, intellectual and developmental disabilities, mental health condition, and social determinants of health (SDOH). SDOH includes factors, such as socioeconomic status, education, neighborhood, physical environment, employment, and social support networks.[7] Beginning in 2024, dual-eligible special needs plans (D-SNPs) are required to include one or more questions in health risk assessments (HRAs) that address key SDOH: housing, food security, and transportation. [8] The goal is to help support plans' efforts in consulting their enrollees on unmet social needs as part of developing care plans that can connect enrollees to LTSS. Individual needs also depend on the types of family or informal caregiver supports available to members. The Family Caregiving Advisory Council, established by the Recognize, Assist, Include, Support, & Engage (RAISE) Caregivers Act of 2017, (Public Law 115-119) published the RAISE Family Caregivers Act Report that outlines recommendations for improving the experiences of the nation's family caregivers. One of the recommendations includes "engag[ing] family caregivers through the use of evidence supported and culturally sensitive family caregiver assessments to determine the willingness, ability and needs of family caregivers to provide support."[9] In addition to unmet social needs, the assessment process can identify barriers to care and is often used to stratify health plan members into risk levels for care coordination purposes and ensure that members are receiving the care they need.

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[4] Centers for Medicare & Medicaid Services. (2021). *FY 2021 Report to Congress*. Retrieved from https://www.cms.gov/files/document/reporttocongressmmco.pdf.

[5] ATI Advisory & Better Medicare Alliance. (2021). *Dual Eligible Beneficiaries Receive Better Access to Care and Cost Protections When Enrolled in Medicare Advantage*. Retrieved from https://atiadvisory.com/dual-eligible-beneficiaries-receive-better-access-to-care-and-cost-protections-when-enrolled-in-medicare-advantage/.

[6] Ibid.

[7] Hinton, E., & Stolyar, L. (2021). *Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)*. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/.

[8] Centers for Medicare & Medicaid Services. (2022). *Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs [CMS-4192-F]*. Retrieved from https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[9] RAISE Family Caregiving Advisory Council. (2021). *Recognize, Assist, Include, Support, & Engage (RAISE) Family Caregivers Act Initial Report to Congress*. Retrieved from https://acl.gov/sites/default/files/RAISE-InitialReportToCongress2021_Final.pdf.

A member's race/ethnicity, gender, and cultural and linguistic background influence the types of supports that will work best for them. Research indicates that Black, Indigenous, and People of Color (BIPOC) and individuals with limited English proficiency, often experience lower quality of health care and have poorer health outcomes.[11] The changing diversity in plan enrollment highlights the importance of health plans understanding and addressing the cultural and linguistic needs of the populations they serve.[12] Health plans can consider hiring and recruiting multilingual staff and providers with different cultural and social perspectives, as well as educating all staff on the diversity of their members, to facilitate culturally and linguistically inclusive services that are respectful of and responsive to member needs and preferences. Additionally, health plans can develop a language access plan, outlining steps to reduce disparities between individuals for whom English is not their first language and native English speakers in access to services. Understanding and addressing an individual's person-centered service plan will also help health plans ensure they are addressing the cultural and linguistic needs of each individual.

Understand the Local Provider Environment

Health plans benefit from understanding the local provider environment, as it can greatly affect enrollee access to care. Providers are less likely to accept new Medicaid patients than new patients insured by other payers.[13] In 2017, Kaiser Family Foundation (KFF) surveyed Medicaid managed care plans on strategies to address provider network issues. Plans reported the use of strategies, such as direct outreach to providers, financial incentives, automatic assignment of members to Primary Care Providers (PCPs), and prompt payment policies. Plans also reported on challenges in the recruitment of specialty providers versus recruiting primary care providers to their networks.[14] In June 2021, CMS announced plans to introduce a series of technical assistance toolkits (e.g., behavioral health access, strategies for ensuring provider network adequacy) to assist states in complying with various managed care standards and regulations. Additionally, in response to the COVID-19 pandemic, states were provided new options and flexibilities under existing managed care rules to direct/bolster payments to Medicaid providers and to preserve access to care for enrollees.[15]

Person-Centered Planning

Person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community.[10] Person centered planning aims to preserve member autonomy, while engaging natural supports in helping to determine LTSS needs. A key component of person-centered planning is understanding an individual's cultural, racial, and ethnic identity to best inform their care needs and plans. Additionally, consider the role of an individual's natural supports (e.g., family members, informal caregivers) as well as the mental and physical availability of these supports.

Create a Person-Centered Service Plan

[10] Administration for Community Living (2022). *Person Centered Planning.* Retrieved from https://acl.gov/programs/consumer-control/person-centered-planning#:~:text=Person%2Dcentered%20planning%20(PCP),person%20who%20receives%20the%20support.

[11] Agency for Healthcare Research and Quality. (2019). *Planning Culturally and Linguistically Appropriate Services*. Retrieved from https://www.ahrq.gov/ncepcr/tools/cultural-competence/planclas.html.

[12]Ibid.

[13] Hinton, E., Rudowitz, R., Stolyar, L., & Singer, N. (2018). *Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care*. Retrieved from https://www.kff.org/report-section/medicaid-managed-care-plans-and-access-to-care-provider-networks-and-access-to-care/.

[14] Ibid.

[15] Kaiser Family Foundation (2020). *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic.* Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/.

States with HCBS are required to develop individualized, person-centered service plans with participants in addition to their overall care plans. The role of the health plan in the individualized planning process will vary depending on the state and the timeline for service planning. Health plans will want to ensure clear documentation of the state's planning process and the plan's role.

- **Resources.** There are several person-centered planning processes. The National Center on Advancing Person-Centered Practices and Systems (NCAPPS) provides technical assistance to states, tribes, and territories in implementing person-centered thinking, planning, and practices and published A National Environmental Scan of Foundational Resources and Approaches to be used as a resource to inform states' person-centered processes. Additionally, the University of Minnesota Institute on Community Integration provides a manual for person-centered planning facilitators, which combines content from several different programs.

Review your State's Functional Assessment Tool and Requirements

It is important for health plans and states to have an approved protocol clearly describing responsibilities, timeframes, and reporting requirements for assessments in health plan contract terms. The number of members that require assessment may vary based on the enrollment policies in each state. Many states require a functional assessment for Medicaid enrollees who need HCBS. Depending on your state, the functional assessment may be completed by the state, a third-party, or the health plan. In other cases, health plans may be required to complete a comprehensive health assessment while another party completes each member's functional assessment. If the functional assessment is conducted outside the health plan, health plan staff will often have access to the results. For a brief overview of the types of functional assessment processes states use, see an overview from The SCAN Foundation.

- **Assessment of social determinants of health**. Research indicates that addressing SDOH is vital for improving health outcomes and reducing health disparities.[16] To address these factors, some states require MCOs to conduct assessments and connect members to social supports as part of their MCO contract.[17] As of July 2019, 24 states require MCOs to assess members for potential unmet social needs and help them address those needs.[18] Additionally, federal and state governments are exploring a requirement that plans serving dually eligible populations include SDOH in their health risk assessments.
- **Remind members of reassessment requirements.** While reassessment will most likely be performed by the same entity that determines initial functional eligibility, health plans have an active role in reminding members of upcoming reassessment periods. The timing of reassessments will vary depending on the guidelines of the state (e.g., every six months or one year after initial enrollment). Assessment can impact the eligibility of members. Health plans can work with their state to inform members about reassessment processes and deadlines. This will help ensure that members do not experience a gap in Medicaid coverage and needed services.

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[16] Hinton, E., & Stolyar, L. (2021). *Medicaid Authorities and Options to Address Social Determinants of Health (SDOH)*. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh/.

[17] Manatt, Phelps & Phillips, LLP. (2021). *Medicaid's Role in Addressing Social Determinants of Health*. Retrieved from https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html.

[18] Ibid.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/. The list of resources in this guide is not exhaustive. Please submit feedback to RIC@lewin.com.